

## Outpatient wound care provided to an older person (Opinion 20HDC01688)

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1. The Health and Disability Commissioner (HDC) received a complaint from Mrs A via referral from the Nationwide Health and Disability Advocacy Service relating to the care provided to her mother, Mrs B, by Health New Zealand|Te Whatu Ora between 16 Month1<sup>1</sup> and 23 Month2 2020. This report focuses on the outpatient wound management by district nurses, and communication between the healthcare providers.

### Summary of events

2. On 14 Month1 2020 Mrs B<sup>2</sup> (aged 72 years at the time of events) presented to a medical centre with a leg wound (sustained on 3 Month1 2020) that was not healing. Mrs B was reviewed by nurse practitioner (NP) C.
3. At this appointment, Mrs B reported reduced appetite, nausea, headaches, fever, and tiredness. NP C recorded Mrs B's temperature<sup>3</sup> and that the wound was infected, with a crusted thick scab. A wound swab was taken, the wound was debrided,<sup>4</sup> and oral antibiotics (flucloxacillin) were prescribed. On 15 Month1 2020 NP C referred Mrs B to the Health NZ Community Nursing Service. The results of the wound swab showed '[h]eavy growth of *Staphylococcus aureus*'.<sup>5</sup>
4. On 16 Month1 2020 Mrs B began outpatient treatment for her wound through a wound clinic. During the initial assessment, it was noted that the wound had no obvious signs of infection, and that Mrs B was on antibiotics. The wound was dressed using an antimicrobial dressing product.<sup>6</sup> A wound assessment form was partly completed,<sup>7</sup> with the wound being ticked as a 'skin tear' with no factors affecting healing recognised. It was deemed that the wound would take approximately six weeks to heal, and Mrs B was booked for wound care twice a week.
5. On 20 Month1 2020 Mrs B presented to a public hospital's Emergency Department (ED) with diarrhoea, which was thought to be a side effect of the flucloxacillin. Mrs B was prescribed

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<sup>1</sup> Months are referred to as Month1 to Month3 to protect privacy.

<sup>2</sup> Mrs B had a history of serum lupus erythematosus (SLE), an autoimmune disorder.

<sup>3</sup> Clinical notes show that no other observations (ie, blood pressure, pulse rate, respiratory rate, or oxygen saturation) were taken.

<sup>4</sup> The clinical notes state: 'Cleaned with warm tap water, skin prep, solosite [wound gel] and ulcer dressing.'

<sup>5</sup> The results were received on 16 Month1 2020 and noted that *Staphylococcus aureus* is susceptible to flucloxacillin (an antibiotic).

<sup>6</sup> A wound dressing used to help to reduce the risk of infection. Clinical notes show that on each visit to the wound clinic, Mrs B's wound was dressed with an antimicrobial dressing.

<sup>7</sup> This was the only wound assessment form completed.

loperamide.<sup>8</sup> Following the ED presentation, Mrs B attended the wound clinic, where her wound was cleaned and redressed and reported as unchanged. A Health NZ Adverse Event Review (AER), dated 14 April 2021, noted that Mrs B advised the district nurse that 'she had stopped her antibiotics due to experiencing a reaction'; however, the ED doctor recalled that Mrs B was close to completing the course and therefore did not stop the antibiotics.<sup>9</sup>

6. Between 23 Month1 and 13 Month2 2020 Mrs B attended the wound clinic seven times to have her dressing changed. At each visit, the district nurses handwrote their findings on a wound chart, including a description of the wound, the amount and type of exudate,<sup>10</sup> and any care plan changes. Health NZ acknowledged that these notes were limited, and that overall, the clinical documentation should have been completed to a higher standard.
7. While some improvement in the wound was noted on 30 Month1 and 3 Month2 2020, between 7 and 13 Month2 2020 increased exudate was noted, although there was no mention of deterioration. On 17 Month2 2020 a district nurse noted mild oedema<sup>11</sup> and warmth to the wound, and that Mrs B was experiencing pain at night. The nurse believed that Mrs B had developed an arterial ulcer<sup>12</sup> and referred her to wound clinical nurse specialist (CNS) D.
8. During this time, the nurses did not communicate with the GP about further investigation for infection. Health NZ acknowledged that the wound was not healing 'as per a normal wound trajectory' and that ideally this would have resulted in an earlier referral to the CNS, but it stated that the wound was not assessed as deteriorating until 17 Month2 2020. Health NZ acknowledged that at this time, possible infection could have been considered, and the GP advised.
9. CNS D reviewed Mrs B on 19 Month2 2020 and noted moderate erythema (redness of the skin), but no clear signs of infection. Mrs B reported having increased symptoms of SLE and general unwellness, although she denied having any nausea, diarrhoea, fever, or tachycardia. CNS D considered that the slow healing was likely due to a flare-up of SLE, and she was concerned that Mrs B might be developing a low-grade infection. The wound was measured and mapped, but Mrs B's wound was too painful for a Doppler assessment<sup>13</sup> to be carried out.
10. CNS D advised Mrs B to see her GP to discuss her pain management (and for the Doppler assessment to be completed) and to get blood tests to confirm a possible infection.<sup>14</sup> Mrs B reported that she would be seeing the GP that day, although it is unclear whether this

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<sup>8</sup> A medication used to treat diarrhoea.

<sup>9</sup> Clinical notes provide no further information as to whether the ED doctor advised Mrs B to continue taking the antibiotics or whether the district nurse enquired about this further.

<sup>10</sup> Fluid produced by the body in response to tissue damage and wound healing.

<sup>11</sup> Build-up of fluid in the body, which causes swelling of the affected tissue.

<sup>12</sup> Skin breakdown due to inadequate blood supply to the affected area.

<sup>13</sup> An ultrasound test to measure blood flow. Health NZ stated that a Doppler assessment is required to confirm a diagnosis and complete a long-term treatment plan.

<sup>14</sup> A follow-up appointment with CNS D was scheduled for 24 Month2 2020, and a Doppler assessment was booked for 4 Month3 2020.

appointment had been booked. CNS D told HDC that she cannot recall whether she called Mrs B's GP and spoke to someone or left a message. However, she stated that it was her usual practice to do so, particularly if blood tests were needed for a specific reason, and she acknowledged that she should have recorded whether she made the call, and the information given. Health NZ stated that documentation and communication systems at the time of these events 'did not support staff in maintaining a robust care pathway'. Health NZ acknowledged that it would have been appropriate for the district nursing service to contact Mrs B's GP to ensure that CNS D's advice was actioned.

11. On 22 Month2 2020 Mrs B called the district nursing service reporting increased pain in her wound. She was referred to RN E,<sup>15</sup> who at that time was visiting patients in the community. RN E assessed Mrs B at her house immediately following another patient visit.<sup>16</sup> The wound was cleaned and dressed, and no signs of infection were noted. RN E recorded: '[N]il heat/redness/odour.' Mrs B reported having reduced appetite, some rigors,<sup>17</sup> and diarrhoea, but she denied any shortness of breath, urinary symptoms, confusion, dizziness, headaches, nausea, or vomiting.
12. RN E considered that Mrs B had either a possible stomach bug or a flare-up of her SLE. RN E was concerned about Mrs B and advised her to go to ED. RN E told HDC that Mrs B declined attending the ED as she had been there recently with diarrhoea, and she would be seeing her GP midweek for blood tests. Mrs B was advised to keep up her fluids and to attend the wound clinic on Monday 24 Month2 2020. RN E said that Mrs B agreed to call an ambulance if she became more unwell.
13. Clinical notes show that a full set of observations were not taken or recorded during this visit, although RN E checked Mrs B's pulse manually and documented 'non-tachy<sup>18</sup>'. RN E acknowledged that she should have recorded the pulse rate as a number and that Mrs B's blood pressure (BP) and objective temperature should have been taken.<sup>19</sup> Health NZ's AER noted that a full set of observations should be completed whenever there are concerns about the wellbeing of a patient, and that district nursing vehicles routinely carry the required equipment to check a patient's BP and temperature. However, Health NZ stated that in this case, recording a full set of manual observations would not have made a difference to the advice given to Mrs B (to attend ED for further assessment) or the outcome.
14. Sadly, Mrs B passed away shortly afterwards from cellulitis. I offer my sincere condolences to Mrs B's family.

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<sup>15</sup> RN E is no longer employed by Health NZ.

<sup>16</sup> Health NZ told HDC that district nurses cannot access electronic copies of clinical notes on their visits, so RN E was required to undertake an acute assessment of Mrs B without access to her clinical notes.

<sup>17</sup> Severe chills with violent or exaggerated shivering.

<sup>18</sup> No tachycardia (fast heart rate).

<sup>19</sup> RN E told HDC that she took a subjective temperature by touching Mrs B's forehead, which did not feel hot.

### Health NZ's Adverse Event Review

15. Health NZ's AER found that a lack of access to a shared electronic patient information system was an issue and concluded that had this been in place, 'it would have aided a coordinated approach to [Mrs B's] care across the services'. Health NZ's AER found that improvements in documentation, communication, connectivity, and collaboration were required. In particular, a digital patient information system that could be accessed by GPs, the district nursing service, and ED staff was needed.

### Scope of Investigation

16. The following issues arising from the complaint were investigated:
- *Whether [Health New Zealand|Te Whatu Ora] provided [Mrs B] with an appropriate standard of care between 16 [Month1] 2020 and 23 [Month2] 2020 (inclusive).*
  - *Whether [CNS D] provided [Mrs B] with an appropriate standard of care on 19 Month2 2020.*

### Responses to provisional opinion

#### *Mrs A*

17. Mrs A was given the opportunity to respond to the provisional opinion. Mrs A stated that the provisional opinion was 'not easy to read', as had many things been done differently, this would have 'changed the outcome, and most importantly, resulted in [Mrs B] not suffering on with a wound that ended up not healing, making her unwell and in pain, and ultimately, leading to her death'. Mrs A told HDC that she is pleased that she 'followed her instincts' and asked questions about Mrs B's care and hopes that 'the changes brought about by [her mother's] death will help other patients in the future'.

#### *NP C*

18. NP C was given the opportunity to respond to the provisional opinion; however, she had no further comments to make.

#### *Health NZ*

19. Health NZ was given the opportunity to respond to the provisional opinion; however, it had no further comments to make.

#### *CNS D*

20. CNS D was given the opportunity to respond to the provisional opinion. Her comments have been integrated under the 'changes made' section.

#### *RN E*

21. RN E was given the opportunity to respond to the provisional opinion. RN E stated that she now works in theatre and no longer sees patients outside of theatre, where changes in their wellbeing would require her to take a full set of observations. In addition, her current manager provided a letter of support confirming her competence and capabilities as a nurse.

*Medical centre*

22. The medical centre was given the opportunity to respond to the provisional opinion. The medical centre acknowledged the ‘profound loss of a beloved family member’ and stated that while this experience has been deeply challenging, it has also provided valuable lessons that will guide efforts to improve patient care and prevent similar incidents in the future. The medical centre’s other comments have been integrated elsewhere in this report where relevant.

**Independent clinical advice**

23. Independent clinical advice was received from NP Jenny Phillips (Appendix A). NP Phillips identified the following deficiencies in the care provided to Mrs B, primarily pertaining to documentation and communication:
- NP Phillips was mildly critical of NP C’s standard of documentation, noting that no BP was recorded, which she advised would have been expected for a patient with a possible infection, and clinical notes could have been more accurate around wound debridement.
  - NP Phillips was critical of the standard of the district nurses’ documentation — in particular that wound assessment forms were not completed regularly. Furthermore, she advised that the failure to escalate care to either the GP or CNS when signs of infection increased (prior to the referral to CNS D) was a moderate departure from the standard of care.
  - NP Phillips was mildly critical that CNS D failed to ensure that Mrs B followed up with her GP, given the flare-up of her SLE and potential infection.
  - NP Phillips was moderately critical that a full set of observations, including pulse rate, BP, and temperature, was not completed and documented as part of RN E’s assessment, given Mrs B’s symptoms.

**My decision**

24. This case demonstrates the importance of communication and collaboration among providers, as well as accurate documentation, to ensure quality and continuity of services. Having reviewed all the information, and accepting the advice of my clinical advisor, I have made the following decisions:

*Health NZ — breach*

25. At the outset, I agree with the finding in Health NZ’s AER that had the GP, ED, and district nurses had access to a shared electronic patient information system, the care provided to Mrs B could have included a more integrated approach across the services. Nonetheless, as acknowledged by Health NZ, clinical documentation was not maintained to a high standard by the district nurses, and there was a lack of communication with Mrs B’s GP to support continuity of care.
26. For failing to complete clinical documentation between 16 Month1 and 23 Month2 2020 to an appropriate standard and to escalate care to either the GP or CNS when the wound was

not healing and signs of infection increased (prior to the referral to CNS D on 17 Month2 2020), I find Health NZ in breach of Right 4(1)<sup>20</sup> of the Code of Health and Disability Services Consumers' Rights (the Code).

27. However, I acknowledge the significant improvements in documentation and communication made by Health NZ (discussed further under 'changes made'), which I note will assist all providers in delivering a higher standard of care. I consider these to be appropriate remedial actions.

*RN E — adverse comment*

28. I am critical that RN E failed to complete and document a full set of observations as part of her assessment on 22 Month2 2020, given Mrs B's symptoms. I acknowledge the finding in Health NZ's AER that this would not have changed the advice given to Mrs B, or the unfortunate outcome of this case. However, Health NZ also noted that a full set of observations should be completed whenever there are concerns about the wellbeing of a patient (as in this case), and that district nursing vehicles routinely carry the required equipment to undertake these observations. I consider that RN E should have completed a full set of observations for Mrs B.

*CNS D — educational comment*

29. I have considered whether CNS D provided Mrs B with an appropriate standard of care. While I am not critical of the care CNS D provided, there is a learning opportunity in relation to her follow-up of the GP review. I acknowledge that Mrs B told CNS D that she would be seeing her GP later in the day on 19 Month2 2020. However, CNS D did not follow up this to ensure that the appointment took place. This should have occurred, particularly given the concern about possible infection and that confirmation of this, as well as the Doppler assessment, were dependent on the GP review. Furthermore, while I acknowledge CNS D's submission that it is her usual practice to contact the GP, by her own admission this was not documented.
30. However, I note that communication systems at this time were not conducive to a collaborative environment, and I acknowledge that the introduction of 'Note to GP' (discussed further under 'changes made') will improve communication with GPs. I remind CNS D to ensure that she documents all actions taken in relation to patient care, including when GP contact is made.

*NP C — educational comment*

31. I consider that NP C's documentation should have been completed to a higher standard, and therefore I remind her to ensure that all relevant observations (BP in particular) are completed and recorded, and that clinical notes are documented thoroughly and accurately.

**Changes made**

32. As a result of Health NZ's AER, the following changes have been made:

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<sup>20</sup> Right 4(1) of the Code states: 'Every consumer has the right to have services provided with reasonable care and skill.'

- ‘Note to GP’ has been established within the Concerto ICT system (digital portal) for district nurses to be able to email GPs directly and escalate any concerns. This, combined with district nurses’ clinical notes being included within the electronic record, will increase transparency and ease of communication between the services.
  - All patient files now contain an observation chart, which includes a flowchart of what to do if the patient is unwell.
  - Patient observations are now routinely recorded on admission to the service and whenever a nurse is concerned about a patient.
  - An escalation pathway and flowchart regarding what to do after hours if a patient is unwell has been introduced.
  - A new admission form has been developed, which incorporates ACC documentation and more detail regarding assessment and monitoring.
  - Wound management care plans have been reformatted to be more prescriptive in terms of interventions such as Doppler assessment and CNS referral dates. CNS D stated that the care plans must be completed at each district nurse assessment and include mapping measuring of the wound and fortnightly photographs of wounds to track wound progress.
  - Health NZ has now acquired a toe pressure machine for use in situations where a Doppler assessment is not possible. CNS D stated that this machine makes a similar assessment as the Doppler (although not to the same standard) but is less invasive and allows an assessment of the wound to be conducted when the patient is in pain.
  - Wound charts have been amended to allow for more detailed notes to be written legibly on each visit by the district nurse.
  - A Community Wound Dressing policy and procedure document is being created and will be implemented shortly.
  - An audit of all vehicles has been completed to ensure that all have the right equipment for recording patient observations.
33. CNS D stated that after being new to the role in Month2 2020, in terms of furthering her own education, she has completed a Post Graduate Diploma<sup>21</sup> and achieved an ‘expert’ grade portfolio. She has also become a New Zealand Delegate for both the New Zealand Wound Care Society and the Tissue Viability Team. CNS D has also been working actively with various people within Health NZ to change processes, improve documentation, and provide education to the district nurses to improve the services provided to wound-care patients.
34. The medical centre told HDC that on 24 May 2022 it hosted a wound-care session with the clinical team facilitated by CNS D, which covered wound assessment and dressing,

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<sup>21</sup> Incorporating papers highly relevant to this complaint, including Pathophysiology, Pharmacology, Clinical Assessment and Decision Making, Advanced Wound Management, and Conservative Sharp Wound Debridement.

documentation, and referral pathways. These internal training sessions will be scheduled regularly.

35. In response to the provisional opinion, the medical centre told HDC that it has implemented several measures to enhance wound-care training and internal learning opportunities, as well as the following further changes:
- Increased the frequency of external wound-care training sessions. A training session was held in February 2025, and another training session was scheduled for March 2025.
  - Informal wound cases are discussed regularly by 2–3 staff members and serve as a valuable opportunity to share knowledge and improve patient care.
  - The Infection Prevention Control Officer regularly attends external training sessions to stay updated on best practices and to ensure that protocols are current and efficient.
  - The medical centre’s ‘Wound Policy’ was reviewed at the end of 2024 and, by adhering to this policy, it can ‘significantly enhance the quality of care provided and ensure better outcomes for patients’.

### Recommendations

36. I recommend that Health NZ:
- a) Provide a written apology to Mrs B’s family for the deficiencies outlined in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B’s family.
  - b) Provide HDC with an update on the establishment of a digital patient information system, within one month of the date of this report.
  - c) Provide HDC with a copy of the new Community Wound Dressing policy and procedure, within one month of the date of this report.

### Follow-up actions

37. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, will be sent to the Nursing Council of New Zealand.
38. A full copy of this report will be sent to the Coroner.
39. A copy of this report with details identifying the parties removed, except Health NZ and the clinical advisor on this case, will be sent to the New Zealand Nursing Organisation, the Ministry of Health | Manatū Hauora, the New Zealand Wound Care Society Incorporated, the Health Quality & Safety Commission | Te Tāhū Hauora, and HealthCERT and will be placed on the Health and Disability Commissioner website, [www.hdc.org.nz](http://www.hdc.org.nz), for educational purposes.

Rose Wall

**Deputy Health and Disability Commissioner**

## Appendix A: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from NP Jenny Phillips on 19 June 2021:

### **'Report on [Mrs B]**

#### **Case C20HDC01688**

This report covers the care of [Mrs B] relating to the wound management of the client. It will cover the questions posed by the HDC around case management. At the beginning of this report, I am highlighting my immediate thought that this patient may have had a vasculitic ulcer based on her Serum Lupus Erythematosus (SLE), however, throughout her care no one seems to have considered this and this will be discussed further in Number 5.

HDC requested comments on the following:

#### *1. The assessment and treatment of the wound by NP [C] on 14 [Month1] 2020*

The assessment by the Nurse Practitioner (NP) included an holistic assessment which included temperature as the patient reported feeling feverish, but temperature was normal. No BP was recorded which I would expect to be routine for a patient with a possible infection. A diagnosis of wound infection was made and Flucloxacillin prescribed which is in line with BPAC (2017) recommendations around wound/skin infections. The patient had denied being allergic to penicillin.

The wound was reported as having a crusted thick scab, but there was no official wound assessment — unfortunately this is a common failing in General Practice where most of them do not have even basic wound assessment forms and rely on subjective assessments. The standard should be that every wound has an assessment using TIME (Rice, 2015) which is a simple mnemonic, however, the reality is that this does not happen through the majority of General Practices.

Treatment of the wound stated that it was debrided — this required more information — there are 6 methods of debridement varying from sharp removal of dead tissue through to autolytic debridement, which I assume the NP was trying to achieve when she applied the Solosite gel, as this should soften and remove the thick scab. However, this is not best recommended practice for an infected wound (IWII, 2016).

#### *What is the standard of care/accepted practice?*

The patient was reviewed and commenced on antibiotic therapy in line with BPAC (2017) recommendations which is an accepted standard of care.

No formal wound assessment was carried out, however, this is unfortunately normal practice in the majority of General Practices, and would not have impacted on the care she was given at the time as she was then referred directly to the DN service. Her notes could have been more accurate around wound debridement as it is unclear what this

entailed, or if it was just the application of the Solosite gel — this was a mild breach of a standard of care.

*Recommendations for improvements:*

Ideally General Practice to introduce a TIME assessment tool, but the reality is that this may not occur. Encourage NP to be more specific in her notes around what treatment she is actually giving to the wound itself, but her commencement of antibiotics and referral to DN were absolutely the correct actions.

*2. Assessment and treatment of [Mrs B's] wound by the District Nurse (DN) from 16 [Month2] 2020.*

The DN assessment completed on admission to the service on 16 [Month1] 2020 was partly completed. The wound was ticked as being a skin tear, but given the time it had been present, and the size of it, this was an inaccurate assessment of a leg wound/ulcer. There were no factors affecting healing ticked — I would have ticked, anti-inflammatory medication, lower leg wound/ulcer and added SLE under the “other” category. There was a lower leg assessment form in the documentation which states it is to be completed by the CNS wound — there is no reason a DN cannot fill in a large amount of this form to help point towards the cause of lower leg wounds not healing.

The DHB wound assessment form was completed but this is the only time it was filled in, wound assessment should be completed and recorded regularly, as it is the main driver of the care plan. “Wound assessment should be repeated at any dressing change, or if there is a clinical indication” (Phillips et al. 2020, p5). The DNs did try to write in their findings under the changes to care plan section of their documentation, but there is little room here for this whereas the wound assessment form with ticks against all aspects of the wound assessment would have been much clearer to follow. Changes of dressings were difficult to follow including why they were used, but the DN did start using anti-microbial dressings which are recommended for localised infection (IWII, 2016). It is also noted that they did not observe signs of infection on the initial assessment, possibly because the antibiotics had started to work.

Other observations as the wound dressings continued include:

23 [Month2] 2020 Wound deteriorated different antimicrobial dressing — this is where if the actual wound assessment chart was filled in it would be easy to see what the deterioration was.

27 [Month2] 2020 — Sutherland stocking applied. This is a compression system, and although she had oedema, no assessment had been carried out to check if her arterial circulation was satisfactory (AWMA & NZWCS, 2011). It is noted that she did not often seem to wear it and stated that it hurt which would suggest her vascular circulation may have been compromised.

The wound then continued not to heal and in fact to get worse, with increase in exudate, warmth, oedema and pain at night until a referral was made to the wound Clinical Nurse Specialist (CNS) on the 17 [Month2]. During this time no communication

was made to the GP for further investigation around infection, despite the fact that the signs above are all overt signs of local infection (IWII, 2016).

The CNS notes are squashed in with the general DN notes which is unusual, normally a CNS will write specific and comprehensive notes and although she could not complete an ABPI on that day because of the patient's increasing pain, she did not complete any of the CNS leg ulcer assessment form which I would have expected her to do and the wound assessment chart. She did note that the patient had a flare up of her SLE and was not feeling great — I would have hoped that a Wound CNS would then be aware that the patient might have a vasculitic ulcer and contact the GP for further tests, and also to report that the patient has a flare up of her SLE. She did advise [Mrs B] to see her GP for blood tests, and noted that she was due to see her GP for pain relief, but it is not clear when this was to be, and given the increase in pain this should have been a priority to follow up. Vasculitic ulcers are known for being very painful, and also an increase in pain can be an indicator of an increase in infection in a wound. An appointment for the ABPI was made for [Month3] 4<sup>th</sup>.

*What is the standard of care/accepted practice?*

For DNs the accepted standard of practice would be wound assessment forms to be completed as necessary (when wound changes) and every 1–2 weeks depending on local policy. This was not done. This is a departure from normal accepted practice at DN level, but will also depend on what their local wound policy describes as normal practice for wound assessment. The failure of the DN to contact either the CNS earlier or the GP when signs of infection increased is concerning and a severe departure from the standard of care, deviating from code 4:1 of the RN competencies (Nursing Council NZ, 2007) which state that an RN should “collaborate and participate with members of the health care team to facilitate and co-ordinate care.”

For the CNS a complete assessment on the initial visit to her (excluding the ABPI) would be considered a normal standard of practice — this is why there are CNS clinics and appointments in the majority of DHBs. Also, evidence of this assessment and decisions would be well documented. This is a severe departure from accepted standard of care at this level. Although she asked the patient to see her GP the CNS should have followed this up to ensure that action was taken, particularly as her SLE had flared up and there were also signs of wound infection. This is a moderate breach of care under 4:1 as above.

*Recommendations for improvement to help prevent similar occurrences in the future.*

Review of DHB wound policy to see whether it defines when assessment should be done and also signs of local and systemic infection and actions to be taken (IWII, 2016) which should include when to contact CNS and/or GP. Further education to staff around completing wound assessment forms and amendment to wound charts to allow for far more detailed notes to be legibly written for each visit.

Specific documents for CNS wound to fill in — I have seen these in several other DHBs, a stamp stating **CNS wound** and then comprehensive notes written in the medical/nursing notes which are also easily seen by anyone wanting to read them.

Wound CNS in NZ are usually given to nurses with an interest and who have managed wounds in their practice for a period of time (not specified anywhere), thus the standard is variable. Providing the CNS with study time and possible costs to pursue further education at conferences — NZWCS has a conference alternate years — or on line or in person will help them to improve their practice and knowledge in this ever changing speciality.

*3. Whether communication with [Mrs B] and action taken following her phone call on the 21 [Month2] was appropriate.*

Although [Mrs B] called the GP practice on [Month2] 21st it is reported that she only stated she had an oozy wound, not that she felt unwell in any way. She was booked for a review and Practice Nurse dressing — although the notes do not state when this was to be. In her review note the Practice Nurse ... states that the patient probably did not mention she was feeling unwell or this would have been noted. She also stated that if the patient had said how unwell she felt or if the District Nurses had called, she would have fitted the patient into acute nurse template for a same day surgery visit. With the information the patient apparently gave the Practice Nurse her action was appropriate.

*4. Assessment and treatment of [Mrs B's] wound on 22nd [Month2] 2020 and follow up action.*

[Mrs B] phoned the DN on 22nd [Month2] reporting increasing pain in her wound. A referral was made to a DN who was already on the road and she visited as soon as she had seen the patient she was visiting. For this reason, she did not have [Mrs B's] notes with her. The district nurses make retrospective notes when they return to base following their visits but it appears this was not done on this occasion as the notes were verbal and transcribed — see ACC verbal contacts form. The wound was reported as having no signs of infection — despite the fact that on the 19th it was noted that there was surrounding erythema by the CNS — which was put down to the SLE. The patient was complaining of decreased appetite, rigors and diarrhoea with a query that this was because of her SLE flare up; it does not seem to have been considered that this could have been because of infection of local or systemic. It was suggested that she go to ED but the patient did not want to do this because of a previous experience and long wait. Patient was recorded as “non-tacky”, so presumably her pulse was taken, but it would have been more professional to record that actual pulse rate; but there was no record of a temperature or BP. She was advised to keep fluids up and attend clinic on ... The antimicrobial wound dressing was changed on the wound.

Given her description of how she was feeling, at a minimum I would have expected the DN to record the patient's temperature and BP, and if the DN do not carry equipment to do this, then they should or the DN should have requested that someone visit from base to do this. Additionally, the patient should have been encouraged far more to attend ED — or if they have an emergency GP clinic in [the region] — to go there. If the

patient continued to refuse, the daughter could have been contacted to try to reason with her mother and be informed of her condition.

*What is the standard of care, accepted practice?*

For all of these questions in this review (with the exception of the NP), there has been a breach of accepted standard of care according to Competency 2.2 in the Nursing Council competencies, which states that “undertake a comprehensive and accurate nursing assessment of health consumers in a variety of settings” but none as much as this last one. I am sure the DN was rushed having an extra patient into her workload, but given the symptoms baseline observations would be a basic standard requirement and not completing that is a severe departure from a standard of care. There has also been a breach of competency 4:1 requiring collaboration with the health care team.

*Recommendations for improvement to help prevent similar occurrences in the future.*

Extra visit time or electronics or recorders to record notes at the time — this could be either additional 5 minutes time per visit to record in written notes, or tablets or Dictaphones to make notes relating to patient visits. Both of these cost money, but in this day and age, and given how many visits a DN can do in one run this should be considered.

A clear policy of who should be contacted — particularly at weekends — where there are concerns for a patient. If there was a manager on call for the community they should have been notified, or if there was an emergency GP clinic and also the daughter.

The equipment (if not in all their bags) for DN to take BP and temperature and a guideline to do this for any patient complaining of concerning symptoms.

*5. Any other matters in the case which depart from the standards of care?*

The standards of care have been covered in questions 1–4 however, SLE was probably a major factor in some of the problems with [Mrs B]. The fact that she had a flare up was not recognised as significant by any of the nurses or medical staff who saw her and nor was there recognition that her non-healing ulcers could have been vasculitic. Shanmugam et al (2017) recognised that while a rare complication of SLE, leg ulceration is well recognised and comprised of vasculitic ulcers, often combined with venous insufficiency. Recommended treatment is for multi-disciplinary management also involving vascular investigations and the rheumatologist. Oakley (2016) recognises that leg ulcers with an inflammatory histology can be difficult to diagnose and treat, however, had this option been considered earlier it may have had an impact on all of her symptoms and her wound.

Additionally, the assumption in ED that she was allergic to Flucloxacillin seems strange given that diarrhoea is a common side effect (BPAC, 2017) and the fact that she was never started on another course of antibiotics seems to be an oversight.

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June 19 2021

**Note:** There is one mention in the documentation provided by HDC that the patient had cellulitis from streptococcus pyogenes. Nowhere can I find any mention of this bacteria, all the available results and reports identify staphylococcus aureus as the main invading bacteria.

**References:**

AWMA and NZWCS (2011) *Australian and NZ clinical Practice Guideline for Prevention and Management of Venous Leg Ulcers*. New Zealand Wound Care Society [www.nzwcs.org.nz](http://www.nzwcs.org.nz)

BPAC (2017) Antibiotics: choices for common infections, [bpac.org.nz/antibiotics/guide.aspx](http://bpac.org.nz/antibiotics/guide.aspx)

International Wound Infection Institute (2016) *Wound Infection in Clinical Practice* Wounds International

Nursing Council of New Zealand (2007) *Competencies for Registered Nurses*. Nursing Council NZ

Oakley A., (2016) *Differential diagnosis of leg ulcer*, Feb DermNet NZ

Phillips. J., Gruys. C., Dagger. G. 2020 *Advisory document for wound bed preparation in NZ*. New Zealand Wound Care Society [www.nzwcs.org.nz](http://www.nzwcs.org.nz)

Rice. J. (2015) *Advanced wound assessment*. NZWCS Conference

Victoria K. Shanmugam, MD, MRCP,1 Divya Angra, BA, Hamza Rahimi, BS, and Sean McNish, MS1 (2017) Vasculitic and autoimmune wounds *J Vasc Surg Venous lymphat disord Mar: 5 (2) 280–292'*

The following further advice was obtained from NP Phillips on 14 October 2023:

**'Further review of 20HDC01688**

Te Whatu Ora ... report:

Page 1: regarding the possibility of a vasculitic ulcer, this should always be a consideration for a patient with auto-immune disease. Regarding the coroner's report, cellulitis is a spreading infection which can be fatal, but occurs from any sort of injury or type of ulcer, it does not occur without injury. See also under page 8.

Regarding systems failures versus individual, this report was prepared in the same way that previous reports have been done and if this is to change then HDC need to notify those of us preparing reports around this. Several system failures were identified or suggested and it is good to see that a complete overhaul of communication and documentation has taken place.

Page 4: DN documentation: As stated in the original report while some of the lack of documentation was a departure from normal care, that also would depend on the local policies. Te Whatu Ora, have described how the documentation has now been amended.

Contact with GP or CNS: Can be downgraded to a moderate departure from the standard of care as there was deterioration of the wound prior to the referral to the CNS.

Page 5: I accept that patients have the right to refuse referral, additionally did not realise that the daughter was not a named point of contact for the patient and should have checked on this for the report. I note that the brother was contacted. Standard of care relating to this can be downgraded to mild — relating to lack of full observations only.

Page 6: can be downgraded to a moderate deviation from a standard of care — whether or not a full set of manual observations would have made a difference to the outcome or not is not relevant, nurses completing full documentation as part of an assessment where there is a concern for a patient is.

Page 8–9: There seems to be some misunderstanding around doppler assessment by Te Whatu Ora — a doppler assessment is an indicator of arterial insufficiency which could indicate an arterial ulcer, or shows if it is safe to apply compression for a venous ulcer; it does not diagnose venous ulcers and is of no use in recognising vasculitic ulcers which are hard to diagnose. This is why they should always be in the back of mind of any practitioner dealing with patient with auto-immune diseases. DermNet state the following relating to diagnosis of vasculitic (inflammatory) ulcers.

*Inflammatory causes of leg ulceration can be difficult to diagnose and difficult to treat.*

*If considering an inflammatory cause of leg ulceration, diagnostic tests may involve:*

*Deep skin biopsy of ulcer edge for histology, fungal/mycobacterial culture, direct Immunofluorescence*

*CBC, CRP/ESR, c/p-ANCA, metabolic panel, protein electrophoresis and immunoglobulins, coagulation studies, antiphospholipid antibody, cryoglobulins, cryofibrinogen, ANA, complement, hepatitis B/C serology, blood cultures Urinalysis (Oakley, 2016).*

Additionally venous and arterial investigations are needed to exclude those as the type of ulcer.

Page 10: On review this can be downgraded so that the assessment is not a departure from care and the failure to follow up around GP visit is a mild departure. It is noted that with the improvement in communication this will be an easier process in the future.

CNS Wound:

Reviewed recommendations: Given the documentation in use at the time the recommendation around the standard of care relating to assessment and decision making can be removed and it is good to see that the documentation has been totally renewed now. The breach of care around the GP referral (4:1) can be downgraded to mild and again it is noted that the CNS is changing her practice around this. Also see page 10 in Te Whatu Ora report.

It was really good to read this report and see the changes made in documentation which would assist everyone to see more clearly progress of patients' wounds. [CNS D] was a relatively new CNS at the time of the report, but has been doing all she can to further her knowledge and support wound management practice in New Zealand.

Jenny Phillips

14 October 2023

Reference: Oakley. A. (2016) Differential diagnosis of leg ulcers. DermNet.'