Bupa Care Services New Zealand Limited
Nurse Practitioner, NP C

A Report by the

Deputy Health and Disability Commissioner

(Case 20HDC00038)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman when she was residing at a rest home managed by Bupa Care Services New Zealand Limited (Bupa) in 2019. The woman was admitted to the rest home and was noted to have a chronic ulcer on her right lower leg and a stage three pressure injury on her right heel. The report discusses the management of the woman's wounds by the rest home and a nurse practitioner prior to her being admitted to hospital with extensive ulceration on both her lower legs.

Findings

2. The Deputy Commissioner found that the nurse practitioner breached Right 4(1) of the Code for failing to assess, document and escalate the woman's wounds appropriately.

3. The Deputy Commissioner found that Bupa breached Right 4(5) of the Code for failing to ensure that a referral to a wound clinic was followed up and by failing to escalate the woman's wounds to specialist services. The Deputy Commissioner considered that these omissions highlighted a failure to ensure continuity of care.

Recommendations

4. The Deputy Commissioner recommended that Bupa provide a written apology to the woman's whānau, consider amending its policies to provide clarification, consider making the Ko Awatea wound care management course compulsory for all registered nurses employed by Bupa in parts of the country where the course is available, update its wound evaluation chart to include space for more detail, and update HDC on whether it has continued to run courses in conjunction with a company that makes wound care products.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother, Mrs A, by Bupa Care Services New Zealand Limited. The following issues were identified for investigation:

- *Whether Bupa Care Services New Zealand Limited provided Mrs A with an appropriate standard of care between 21 Month1[1] and 25 Month3 2019 (inclusive).*
- *Whether Nurse Practitioner (NP) C provided Mrs A with an appropriate standard of care between 22 Month1 and 23 Month3 2019 (inclusive).*

6. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

[1] Relevant months are referred to as Months 1–4 to protect privacy.

7. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
NP C	Provider/nurse practitioner
Group provider/care home	

8. Further information was received from a medical centre and Te Whatu Ora.

9. Independent clinical advice was obtained from NP Julie Betts (Appendix A) and registered nurse (RN) Karole Hogarth (Appendix C).

Information gathered during investigation

Background

Introduction

10. On 8 January 2020, this Office received a complaint from Ms B about the care provided to her late mother, Mrs A (aged in her eighties at the time of these events), by a Bupa Care Services New Zealand Limited care home. Ms B was particularly concerned about her mother's wound management in 2019, prior to her mother's admission to a public hospital (Te Whatu Ora).

11. Mrs A had several comorbidities, including insulin-dependent diabetes.[2] Her medical history also included dementia and ischaemic heart disease. On 21 Month1, Mrs A was transferred to the care home from another facility. On arrival, it was noted that Mrs A had a chronic ulcer[3] on her right lower leg and a stage three pressure injury[4] on her right heel.

12. On 23 Month3, Mrs A was admitted to the public hospital with a worsening cough and necrotic wounds.[5] On admission, Mrs A was found to have extensive ulceration[6] on both her lower legs. She was treated[7] for pneumonia[8] and infected necrotic ulceration of her legs. On 7 Month4, Mrs A was discharged from hospital to another care home (also owned and operated by Bupa Care Services New Zealand Limited). Sadly, Mrs A died on 16 Month4.

NP C

13. Over the two-month period she was residing at the care home, Mrs A's wound management was overseen by NP C, who was employed by a medical centre that had a contract with Bupa

[2] Type 1 diabetes (a chronic condition in which the pancreas produces little or no insulin).
[3] Areas on the legs, ankles, or feet where underlying tissue damage or trauma has caused skin loss, leaving a raw wound that takes a long time to heal.
[4] Stage 3 pressure injuries extend through the skin into deeper tissue and fat but do not reach muscle, tendon, or bone.
[5] Wounds containing dead tissue.
[6] Open sores that are slow to heal.
[7] With intravenous and oral antibiotics.
[8] An infection of the lungs.

to provide services for the care home. The scope of practice for a nurse practitioner is defined by the Nursing Council of New Zealand[9] as:

> 'Mātanga tapuhi nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practise beyond the level of a registered nurse. Mātanga tapuhi nurse practitioners work autonomously and in collaborative teams with other health professionals to promote health, prevent disease, and provide access and population health outcomes for a specific patient group or community.'

14. NP C was assigned to work at the care home, at times rotating with general practitioners (GPs). NP C qualified as a nurse practitioner in January 2019. She told HDC that at the time of these events she was still working under supervision.[10] She stated:

> 'I registered as a Nurse Practitioner that year. The recommendation from [the Nursing Council of New Zealand] is for ongoing supervision for the first 12 months after qualifying as clinicians navigate from novice and consolidate practice. It is a vulnerable time for newly qualified NPs.'

15. The nurse practitioner position description (as provided by the medical centre) states that nurse practitioner consultative appointments can include wound assessment, which would require the nurse practitioner to '[a]ssess wound, clinical picture, decide on course of treatment and management including medication. Refer as appropriate to other nursing or medical services.'

Admission to the care home — 21 Month1

16. Mrs A was transferred to the care home on 21 Month1 from another facility. On admission, it was noted that Mrs A had a chronic ulcer on her right lower leg and a stage three pressure injury on her right heel. The care home advised that Mrs A's wound had been re-dressed prior to her transfer to the care home, and, because she said that she was tired, 'a decision was made that these dressings would be removed the following day and the wounds fully assessed'. The care home stated that consistent with Bupa processes and HealthCERT[11] requirements, a section 31(5)[12] notification was made to the Ministry of Health to advise it of the stage three pressure injury.

[9] https://www.nursingcouncil.org.nz/public/nursing/scopes_of_practice/nurse_practitioner/ncnz/nursing-section/nurse_practitioner.aspx.

[10] To register in the nurse practitioner scope of practice (among other requirements) a nurse must go through a minimum of 300 hours' clinical supervision (see: https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/nurse-practitioners-new-zealand). However, this is not a requirement following registration unless the nurse practitioner is changing their scope of practice (specialty).

[11] HealthCERT (Ministry of Health) is responsible for ensuring that hospitals, rest homes, residential disability care facilities and fertility providers provide safe and reasonable levels of service for consumers, as required under the Health and Disability Services (Safety) Act 2001.

[12] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about any health and safety risk to residents, or a situation that puts (or could potentially put) the health and safety of people at risk. Currently, HealthCERT requires aged residential care

22–28 Month1

17. On 22 Month1, Mrs A's wounds were redressed by a registered nurse, and a pressure injury short-term care plan was commenced for management of her right heel pressure injury.

18. Mrs A was also assessed by NP C, who documented that both wounds (the chronic ulcer and the stage three pressure injury) had been redressed that day. NP C discussed the wounds with the charge nurse (in relation to pain management) and documented that Mrs A had not complained of pain during the dressing change. No other concerns relating to the wounds were documented but following the discussion between NP C and the charge nurse, on 28 Month1 NP C made a referral to a wound care specialist via an ACC community nursing referral (which subsequently was declined).

19. NP C documented Mrs A's management as including 'wound management'. However, she did not record whether she viewed the wounds herself, and she did not document Mrs A's wounds on Mrs A's 'problem list'. NP C could not recall why she did not do so. She told HDC:

> '[Mrs A] arrived with the chronic wounds from the previous facility, and I should have recorded that on her problem list … I did not see the wounds on her arrival to the facility. I should have classified it myself and recorded it.'

20. On 23 Month1, an initial wound assessment and plan was completed for the stage three pressure injury on Mrs A's right heel. The care home told HDC that from 23 Month1, wound assessment and evaluation documentation was maintained 'as planned'.

21. On 26 Month1, an initial referral for advice about the management of Mrs A's pressure injury and the chronic ulcer on her right lower leg was sent to the wound clinic, accompanied by photographs of the wounds. The clinical nurse specialist from the service responded to the request on 27 Month1 and recommended several interventions[13] and advised that care home staff should send further photographs in two weeks' time (or earlier) if they were concerned. The clinical nurse specialist also advised care home staff that the photographs sent were of poor quality, and asked staff to provide images of better quality. However, no further photographs were sent to the wound clinic. A summary of the wound care provided by the care home to Mrs A indicates that NP C viewed the wounds on 28 Month1. However, there is no documentation of this review by NP C in Mrs A's clinical record.

22. In relation to why NP C made a referral to ACC on 28 Month1 (two days after the referral to the wound clinic and one day following receipt of the advice from the Clinic on 27 Month1), NP C told HDC:

> '[W]hat I recall is the nurse specialist was not available, and so [I] referred for further support, an effort to access all available resources, from ACC for hands on support and

providers, hospices, and maternity services to report all pressure injuries at stage 3 and above on a separate form.

[13] Including an acetic soak daily, dressing with Hydrosorb gel or IntraSite gel and Cuticerin, and a soft bandage and crêpe bandage toe to knee.

assessment, as it was re-iterated that her wounds could be classified under an ACC code and worth to try them again.'

23. NP C said that she does not have any memory of response details from the clinical nurse specialist at Te Whatu Ora.

Month2

24. NP C reviewed Mrs A on 4 Month2, as she had been experiencing a burning sensation in her right leg on mobilisation. NP C documented that the wounds were to be 'review[ed] as necessary', but it is unclear from the documentation whether NP C reviewed the wounds in person.

25. NP C told HDC: 'My only conclusion is if it wasn't recorded then I may not have seen [the wounds].' She explained that as she was a junior nurse practitioner at the time, she would not have known to undertake standard examinations such as palpating pedal pulses or identifying arterial flow. NP C stated: 'I was not of the practice or of the knowledge base of examining for these or managing appropriately chronic wounds.'

26. On 23 Month2, Mrs A fell and sustained a skin tear to her left leg. An initial wound assessment plan was commenced, and the wound was documented as being 3cm in length and 5cm in width. However, a clinical entry in the nursing notes of 24 Month2 documented that the skin tear 'look[ed] like an old wound'. Between 24 Month2 and 8 Month3, the progress of the wound was documented as per the table below. The documentation of the progress of the wound did not include the pattern of wound healing.

Date	Size	Appearance of wound bed L) leg
	3cm (L) x 5cm (w)	100% granulating
	3cm (L) x 5cm (w)	90% granulating, 10% sloughy (yellow)
	3cm (L) x 5cm (w)	20% granulating, 80% necrotic
	7cm (L) x 5cm (w)	100% granulating

27. The care home told HDC that the skin tear 'was the precursor to a chronic ulcer formation on Mrs A's left lower leg and the wound care products were updated accordingly'.

Month3

28. On 15 Month3, Mrs A was assessed by NP C for a chesty cough that had been present for two days. NP C documented that she also reviewed Mrs A's wounds 'via pictures'. She noted: 'Step up pain relief. Wounds getting bigger. Send urgent referral to surgical team.'

29. NP C told HDC that as the wounds were worsening and she was not sure what to do next, she discussed Mrs A's care with one of the GPs at the medical centre. NP C said that following the discussion, she telephoned the surgical registrar at the public hospital to discuss whether Mrs A could be sent in for review as an acute admission. NP C said that she was advised to send an 'e-referral' and was told that it would be triaged (as opposed to sending Mrs A in as an acute admission). NP C sent the referral on 18 Month3. She said that

the delay occurred because she was not able to send the referral from the care home and had to wait until she was next at the medical centre.

30. On 23 Month3, NP C reviewed Mrs A because of her worsening cough. NP C documented that Mrs A had been referred to the surgical team at the public hospital for necrotic wounds on 18 Month3.

31. Later on 23 Month3 Mrs A was admitted to hospital for a chest X-ray. She was found to have extensive ulceration of both lower legs and she was treated for pneumonia and infected ulceration of her legs.

Subsequent events

32. On 7 Month4, Mrs A was discharged from hospital to another care home (also owned and operated by Bupa Care Services New Zealand Limited).

33. Sadly, on 16 Month4, Mrs A passed away.

Further information

Care home

Wound management

34. The care home provided HDC with a copy of its 'Wounds — Management of' policy that was in place at the time of these events (relevant sections are included at Appendix C).

35. The care home said that nursing staff regularly discussed Mrs A's condition, care needs and wounds at the Clinical Review meetings. The care home stated:

> 'These are nurse-led meetings which focus on new residents or residents whose condition are causing a concern to ensure there is senior nurse clinical oversight and a coordinated delivery of care approach to manage the concern.'

36. The care home told HDC that it was not standard practice at the time of the events to document the direction of a wound's healing, but that it was making changes to its wound care instructions and will look to 'incorporate this into the revised documents'. The care home said that while healthcare provision is a team approach, the registered nurses providing wound care, as well as the clinical manager, are responsible for reviewing and evaluating wound healing and documenting accordingly. The care home stated that responsibility would be shared further when a referral for support to external wound care specialist services was made, with notes and advice expected to be communicated and documented appropriately as part of the clinical file to support staff in their wound care. The care home said that this may include practitioners such as wound nurse specialists, nurse practitioners, and GPs.

37. In relation to specialist input, the care home told HDC:

> 'Chronic wounds are often more difficult to heal due to the aetiology being more complex to determine and often multiple comorbidities which impact on the [body's] ability to renew damaged cells and tissue. Chronic wound ulcers (which are not the

> same as pressure ulcers, bedsore or pressure injuries and require different consideration and treatment), can often take more than several months (if ever) to heal.'

Staff training

38. The care home said that Bupa provides an extensive education programme for clinical staff, which includes wound care training. Staff are supported to complete online Ko Awatea Wound Management training, and in 2019 seven of the care home's registered nurses completed the training. The care home also told HDC that several other sessions, specifically around wound care, wound product selection, negative pressure wound healing, and pressure injury and prevention were facilitated by internal and external presenters to the care home clinical staff.

NP C

39. NP C told HDC that she would visit the care home on a rotating roster. The shifts would take place in the morning and would last three hours, during which she was expected to see 'as many [patients] as reasonably possible'. She told HDC:

> 'For concerns or issues raised outside of those hours, they are faxed to [the general practice] and addressed by who the GP/Nurse NP who is on that day, which would normally be at the end of the day, as the clinic templates will always be full, with little room to do extra tasks, unless in our lunch breaks or at the end of the day. Urgent cases would be picked up by the practice nurse and brought to the attention of the GP or NP.'

40. NP C told HDC that she had little experience in chronic wound care, and her experience was largely in general practice and prison nursing. She said that she did not have formal training in gerontology besides the work she had done in general practice. NP C stated:

> 'Once I qualified as an NP, I was put into the Rest-home and Hospital immediately to [fulfil] the contractual obligations between Bupa and [the medical centre]. I was the on-call clinician 7 days a week, calls were taken any time of the day or night outside of office clinic hours. I did the on call on my own for the next two years.'

41. NP C said that in hindsight Mrs A needed to be seen by 'an experienced clinician, and not a novice NP that I was. I can't remember if she was or not.' NP C said that at the time she did not have the knowledge to identify that Mrs A's care required escalation to a senior clinician sooner. NP C stated:

> 'In the past four years my learning … has grown exponentially, what I know now, clinically and the physiological process, I would have done things much differently from the day of [Mrs A's] arrival.'

42. NP C said that she continues to grow her practice through professional development opportunities, peer reviews and professional networking. She stated:

> 'Although I haven't much needed to manage chronic wounds in the general practices I am working in, and rarely do they present, but I have a far better understanding of

> factors of wound healing, vascular factors, specialties to discuss with, timely referral, and am much more confident to speak to hospital specialists and advocating for my patients, a skill that has taken some time to acquire.'

Medical centre

43. The medical centre told HDC that NP C was employed by the medical centre in 2017 under the Nurse Practitioner Training Programme, for 40 hours per week. The medical centre provided HDC with a copy of a letter from the School of Nursing at NP C's education provider, outlining the 'supervisor responsibilities' for the supervision of nurse practitioners. The letter states that supervision is to occur for a minimum of 500 hours over two semesters. The medical centre said that NP C worked under supervision during her training period of one year (under the mentorship of the Clinical Director), prior to her sitting and passing her exams in January 2019, at which stage she registered as an independent clinician (prior to these events).

44. The medical centre told HDC that following registration, NP C continued to work two to three hours per week at the care home with other doctors, but that often NP C would cover the rest home side of the care home, while the doctor would consult on the hospital side. The medical centre advised that as part of formal review and professional development, NP C was supported by the practice in achieving her developmental needs, and she took part in a monthly peer review group and had a formal performance development meeting in which 'management discussed her excellent performance and enormous contribution to [the] practice'.

45. The medical centre also said that as part of NP C's orientation and ongoing training, she attended the care home with other GPs, and attended discussion/peer review group with other doctors. The medical centre stated: '[NP C] was continually updating and adding to her skills.' The medical centre also provided HDC with a copy of NP C's training records. The medical centre said that NP C had orientation to on-call, 'as the discussion happened during the day with other clinicians'. The medical centre stated: 'In fact, [NP C] was 3rd or 4th in line for on call and she was fully supported by other doctors as we were a cornerstone GP teaching practice.' The medical centre said that usually there were never very many after-hours calls due to the practice policy that if a resident was unwell, they would go to hospital directly, and the care home would let the medical centre know the next morning.

46. The medical centre told HDC that NP C never raised any concerns regarding her practice or any other matters pertaining to the care home. The medical centre stated:

> '[NP C] also liaised very effectively with other members of the multidisciplinary team such as Geriatricians[,] various other hospital consultants, psycho-geriatrics to discuss mental capacity, physios, [occupational therapists], dieticians etc. She did not hesitate to pick up the phone and ask for advice if it was required.'

47. The medical centre said that doctors at the practice were always available for comment, and there is 'a culture of regular peer review and case management discussion'. The medical

centre stated that there is also the ability for employees to send daily emails and photographs for comment and input from the wider clinical team.

Responses to provisional opinion

48. Ms B, NP C and the care home were given an opportunity to comment on relevant sections of the provisional report. Where appropriate, their comments have been incorporated into the body of this report.

Ms B

49. Ms B told HDC:

> 'Further to my comments on your letter, I would like to inform you that [another hospital] told my sister [the Enduring Power of Attorney] at the time that they were unaware of my mother's wounds prior to her admission and were totally horrified when they removed the bandages from Mum's legs. They took very graphic photos which I have attached just a few. They told my sister that these pressure sores were totally preventable with correct care. They also stated that this needs to be addresse[d] as this is the worst case they have seen with some wounds being so deep the tendons in the leg are visible.'

NP C

50. In response to the provisional opinion, NP C advised that she would like to provide an apology to Mrs A's whānau. This has been provided to HDC for forwarding. In addition, NP C advised that since March 2022 she has completed 129.3 hours of professional development and, of this, 39.3 hours have included further education on wound management, documentation, and escalation of care. NP C provided HDC with certificates of her completed courses.

Bupa

51. In response to the recommendation that it consider making the Ko Awatea wound care management course compulsory for all registered nurses, Bupa told HDC:

> 'Bupa has robust wound care management systems already in place including annual education, competency assessments, and an ongoing education plan in collaboration with [the wound care product company]. Individual care home teams access additional training and support that is available within their regions (Ko Awatea courses are not available nationally and can therefore not be a compulsory course for all registered nurses).'

52. Bupa accepted all other recommendations and said that it will 'commence work to complete these in due course'.

Opinion: NP C — breach

Wound assessment and management

22 Month1

53. NP C assessed Mrs A on 22 Month1 following her admission to the care home on 21 Month1. NP C did not view Mrs A's wounds during this assessment because the dressings had already been changed. However, NP C discussed the wounds with the charge nurse (in relation to pain) and documented that Mrs A experienced no pain during the dressing change. NP C recorded that Mrs A's management included 'wound management' but did not document the wounds in Mrs A's 'problem list'. However, following the discussion between NP C and the charge nurse, NP C referred Mrs A to a wound care specialist via an ACC community nursing referral on 28 Month1 (although subsequently this was declined).

54. NP C told HDC that it was an oversight that she did not document the wounds on Mrs A's problem list. She told HDC:

> '[Mrs A] arrived with the chronic wounds from the previous facility, and I should have recorded that on her problem list … I did not see the wounds on her arrival to the facility. I should have classified it myself and recorded.'

55. As part of my assessment of this complaint, I sought independent clinical advice from NP Julie Betts.

56. NP Betts advised that it is concerning that NP C did not document Mrs A's wounds on her problem list. NP Betts said that the chronic nature of the wounds would have had an impact on Mrs A's quality of life, and the failure to document this on her problem list could mean that they were overlooked at subsequent nursing reviews. In particular, NP Betts advised that when other clinicians involved in Mrs A's care went to have a quick review of the file, it would not immediately be clear that her wounds were a 'problem' alongside her other comorbidities, and therefore it would be difficult to 'connect the dots' between the two (her comorbidities and wounds). NP Betts advised that this failure constitutes a moderate departure from an accepted standard of care.

57. I agree with NP Betts. Clearly the problem list was a pivotal source of key information. In the context of care being provided in an aged residential care facility, where several different providers are involved in the provision of care, it is imperative that all relevant information is documented in a patient's clinical record to ensure continuity of care. Accordingly, I am critical that NP C failed to document the wounds in Mrs A's problem list.

58. NP Betts advised that it was acceptable for NP C not to have viewed the wounds on the initial assessment because the dressings had been changed recently, and to change the dressings again would have been arduous for both Mrs A and the nursing staff. However, NP Betts advised that it would have been appropriate for the wounds to be viewed either via digital image or at the next nurse practitioner consultation (in the next one to two weeks). NP Betts said that this was particularly relevant given that the conversation between

NP C and the charge nurse resulted in a request for specialist input via ACC on 28 Month1 (indicating that it was appreciated that the wounds required specialist input at that time).

59. I accept that it was appropriate for NP C not to have viewed Mrs A's wounds on admission, provided they were reviewed by digital image or at the next consultation within one to two weeks' time. However, I note that although the wound care summary provided to HDC by the care home indicates that Mrs A's wounds were viewed by NP C on 28 Month1, there is no documentation of this review in NP C's clinical notes.

4 Month2

60. On 4 Month2, NP C examined Mrs A because she had a burning pain in her right leg on mobilisation. However, NP C did not document whether she examined Mrs A's wounds or whether she discussed them with nursing staff.

61. NP C told HDC that she cannot recall whether she reviewed the wounds in person. She stated: 'My only conclusion is that if it wasn't recorded then I may not have seen [the wounds].' She said that she was reliant on nurses' observations and wound care plans because usually Mrs A's wound cares had been completed before she reviewed Mrs A.

62. With the evidence before me, I find it more likely than not that NP C did not review Mrs A's wounds in person on this occasion and did not discuss them with nursing staff.

63. NP Betts advised that in the event of increasing pain, standard practice would be for the wounds to be viewed physically to ascertain how extensive they were, whether a change in the wounds was contributing to the pain, and whether escalation to secondary services was warranted to assist with diagnosis and management. NP Betts said that in addition to viewing the wounds, the size of the wound, tissue type, exudate levels and peri-wound appearance should all be documented. NP Betts advised that at the very least, she would expect that nursing staff would have recorded the objective parameters of wound healing and that such assessment findings would be discussed with, and summarised by, the nurse practitioner (for example, wound improving, wound stable or wound worsening and the reasons why).

64. NP Betts advised that the failure to view the wounds and discuss assessment findings would constitute a severe departure from accepted practice. I agree. From the information available to me, including the lack of documentation, clearly none of the above occurred during NP C's review of Mrs A on 4 Month2. Accordingly, I accept NP Betts' advice and am very concerned about this omission by NP C.

65. NP Betts also advised that as Mrs A was a diabetic, any assessment regarding a complaint of increasing lower leg pain should include palpation of pedal pulses to aid in differential diagnoses, ascertain the contributing factors to the pain, and to identify whether any decreased arterial inflow exists or not. NP Betts said that if this did not occur, then she would consider the omission to be a severe departure from an accepted standard of care.

66. NP C told HDC that she would not have palpated Mrs A's pedal pulses or identified arterial flow, because she would not have known to do so at the time. NP C told HDC:

> 'I was not of the practice or of the knowledge base of examining for these or managing appropriately chronic wounds. I was a junior Nurse practitioner without the skills of chronic wound management.'

67. However, NP Betts advised that palpation of pedal pulses would be considered a standard part of a 'top-to-toe' assessment at the level of a nurse practitioner. She said that despite NP C being a junior nurse practitioner, it would be expected practice that she attempt to palpate pedal pulses. NP Betts advised that if NP C was unable to do so, or was not sure of the result of her examination, she should have sought 'input/discuss[ed] the case with her mentor colleagues and the outcome of this [should have been] documented'.

68. I agree. While acknowledging NP C's comments, I consider that as a trained health professional, at the very least it was within her scope to be able to conduct a standard 'top-to-toe' assessment. I also note that NP C's position description states that nurse practitioner consultative appointments can include wound assessment, which would require the nurse practitioner to '[a]ssess wound, clinical picture, decide on course of treatment and management including medication. Refer as appropriate to other nursing or medical services.'

69. Accordingly, I accept NP Betts' advice that the failure to assess the wounds adequately on this occasion constitutes a severe departure from accepted standards.

70. In addition, NP Betts advised:

> '[W]ith increasing symptomology of pain (noted by both NP and GP on 4th and 19th [Month2] respectively) I cannot help but think that escalation or discussion with DHB specialist services at either of these time points may have affected the outcome.'

71. I accept this advice, and I encourage NP C to reflect on NP Betts' comments in this regard.

Conclusion

72. NP C had a responsibility to provide Mrs A with an appropriate standard of care. I acknowledge that NP C was a junior nurse practitioner at the time of the events. However, in my view, it would be reasonable to expect that a clinician at the level of a nurse practitioner would be qualified and sufficiently knowledgeable to assess and document wounds adequately. If NP C considered this to be outside her area of expertise, then I would have expected her to escalate Mrs A's care appropriately to more experienced colleagues. Although I accept that NP C did do this at times, there were also times where she did not do so. In addition, I am concerned at NP C's failure to document Mrs A's wounds on her problem list, meaning that as time went on, clinicians involved in her care subsequently would not have been alerted to the wounds immediately as an ongoing concern.

73. As part of my assessment of the care provided by NP C to Mrs A, I sought NP Betts' advice on the adequacy of the training, support, and mentorship provided to NP C by the medical centre (her employer at the time of these events). NP Betts advised:

> 'I believe [the medical centre] have demonstrated that they provided appropriate support, training and mentorship to [NP C] during her employment, in relation to working as an NP in aged residential care … Additionally, [NP C] had formal review of her developmental needs during her novice year as an NP. It appears [NP C] was well supported during her internship and first year of practice as an NP in a collaborative model of practice.'

74. I also note that despite NP C's statement that she was a beginner nurse practitioner under supervision at the time of these events, she had in fact registered and completed her year of supervision (500 hours) prior to this. Therefore, I accept that the medical centre was not required to supervise NP C between Month1 and Month3. The medical centre also advised HDC that following registration, NP C was rostered on with a doctor to complete the rounds at the care home, but often NP C covered the care home side while the doctor consulted on the hospital side. In any event, I accept that it was reasonable for the medical centre to expect NP C to be competent to practise independently and to be responsible for her own practice.

75. Considering the above, I am satisfied that NP C was supported adequately as a junior nurse practitioner, and I accept that the departures from an appropriate standard of care (as outlined by NP Betts above) are attributable to NP C.

76. Accordingly, I find that NP C failed to provide Mrs A services with reasonable care and skill and breached Right 4(1)[14] of the Code of Health and Disability Services Consumers' Rights (the Code).

Review of wounds via images — other comment

77. On 15 Month3, NP C documented that she reviewed images of Mrs A's wounds (as opposed to viewing them in person).

78. NP Betts advised that using images to review wounds is not a consistently reliable method of wound review and does not replace the need for face-to-face review. She advised that this is due to the quality of the images being dependent on the skill of the person taking the image, and that the quality of the image can result in misrepresentation of the type of tissue in the wound and the severity/extent of the wound. NP Betts advised that usually images are used when distance or access is a problem between clinician and patient and/or if the wound is stable or healing. She said:

> '[T]he ability to record wounds digitally can provide a false sense of security leading to reduced frequency of face-to-face wound review, as taking an image can be left for nursing staff to send later which if forgotten or is an inaccurate image can lead to misinterpretation of the actual state of the wound.'

[14] Right 4(1) of the Code stipulates: 'Every consumer has the right to have services provided with reasonable care and skill.'

79. I agree. In this case, there were no accessibility factors to inhibit NP C's ability to view the wounds in person. In addition, the wounds were clearly not stable or healing, and by 15 Month3 were in fact getting worse.

80. Although NP Betts raised concerns about images being used in lieu of a face-to-face wound assessment, she did not consider it to be a departure from the accepted standard of care.

81. I accept this advice, but I encourage NP C to reflect on her practice in this regard.

Opinion: Care home — breach

Introduction

82. As a healthcare provider, Bupa (as the owner of the care home) is responsible for providing services in accordance with the Code. The care home had a duty to provide services to Mrs A with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate reasonable care.

83. My independent advisor, RN Karole Hogarth, was asked to provide clinical advice in relation to several aspects of the care that Mrs A received at the care home. RN Hogarth advised that Mrs A's wounds appear to have been dressed regularly with appropriate dressings as instructed and documented in the daily notes, and she did not identify any issues in the standard of the wound care provided to Mrs A by nursing staff at the care home. She also considered that the standard of daily hygiene cares and pain management was appropriate. Accordingly, I have focused on the standard of documentation within the care home and the timeliness and appropriateness of escalation of Mrs A's wound management.

Escalation to specialist

84. On 26 Month1, care home staff sent an initial referral for advice about the management of Mrs A's wounds to the wound clinic. The referral was accompanied by photographs of the wounds.

85. On 27 Month1, a clinical nurse specialist from the wound clinic responded to the request and recommended several interventions but advised that the photographs were of poor quality and asked the care home to provide images of a better quality. Staff at the care home were also advised to send a photograph of the wounds in two weeks' time (or earlier) 'if they were concerned'. However, no further images of the wounds were sent by the care home.

86. RN Hogarth advised that current protocols indicate that with monthly reassessment of wounds, there should be a noted 25% reduction in size and that the failure for a wound to heal within 12 weeks should warrant a referral to a specialist. Although the wounds were 'seen' by the wound specialist at the wound clinic, the photographs were of low quality. Despite this, staff at the care home did not follow up with photographs of better quality. In addition, the wound specialist advised that further photographs should be sent in two

weeks' time or earlier if staff were concerned, but again this was not followed up by staff at the care home.

87. The care home told HDC:

> 'Chronic wounds are often more difficult to heal due to the aetiology being more complex to determine and often multiple comorbidities which impact on the [body's] ability to renew damaged cells and tissue. Chronic wound ulcers (which are not the same as pressure ulcers, bedsore or pressure injuries and require different consideration and treatment), can often take more than several months (if ever) to heal.'

88. The care home told HDC that its staff followed procedures in place at the time of the events, in that they continued to review and provide wound care in consultation with the review, assessment and oversight prescribed by NP C. The care home said that further escalation would be expected to be considered upon discussion and agreement of the GP or nurse practitioner providing the oversight.

89. The care home said that healthcare provision is a team approach but that as registered health professionals, the registered nurses providing wound care, together with the clinical manager, have responsibility to review and evaluate wound healing and document accordingly. The care home said that responsibility would be shared further when a referral for support to external wound care specialist services was made, with notes and advice expected to be communicated and documented appropriately as part of the clinical file to support staff in their wound care. The care home said that this may include practitioners such as wound nurse specialists, nurse practitioners, and GPs.

90. RN Hogarth advised that the photographs taken by the hospital (on Mrs A's admission) on 25 Month3 showed advanced ulcer formation with the wounds appearing far larger than was indicated in the wound charts from the care home. RN Hogarth said that both Mrs A's legs had extensive involvement of the posterior aspect (the calf) with sloughy (yellow/white material in the wound bed, usually wet) and necrotic (dead tissue) patches. Further, she said that the rapid deterioration of the skin tear that occurred on 23 Month2 (over the four weeks until it was assessed by the hospital staff) also indicated that the capacity of staff at the care home had been reached in the management of Mrs A's wounds, and an earlier referral should have occurred. I agree.

91. In summary, RN Hogarth advised:

> 'Long standing ulcers are very difficult to treat especially when combined with long term conditions such as in [Mrs A's] case with her diabetes and poor nutrition. Healing can be delayed, and it can be very difficult to manage without intervention especially if they become infected. Recognising when a chronic wound/ulcer is beyond the scope of staff [is] essential for the outcome [of] the patient.'

92. RN Hogarth advised that the failure to escalate Mrs A's wounds appropriately represented a mild to moderate departure from accepted standards. RN Hogarth said that while it was a

mitigating factor that the wounds were referred to the wound clinic on 26 Month1 (indicating an understanding of what support would be needed for the management of the wounds), there was no evidence of follow-up occurring after the initial referral, and there was a gap of seven weeks until the next urgent referral on 15 Month3.

93. I agree with RN Hogarth's advice. Although I acknowledge the care home's comments that staff were guided by the clinical advice from NP C, I consider that some responsibility for this oversight lies with the care home, as it was nursing staff who were viewing the wounds on a regular basis (as stated by NP C).

94. In addition to the failure to escalate the care of Mrs A's wounds, RN Hogarth advised that there appeared to be some confusion within the care home about the process for escalating wounds to specialist services. I agree. While I note that the care home provided HDC with a copy of its policy related to the management of wounds (see Appendix C), I am not satisfied that the existence of this policy mitigates my concerns in this regard.

95. RN Hogarth advised that there did not appear to be an understanding of the process within the care home for referral to specialist wound care services, and that although the care home noted that chronic wounds may never heal, 'this assessment needs to be made by a wound care expert to address the ongoing need to reduce further deterioration, risk of infection and provide comfort'.

96. I agree. In my view, this lack of clarity is the responsibility of the care home. As outlined above, NP C advised that she was reliant on nurses' observations and wound care plans because usually Mrs A's wound cares had been completed before she reviewed Mrs A. The care home told HDC that its staff provided wound care in consultation with the review, assessment and oversight prescribed by NP C, and that further escalation would be expected to be considered upon discussion and agreement of the GP or nurse practitioner providing the oversight. Based on this information, a disconnect clearly existed between NP C and nursing staff at the care home, evidenced by the failure to escalate Mrs A's wound management to specialist services, particularly between 23 Month2 and 15 Month3.

97. Right 4(5) of the Code stipulates that every consumer has the right to co-operation among providers to ensure quality and continuity of services. In my view, by both failing to ensure that the referral to the wound clinic on 26 Month1 was followed up, and by failing to escalate Mrs A's wounds to specialist services (particularly between 23 Month2 and 15 Month3), the care home failed to ensure continuity of care to Mrs A. I consider this to be the responsibility of the care home, as its clinical staff had general oversight of Mrs A's wounds daily and should have recognised the seriousness of the situation that was evolving and escalated their concerns to NP C in a timely manner. I am concerned that they failed to do so, and I find that they breached Right 4(5) of the Code.

Documentation — adverse comment

98. On 23 Month2, Mrs A fell and suffered a skin tear on her left leg. An initial wound assessment plan was commenced, which documented that the wound was 3cm in length and 5cm in width and that risk factors for healing included that Mrs A was diabetic.

99. Ongoing documentation of the wound showed that between 24 Month2 and 8 Month3 it increased from 3cm in length to 7cm in length and that from 4 to 8 Month3 (a period of four days) it went from 20% granulating[15] and 80% necrotic, to 100%. However, the pattern of wound healing was not documented.

100. RN Hogarth advised that the above documented wound observations appear to be incorrect. She advised: 'I would assume that this is an error either of measuring, assessment or had been written about the wrong wound, it does not appear to have been followed up by the person who completed the chart.'

101. The care home told HDC that it cannot recall why there was an error in documentation in relation to the left leg tear, and accordingly it accepted RN Hogarth's advice in this regard. In relation to the documentation of the direction of a wound's healing, the care home told HDC that at the time of the events it was not standard practice to document the direction of a wound's healing, but it is making changes to its wound care instructions and will look to 'incorporate this into the revised documents'.

102. RN Hogarth advised that the ongoing documentation and the amount of detail in the clinical notes could have been improved to show the pattern of wound healing more clearly.

103. I accept RN Hogarth's advice. I also acknowledge the care home's comments that it will look to incorporate the above changes into its revised documents.

Changes made

NP C

104. NP C told HDC that she reflected at length on her care of Mrs A. NP C said that she has developed in her career over the last four years (see paragraphs 41–42) and is motivated to learn more about chronic wounds. She stated that she has enrolled in professional development opportunities, including a webinar about pressure injury care.

Care home

105. The care home told HDC that it made the following changes as a result of these events:

- All registered nurses completed refresher training on Bupa wound care assessment.
- All registered nurses (who had not already done so) would be supported to enrol in the Ko Awatea wound care training.
- All care staff were to attend a toolbox session(s) on wound care assessment and planning.
- An audit on skin assessment was completed for all residents admitted since 1 Month1.

[15] The appearance of red, bumpy tissue in the wound bed as the wound heals.

- In collaboration with specialist colleagues from the wound care product company, between September 2021 and February 2022 it created seven virtual education sessions on national wound care, which all staff were invited to attend. The sessions are readily available to all team members.
- In May 2022 three nurses completed training on 'Wound Care: Negative Pressure Wound Therapy', and currently three nurses are completing a course that includes wound healing, holistic wound assessment, T.I.M.E.[16] and product choice, with a further four nurses enrolled.

Recommendations

106. In my provisional opinion, I recommended that NP C provide a written apology to Ms B and her family for the failings identified in the report, and that she undergo further education on wound management, documentation, and escalation of care and provide HDC with evidence of that education. In response to the provisional opinion, NP C provided an apology to Ms B and her family, which has been forwarded. In addition, NP C provided HDC with evidence that she had completed 129.3 hours of professional development, of which 39.3 hours included further education on wound management, documentation, and escalation of care. Accordingly, I have no further recommendations for NP C.

107. I recommend that the care home:

a) Provide a written apology to Ms B and her family for the failings identified in this report. The apology is to be sent to HDC, for forwarding, within three weeks of the date of this report.

b) Consider amending its policies to include clarification on the following:

   i. When nurse practitioners/GPs should use digital images versus face-to-face review during consultations with residents regarding wounds or where wounds are a concern;

   ii. The requirement to document any discussions between nursing staff and nurse practitioners/GPs in relation to objective information about wound improvement or deterioration, including size, tissue type, exudate, peri-wound tissue integrity and pain;

   iii. The escalation and referral process of the management of chronic wounds, including when to refer (with objective parameters and/or healing times) and what services to contact. In addition, clarification on when referrals should be followed up with specialist services; and

   iv. The documentation of chronic wounds, particularly that photographs are to be of good quality and that the photographs are to be updated in the clinical notes

[16] A clinical decision support tool.

frequently, to ensure that the progression of the wound healing is monitored appropriately.

c) Report back to HDC on the above considerations within six months of the date of this report.

d) Consider making the Ko Awatea wound care management course compulsory for all registered nurses to whom it is available, and report back to HDC on the results of its consideration within six months of the date of this report. In addition, report back on the uptake of Bupa's wound care management education programme, and the wound care management competency assessments undertaken across all its facilities, within six months of the date of this report.

e) Update its wound evaluation chart to include space for more detail, including how the wound is progressing and a time frame within which to seek specialist advice and/or further intervention. Bupa is to report back to HDC on the progress of this recommendation within three months of the date of this report.

f) Update HDC, within three months of the date of this report, on whether Bupa has continued to run courses in conjunction with [the wound care product company].

Follow-up actions

108. A copy of this report with details identifying the parties removed, except Bupa Care Services New Zealand Limited and the advisors on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of NP C's name in covering correspondence.

109. A copy of this report with details identifying the parties removed, except Bupa Care Services New Zealand Limited and the advisors on this case, will be sent to HealthCERT (Ministry of Health), Te Whatu Ora|Health New Zealand, and Te Tāhū Hauora|Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from NP Julie Betts on 15 February 2021:

'I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am currently registered as a Nurse Practitioner with a specialty in wound care. I have a total of 40 plus years' nursing experience. The first seventeen years of my nursing career I was employed as a registered nurse working in both hospital and community practice settings. In 1997 I was employed into a specialist nursing role with a wound care focus. In 2003 I registered as a nurse practitioner and have continued in that position for the last seventeen years. As a nurse practitioner, the focus of my role is providing expert clinical advice and management of patients with complex wounds across primary and secondary services, both in delivering direct patient care and service development to support best practice and improve patient outcomes.

My professional qualifications include registration as a General and Obstetric Nurse and Nurse Practitioner. My academic qualifications include, Advanced Diploma of Nursing, Post Graduate Diploma in Health Science, Certificate of Proficiency (prescribing) and Master of Nursing.

Advice requested:
I have been asked to provide expert advice to the Health and Disability Commissioner regarding the nursing care provided by Nurse Practitioner (NP) [C] to [Mrs A] between 22nd [Month1] and the 29th of [Month3], in particular:

- Appropriateness/adequacy of the reviews completed on
  - 22nd [Month1]
  - 4th [Month2]
  - 15th [Month3]
  - 23rd [Month3]

- Appropriateness/adequacy of the wound care assessment/management
- The timeliness of escalation to GP/Specialist/hospital
- Any other matters that I consider warrant comment.

Information reviewed:
- Comments from [NP C].
- Clinical records from [the medical centre] covering the period from 22nd [Month1] to 29th [Month3] including images of [Mrs A's] wounds.
- [Hospital] discharge documentation dated 7th [Month4].

Subsequent information requested and reviewed:
- BUPA admission assessments booklet for [Mrs A] dated 21st [Month1].

Summary:
[Mrs A] was admitted to a rest home on 21st [Month1]. On her admission she was noted to have a chronic ulcer on her right lower leg and a stage 4 pressure injury on her right

heel. Her medical history included dementia, ischaemic heart disease, insulin dependent diabetes, hypertension and gastro-oesophageal reflux disease.

On the 23rd of [Month2], [Mrs A] fell and suffered a skin tear to her left leg.

On 23rd [Month3], [Mrs A] was admitted to hospital presenting with a productive cough, suspected LRTI and was discovered to have extensive necrotic ulceration of both calves.

Response to advice requested:

1. *Appropriateness/adequacy of the review completed by [NP C] on 22nd [Month1], including wound assessment and management.*

[NP C] examined [Mrs A] on her admission to the rest home on 22nd [Month1]. This examination included cardiac, respiratory, level of consciousness and vital sign assessments. While the wounds were not viewed (as the dressings had already been changed) a discussion was had between [NP C] and the charge nurse regarding the wounds in relation to pain with a comment that there was no pain voiced during dressing change. While no other concerns were noted about the wound the conversation between the charge nurse and [NP C] resulted in a referral to a wound care specialist for assistance with wound management. An ACC community nursing referral was sent to Healthcare New Zealand on 28th [Month1].

The problem list documented from this assessment included cognitive impairment, insulin dependent diabetes, gastro-oesophageal reflux disease, hypertension and ischaemic heart disease. The chronic ulcer and pressure injury were not identified on the problem list. The management plan from this assessment included wound management plan as per charge nurse, charting of meds and baseline bloods.

In this instance I believe [NP C's] assessment meets current standards of practice.

It would be acceptable not [to] view the wounds on admission particularly as the dressings had been done and it would be both arduous for the resident and nursing staff to repeat the process. Having said that, it would also be considered standard practice in the absence of viewing the wounds on admission, that the wounds would be viewed either by digital image or at the next NP/GP face to face opportunity within the next 1–2 weeks. This becomes more relevant considering the discussion about the wounds between [NP C] and the charge nurse, enough to seek specialist nursing input as highlighted in [NP C's] statement. This concern appeared to be centred around the wounds being necrotic and wound specialists having access to dressing materials suitable for necrotic wounds.

It is of concern to me that the wounds were not identified on [Mrs A's] problem list as the chronic nature of the wounds and the impact of that on [Mrs A's] quality of life would be a problem to her, particularly regarding pain and mobility. My concern about not identifying the chronic wounds/ulcers on [Mrs A's] problem list centres around the potential to overlook the problem on subsequent patient review as it would not be highlighted as a current problem.

2. *Appropriateness/adequacy of the review completed by [NP C] on 4th [Month2], including wound assessment and management.*

[NP C] examined [Mrs A] again on 4th [Month2] as she was complaining of pain in her right leg/ulcers. The pain was described as a burning sensation when she stood and walked. At the time of examination [Mrs A] was lying comfortably on her bed. Her vital signs (BP, pulse, resp, temp and O_2S) were unremarkable. There was no documentation that confirmed whether [NP C] examined the right lower leg ulcer/pressure injury or discussed this with nursing staff. The plan from this assessment was to increase [Mrs A's] pain medication and review, as necessary.

In this instance I believe [NP C's] assessment did not meet current standards of practice.

My reason for this is that [Mrs A] was a diabetic and as such any assessment regarding a complaint of increasing lower leg pain should include palpation of pedal pulses to aid differential diagnosis and contributing factors to the pain. While the symptom of the pain noted would normally signal neuropathy, identifying whether decreased arterial inflow exists or not, which could also be a contributory factor, would be considered standard practice.

In addition to this, it does not appear the wounds/ulcers were viewed which in this situation would also be considered a departure from current standards of practice. The reason for this is with increased lower leg pain in a person with diabetes it would be normal practice to view the wounds to ascertain how extensive they were, whether a change in the wounds was contributing to the pain and if so, whether escalation to secondary services was necessary to assist with diagnosis and management.

3. *Appropriateness/adequacy of the review completed by [NP C] on 15th [Month3], including wound assessment and management.*

[NP C] examined [Mrs A] again on 15th [Month3] as she had had a chesty cough for 2 days and was coughing through the night. Examination included cardiac and respiratory assessment and wound review from images presumably taken by the nursing staff. It was noted the wounds were getting bigger and more painful. Her vital signs (BP, pulse, resp, temp and O_2S) were unremarkable. Wound swabs were also taken at this time. The plan from this assessment was to prescribe antibiotics and additional pain relief for the wounds pre-dressing change, follow up the ACC referral, and send an urgent referral to the surgical team to review the wounds which was done on 18th [Month3].

In this instance I believe [NP C's] assessment meets current standards of practice.

While [NP C's] review of [Mrs A] was primarily due to the development of a chesty cough there were obvious problems with the wounds based on [NP C's] statement and clinical notes where she was asked to review images of the wounds and an increase in pain relief was prescribed pre-dressing change. I am assuming review of the wounds was highlighted by the nursing staff because the wounds were becoming more painful at dressing change.

[NP C's] examination and management of the chesty cough was appropriate. It was also appropriate she reviewed images of the wounds/ulcers and as a result she contacted the on call surgical registrar who advised referral to the surgical team. My only comment here is again, regarding checking pedal pulses as part of [NP C's] assessment, given [Mrs A's] pain was increasing. Information about the presence or absence of pedal pulses could have aided triage decision making on the part of the surgical team as to urgency of the referral.

4. *Appropriateness/adequacy of the review completed by [NP C] on 23rd [Month3], including wound assessment and management.*
[NP C] examined [Mrs A] again on 23rd [Month3] as her cough was worsening despite a course of antibiotics. She was lethargic and wound swabs taken on 15th [Month3] returned showing a heavy growth of staphylococcus aureus. It was noted the wounds were necrotic. Examination included respiratory assessment which identified crackles in the base of her lungs. She was drowsy but responsive. Her vital signs (BP, pulse, resp, temp and O_2S) were unremarkable. The plan from this assessment was to refer to hospital for chest x-ray.

In this instance I believe [NP C's] assessment meets current standards of practice.

[NP C's] examination and management of the worsening cough was appropriate as worsening symptoms in this situation would dictate the next step to be chest x-ray. It was also appropriate she reviewed [Mrs A's] wounds face to face as highlighted in her statement and clinical notes and arrange for admission to hospital for review of both a worsening chest and wounds.

Additional comments:
In reviewing this case there are other matters I feel require comment including:

- Wound review

While images were used to review the wounds in this case, it is not a consistently reliable method of wound review and does not replace face to face wound review in the first instance. This is due to the quality of images being dependent largely on the skill of the person taking the image which can affect reproduction of tissue colour and result in misrepresentation of the type of tissue in the wound and hence decision making about severity and extent of the wound. It is generally used as a mechanism when distance or access is a problem between clinician and patient, or the wound is stable/healing.

- Conversations/communication between facility nursing staff and NP

In reviewing this case I cannot help but feel a "disconnect" may exist between nursing staff and NP regarding communication as to the condition/progress of [Mrs A's] wounds. As I have not been party to nursing documentation, I am unable to qualify this but feel the severity of the wounds may not have been conveyed adequately to the NP. It is normal practice as an NP to rely on nursing staff to escalate concerns about progress or otherwise of a wound and put those patients on the NP/GP list for review. Unless

failure to heal or increasing size/worsening symptoms are highlighted by nursing staff it would be normal to assume the wounds are OK. Having said that, it is not just the responsibility of the nursing staff to regularly review complex wounds. As objective information/documentation regarding size of the wounds along with any plans for regular NP/GP wound review is lacking it would be easy in this situation to lose track of whether the patient is responding to the plan of care, and therefore the ability to escalate to speciality services in a timely manner.

- Timeliness of escalation to GP/specialist/hospital

In reviewing this case I believe that [NP C] in referring to an ACC provider for specialist nursing advice regarding management of the right lower leg wound was the first strategy in escalating the management of the wound to a service she felt equipped to help with wound management. Having said that, with increasing symptomology of pain (noted by both NP and GP on 4th and 19th [Month2] respectively) I cannot help but think that escalation or discussion with DHB specialist services at either of these time points may have affected the outcome.

- Specialist support for management of complex wounds in aged care facilities

In reviewing this case I am not sure the NP or facility nursing staff were aware of the process, or if one exists for accessing specialist advice/support regarding management of complex wounds. [NP C] referred to an ACC provider for what she believed was specialist advice, however that was declined, presumably as the wound on the right lower leg was not due to an accident. Several DHBs provide this type of support from a wound clinical nurse specialist. If this is available from the DHB then pathways for access may need to be clarified and if not, it may be something to consider.

Recommendations for improvement that may help to prevent a similar occurrence in the future:

- Development of processes that clarify when wounds are reviewed by NP/GP in the facility including guidelines for use of digital vs face to face review.
- Review communication/documentation between nursing staff and NP/GP clinical file in relation to objective information about wound improvement or deterioration including size, tissue type, exudate, peri-wound tissue integrity and pain being recorded in NP/GP notes.
- Clarify if DHB specialist nursing support is available to aged care facilities and if so, confirm referral process and implement within facility. If such support does not exist within the DHB then the DHB might like to consider this.

Yours sincerely,

Julie Betts RN, NP, MN (Hons), MCNA, MNZWCS. 15th February 2021’

The following clarification was received from NP Betts on 16 June 2021:

> 'Point 2, where I note that "There was no documentation that confirmed whether [NP C] examined the right lower leg ulcer/pressure injury or discussed this with nursing staff", I believe is either a moderate or severe departure from practice depending on whether the wounds were viewed/discussed and not documented or not viewed/discussed at all.
>
> In the event [NP C] did examine the right lower leg ulcer/pressure injury or discussed it with nursing staff but failed to document the examination or discussion with the nursing staff I would consider it a moderate departure from practice. In the event that [NP C] did not examine the right lower leg ulcer/pressure injury or discuss it with nursing staff I would consider it a severe departure from practice.
>
> Point 2, where I also noted that it appeared that the wounds/ulcers were not viewed, I believe is also either a moderate or severe departure from practice depending on whether the wounds were viewed but that action was not documented or not viewed at all.
>
> Again, in the event that [NP C] did examine the wounds/ulcers but failed to document the examination I would consider it a moderate departure from practice, and in the event that [NP C] did not examine the wounds/ulcers I would consider it a severe departure from practice.'

The following further advice was received from NP Betts on 10 [Month1] 2022:

> 'I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am currently registered as a Nurse Practitioner with a specialty in wound care. I have a total of 40 plus years' nursing experience. The first seventeen years of my nursing career I was employed as a registered nurse working in both hospital and community practice settings. In 1997 I was employed into a specialist nursing role with a wound care focus. In 2003 I registered as a nurse practitioner and have continued in that position for the last nineteen years. As a nurse practitioner, the focus of my role is providing expert clinical advice and management of patients with complex wounds across primary and secondary services, both in delivering direct patient care and service development to support best practice and improve patient outcomes.
>
> My professional qualifications include registration as a General and Obstetric Nurse and Nurse Practitioner. My academic qualifications include, Advanced Diploma of Nursing, Post Graduate Diploma in Health Science, Certificate of Proficiency (prescribing) and Master of Nursing.
>
> **Advice requested:**
> I have been asked to review [NP C's] response to my previous expert advice and advise the Health and Disability Commissioner whether the further information causes me to change or amend any of my previous advice in relation to the nursing care provided by [NP C] to [Mrs A] between 22nd [Month1] and the 29th of [Month3]. In particular:

The moderate or severe departure in relation to the review completed by [NP C] on 4 [Month2], including wound assessment documentation.

The moderate or severe departure for the appearance that [NP C] failed to view the wounds/ulcers on 4 [Month2] to ascertain how extensive they were, whether a change in wounds was contributing to pain and if so, whether escalation was necessary to assist with diagnosis and management.

My concerns around the use of images to review [Mrs A's] wounds through the virtual clinic, as this is "generally used as a mechanism when distance or access is a problem between clinic and patient, or the wound is stable/healing".

Information reviewed:
Copy of my previous advice dated 16 February 2021, and amendments dated 16 June 2021.

[NP C's] response dated 10 May 2022.

Summary:
[Mrs A] was admitted to a rest home on 21st [Month1]. On her admission she was noted to have a chronic ulcer on her right lower leg and a stage 4 pressure injury on her right heel. Her medical history included dementia, ischaemic heart disease, insulin dependent diabetes, hypertension and gastro-oesophageal reflux disease.

On the 23rd of [Month2], [Mrs A] fell and suffered a skin tear to her left leg.

On 23rd [Month3], [Mrs A] was admitted to hospital presenting with a productive cough, suspected LRTI and was discovered to have extensive necrotic ulceration of both calves.

Response to advice requested:

1. The moderate or severe departure (depending on whether the wounds were viewed/discussed and not documented or not viewed/discussed at all) in relation to the review completed by [NP C] on 4 [Month2], including wound assessment documentation.
Having read [NP C's] response leads me to change my previous advice with the conclusion that the departure from practice would be considered by myself and my peers as severe.

My reasons for this are that there was no wound assessment documented in [Mrs A's] clinical notes or recollection on the part of [NP C] that she assessed the wounds. [NP C] recalls discussing the wounds with nursing staff, but this appears to be related to requests for pain relief for dressing changes. It is not clear whether these discussions included review of any objective parameters of healing such as size, tissue type, exudate levels or peri-wound appearance.

[NP C] remembers being reliant on nurses' observations, wound care plans and reports as the wounds were dressed prior to medical rounds, so it would appear these were

reviewed and discussed at times during [Mrs A's] episode of care. What is not clear is whether the nurse's observations and findings were discussed in the review by [NP C] on 4 [Month2]. If the wounds were discussed there was no reference to the results of the nurse's observations in [NP C's] entries in [Mrs A's] clinical file.

It is considered standard practice for nursing staff to record objective parameters of healing as outlined above, and that such assessment findings be discussed with and summarised by the NP in the clinical file as wound improving, worsening or stable, and the reason why — for example wounds worsening — increased pain, size, exudate, or wounds improving — decreased size, exudate, pain.

It would also be considered standard practice that in the event of increased pain in the wounds/ulcers that either the wounds would be physically viewed by the assessor (in this case the NP), or as a minimum a summary of nursing staff observations (as exampled above) made in the clinical file to quantify if the reason for pain was related to wound deterioration or not.

The moderate or severe departure for the appearance that [NP C] failed to view the wounds/ulcers on 4 [Month2] to ascertain how extensive they were, whether a change in wounds was contributing to pain and if so, whether escalation was necessary to assist with diagnosis and management.
Having read [NP C's] response leads me to change my previous advice with the conclusion that the departure from practice would be considered by myself and my peers as severe.

My reasons for this are like my response in question one in that, there was no documented evidence that the wounds were reviewed, nor recollection by [NP C] that she reviewed the wounds either physically or by digital image. In her response [NP C] concludes that if she didn't document viewing the wounds then she may not have seen them. She also recalls digital images of the wounds being sent to the practice but the only documented record of this was related to the review on the 15 [Month3].

As the reason for review of [Mrs A] on 4 [Month2] was a complaint of increased pain in her ulcers/legs, and she had a history of diabetes it would be considered standard practice that assessment would include physical assessment of the wounds, quality of skin integrity and perfusion of the lower legs. The reason for this (as I stated in my previous advice) would be to quantify whether a change in the wounds was contributing to the pain and if so, whether escalation to secondary services was necessary to assist with diagnosis and management. [NP C] in her response states she would not have considered palpating pedal pulses nor had knowledge in chronic wounds that would stimulate her to do this. Palpation of pedal pulses would be considered a standard part of top to toe assessment at the level of an NP. Despite [NP C] being a beginning NP, it would be considered standard practice that she attempt to palpate pedal pulses and in the event that she couldn't or wasn't sure of her results she would seek input/discuss the case with her mentor colleagues and the outcome of this documented.

My concerns around the use of images to review [Mrs A's] wounds through the virtual clinic, as this is "generally used as a mechanism when distance or access is a problem between clinic and patient, or the wound is stable/healing".
My concerns around the use of digital images relate to their use as a substitute for face-to-face wound assessment/review. This practice on the surface appears ok but is reliant on good equipment, lighting and photography skills to produce an image that replicates the true appearance of the wound. Added to this, the ability to record wounds digitally can provide a false sense of security leading to reduced frequency of face-to-face wound review, as taking an image can be left for nursing staff to send later which if forgotten or is an inaccurate image can lead to misinterpretation of the actual state of the wound.

It is becoming more accepted as standard practice to use digital images to communicate improvements or deterioration in a wound to whoever may be "overseeing" the management of the wound/patient. This is more common in situations where distance is a challenge such as in community nursing settings (district nurses), rural practice settings (between GPs/specialist services) and in aged residential care. The challenge with using digital images as a means of recording wound progress is that few practice settings have standardised methods or guidelines regarding recording or documenting images which can lead to misrepresentation of the actual state of the wound. For example, the image being accompanied by objective wound data including date, location, size, tissue type, exudate and pain.

In the case of [Mrs A], I don't believe there was a departure from standard care in the use of digital images to record her wounds. In reviewing the case I could only see one recorded instance that digital images had been used to communicate the condition of the wound with the NP, which resulted in referral to specialty services. It may be that nursing staff were taking more frequent images of the wound (which is a reasonably common practice in residential care) but not communicating these formally to the NP. In this instance more regular use and review of digital images when reviewing this patient by the beside might have been helpful as it could have initiated earlier physical assessment of the wounds.

Additional comments:
In reviewing this case there is another matter I feel requires comment, that being:

Supervision of a beginning NP

[NP C] was in her first year of practice as an NP when she provided care to [Mrs A]. As such she would be considered a junior or beginning NP. Beginning practitioners need regular education/supervision relative to their practice area taking into consideration their needs for further knowledge and skill development to manage their expected caseload. I have some concerns about the expectations on her regarding her level of knowledge, skills and practice at that time to enable her to practise safely in an aged residential care environment.

[NP C] states in her response that once she registered as an NP she was expected to practise in the rest home/hospital despite not having the grounding in gerontology she felt was required to manage the complex, integrated needs of the elderly found in aged residential care. She was also expected to be on call seven days/week. Neither of these situations would be considered a reasonable expectation of an NP in their first year of practice. Additionally, I was unable to see any reference to supervisory support or mentorship for [NP C] during this time, which makes me wonder whether sufficient supervision was in place to meet her needs regarding further development and safety to practise.

Recommendations for improvement that may help to prevent a similar occurrence in the future:
Development of a framework for beginning NPs.

Any such framework should facilitate the development of NPs in their early years post-registration or in the event of working in a new scope of practice. The first two years of practice should include mentorship and the ability for regular case review including working alongside an NP/Medical mentor similar to the postgraduate 1&2 programme years in medicine.

Yours sincerely,

Julie Betts
RN, NP, MN (Hons), MNZWCS.

10th August 2022'

The following further advice was received from NP Betts on 1 May 2023:

'My opinion is that [NP C's] supervision/contracted hours would be the responsibility of her employer, in this case the general practice.

My reason for this is that as [NP C] was employed by the GP practice and as the practice had the contract with [the care home] then [NP C] was an employee of the GP practice when she provided care to residents of the facility. My understanding in this situation, based on health and safety legislation and what is considered normal practice in other similar areas, is that the employer is responsible for ensuring that employees (in this case [NP C]) work in an environment that is safe which includes working within scope and level of experience. While [NP C] would have a responsibility for signalling she was working outside her scope or level of experience and required clinical/professional supervision and what that might be, as a novice NP the onus would be on the employer to determine what support [NP C] required to develop clinically/professionally and provide a framework to facilitate that.'

Further clinical advice was received from NP Betts on 31 May 2023:

> 'My yes response is in relation to the adequacy of supervision/mentorship. My reasons for this are that from the response provided by [the medical centre], it appears that [NP C] during her training as an Intern NP and post training as a novice NP, was provided with mentorship (my assumption is this constituted clinical/professional supervision) by a clinical director of the practice. This included the opportunity for peer review, case discussion and clinical advice by email. While there was no reference as to the frequency of supervision it appears the facility for [NP C] to discuss complex cases existed within her work environment. One question I had in relation to this, is whether there was any formal review of developmental needs during [NP C's] novice year. I ask this because it didn't appear to be evident in the role description and while it is the responsibility of both the employer and the NP to address professional development/supervision, (clinical and career development) generally for a novice NP this would involve a formal review of developmental needs 3–6 monthly, which if in existence may have highlighted areas for development.
>
> My no response is in relation to [NP C's] work environment being within her scope and level of experience. My reasons for this are that it is not clear in the response from [the medical centre] that [NP C] had developed the knowledge base to work in residential aged care unsupervised as a novice NP. Additionally, the NP role description provided by [the medical centre] did not contain aged residential care, or on call specifics. This for me, has raised questions that may need clarification to understand entirely whether [NP C] had sufficient experience to work in aged residential care.'

Further clinical advice was received from NP Betts (via telephone call) on 12 June 2023.

Regarding NP C's failure to record Mrs A's wounds on her problem list, NP Betts advised in her initial expert advice: *It is of concern to me that the wounds were not identified on [Mrs A's] problem list as the chronic nature of the wounds and the impact of that on [Mrs A's] quality of life would be a problem to her, particularly regarding pain and mobility. My concern about not identifying the chronic wounds/ulcers on [Mrs A's] problem list centres around the potential to overlook the problem on subsequent patient review as it would not be highlighted as a current problem.*

I asked NP Betts to advise whether she considered this omission to represent a departure from an accepted standard of care, and if she did, to what degree was this a departure (ie mild, moderate, severe).

NP Betts advised that she had considered this and discussed it with colleagues, and it was her view that the failure to document [Mrs A's] wounds on her problem list was a moderate departure from accepted practice. She said that while [Mrs A's] wounds were documented in the medical summary admission form, as time went by this form would get 'lost' in the file and when clinicians went to have a quick review of the file, it would not immediately be clear that the wounds were a 'problem' alongside Mrs A's other comorbidities and therefore it would be difficult to 'connect the dots' between her comorbidities and the wounds.

NP Betts also mentioned that as the clinical records were not electronic, important information such as the 'problem list' is not highlighted as readily and is easier to get lost or overlooked. Upgrading to an electronic system could also be a useful recommendation for the future.

The following further clinical advice was received from NP Betts on 14 June 2023:

> 'I've read through the further information provided by [the medical centre] and believe they have demonstrated that they provided appropriate support, training and mentorship to [NP C] during her employment, in relation to working as an NP in aged residential care.
>
> My reasons for this are that the information provided quantified that [NP C] worked in the Rest home during her internship in a supervised capacity with a GP, she was orientated to the NP role working in the Rest Home again alongside a GP, and that she was 3rd or 4th in line when on call and had collegial GP support during this time. Additionally, [NP C] had formal review of her developmental needs during her novice year as an NP. It appears [NP C] was well supported during her internship and first year of practice as an NP in a collaborative model of practice.
>
> I'm not sure about the question you had regarding whether I consider there has been any departures from an accepted standard of care — do you mean the support provided to [NP C] by [the medical centre]? If so, then no, the additional information provided by [the medical centre] leads me to believe there has been no departures from an accepted standard of care in relation to their support of [NP C] during her internship and first year of practice as an NP.'

Appendix B: Independent clinical advice to Commissioner

The following independent clinical advice was obtained from RN Karole Hogarth on 17 November 2020:

'1. Thank you for the request to provide clinical advice regarding the complaint from the family of [Mrs A] by [the care home] between the 21st [Month1] and 24th [Month3].

In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1989.Upon registration I was appointed to a new graduate position at Waikato Hospital and worked in orthopaedics, surgical and post-natal wards for the first year. I then received a permanent position in the burns and plastics unit at Waikato hospital. Following 2 years' experience in this environment I moved to Saudi Arabia in 1992 working as an RN in the Burn Unit in Dhahran. Upon completion of my contract I moved to England and worked as an RN for an agency providing nursing care in hospitals and community settings. I then moved into a permanent night shift position at BUPA Hull and East Riding, a private hospital in a small community in 1995. On return to New Zealand in 1998 I attended the University of Otago undertaking a combined degree in Zoology and Anatomy completing First Class honours in both in 2001. I worked as an RN in Dunedin at Redroofs Rest home as an RN and casual as a RN at Dunedin Public Hospital during this time. Following the completion of my undergraduate degree I was invited to enrol in a PhD which I did following a further year of travel where I worked as an RN for the Australia blood service in Sydney. While undertaking my PhD in 2004 I was appointed to an academic role 2 days a week at Otago Polytechnic teaching anatomy to Occupational Therapy students. I then expanded my teaching into Bioscience for Nursing and Midwifery students. My PhD research looked at the role of oxytocin in the development and progression of prostate diseases which I completed in the Anatomy Department at the University of Otago in 2009. I was then offered a full-time position in the School of Nursing at Otago Polytechnic teaching sciences. My current role is Associate Professor and Head of Nursing. I am also a Justice of the Peace for New Zealand having completed the requirements for this role in 2016 and reaccreditation in 2018.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by [the care home] was reasonable in the circumstances and why.

With particular comment on:

1. Appropriateness/adequacy of the initial assessment of [Mrs A's] wounds and the subsequent wound care plan;
2. Appropriateness/adequacy of the daily hygiene care provided;

3. Appropriateness/adequacy of [Mrs A's] pain management plan;
4. The timeliness of the escalation to GP/specialist/hospital;
5. Reasonableness of the communication with the family; and
6. Any other matters in this case that warrant comment.

For each question I am asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
c. How would it be viewed by my peers?
d. Recommendations for improvement that may help prevent a similar occurrence in the future.

4. In preparing this report I have reviewed the documentation on file:

1. Letter of complaint dated 2nd January 2020.
2. BUPA's response dated 11th March 2020.
3. Clinical records from BUPA covering the period from 21st [Month1] to 24th [Month3].

5. Background

[Mrs A] ([in her eighties] now deceased) had a history of dementia, ischaemic heart disease, insulin dependent diabetes, hypertension, and gastro-oesophageal reflux disease.

On the 21st [Month1], [Mrs A] was admitted to [the care home]. [Mrs A] was noted to have a chronic ulcer on her right lower leg and stage 4 pressure injury to her right heel.

On the 23rd [Month2], [Mrs A] fell and suffered a skin tear to her left leg.

On the 23rd [Month3], [Mrs A] was admitted to [the public hospital] presenting with a cough. [Mrs A] was discovered to have developed chronic bedsores on both legs.

My comments are confined to the care provided by [the care home].

6. Appropriateness/adequacy of the initial assessment of [Mrs A's] wounds and the subsequent wound care plan.

a. What is the standard of care/accepted practice?

From the information I have been provided, including the nursing notes, wound plans and evaluations by the nursing and healthcare team at [the care home], the initial assessment of [Mrs A's] wounds would be the expected standard of wound care. In the transfer notes the dressing plan indicated dressing changes every three days and this had been done on the day of transfer and was not redone that day at [the care home] due to [Mrs A's] fatigue. The wound assessment the following day was thorough and immediately noted the extent and severity of the chronic leg ulcer and the pressure

area on [Mrs A's] R) lower leg. It was noted at this time that a referral to the wound clinic was recommended and arranged.

The wound on admission was already chronic and non-healing and this was an opportunity for planning and implementing a treatment protocol that would have been in the best interests of [Mrs A] and should have included the aspects below:

- Current wound and dressing
- Pain Assessment
- Dressing choice and rationale
- Compression — rationale to use or not to use i.e. check for distal pulses with Doppler
- Elevation — best way to do this but keep active
- Weekly review to determine direction of healing

Wound Initial Assessment plan for the R) lower leg, 2 areas was initially completed on the 23rd [Month1] and updated on the 1st [Month2], with 2 dressings specified. Further updates occurred with ongoing treatment. Photographs were taken but these were of very poor quality as noted by the NP at the [wound clinic].

The wounds appear to have been dressed regularly with appropriate dressings undertaken as instructed as documented in the daily notes. These were updated regularly. Compression and elevation were part of the plan.

Wound swabs were taken when indicated and antibiotics administered as prescribed.

There are some gaps and errors in the documentation of the wound care for [Mrs A]. The nursing notes and Appendix 13 do not have the same information, with Appendix 13 appearing incomplete in parts.

I noted in the wound assessment and treatment plan of the wound on [Mrs A's] L) lower leg following an injury on the 23rd [Month2] was inaccurate. It was documented that the wound on the L) lower leg increased from 3cm in length to 7cm in length and that it went from 80% necrotic to 100% granulating over a period of 4 days. I would assume that this is an error either of measuring, assessment or had been written about the wrong wound, it does not appear to have been followed up by the person who completed the chart.

Date	Size	Appearance of wound bed L) leg
24 [Month2]	3cm (L) x 5cm (w)	100% granulating
1 [Month3]	3cm (L) x 5cm (w)	90% granulating, 10% sloughy (yellow)
4 [Month3]	3cm (L) x 5cm (w)	20% granulating, 80% necrotic
8 [Month3]	7cm (L) x 5cm (w)	100% granulating

The wound stage 1 pressure area injury to [Mrs A's] sacrum was noted early with interventions to prevent breakdown of the area initiated. The difference in the tissue response in this area when compared to her lower legs is likely to be blood flow related. It shows that staff were able to spot and respond to issues and prevent further deterioration.

The skin tear that occurred on the 23rd [Month2] was noted in the morning following to "look like an old wound" in the nursing notes, there is little information on the wound itself in the notes which would indicate nursing assessment at that time.

Long standing ulcers are very difficult to treat especially when combined with long term conditions such as in [Mrs A's] case with her diabetes and poor nutrition. Healing can be delayed, and it can be very difficult to manage without intervention especially if they become infected. Recognising when a chronic wound/ulcer is beyond the scope of staff is essential for the outcome for the patient.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information given I would consider that there is no departure from accepted practice and care of [Mrs A] in the initial assessment of [Mrs A's] wounds. The wound was dressed and reviewed appropriately at the time of initial assessment.

From the information given I would consider that there is a mild departure from accepted practice in the subsequent wound plan. This is mainly around the ongoing documentation and the amount of detail which could have been improved to show the pattern of wound healing more clearly which may have resulted in further consultation with the complex wound clinic.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that the initial assessment of the wounds on [Mrs A's] R) lower leg were undertaken at the accepted standard of care and that the ongoing reassessment has some areas where practice could be strengthened.

d. *Recommendations for improvement that may help to prevent a similar occurrence in the future.*

Some staff (RNs) have undertaken Ko Awatea wound management education which would be useful to extend further. Regular in-service for ENs and HCAs on the assessment of wounds, monitoring, how to measure accurately, dressings including the timeframe of normal wound healing and what the consequences of non-healing wounds may indicate would be a useful addition to improve outcomes.

Improvement of the documentation in regard to chronic wounds is recommended. This should include photographs (as per the Evaluation of Wound Healing document) that

are of a good quality and that are regularly updated in the patient's file to show the progression of wound healing or not as in this case.

While the wound evaluation chart is useful it lacks the space for detail especially around how the wound is progressing with a time frame noted to seek advice or further intervention. The Wound Initial Assessment and Plan was completed though lacks information. Staff should be encouraged to add detail to this plan to ensure consistency of dressings.

7. Appropriateness/adequacy of the daily hygiene care provided.

a. What is the standard of care/accepted practice?

As indicated in the nursing notes [Mrs A] was assisted with her daily cares including washing or showering. Some days [Mrs A] declined or was too fatigued to shower, it is noted, and alternative hygiene measures taken.

"Full cares" would indicate a full wash or shower, toileting, hair, teeth, assistance with dressing and support with mobility and meals as needed.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information given I would consider that there is no departure from accepted practice and care of [Mrs A]. The nursing notes indicate that [Mrs A] received appropriate assistance with her cares on a daily basis.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that the documented actions meet the accepted standard of care.

d. *Recommendations for improvement to prevent a similar occurrence in the future.*

It would be useful to define "full cares" to ensure that standards are maintained.

8. Appropriateness/adequacy of [Mrs A's] pain management plan.

a. What is the standard of care/accepted practice?

[Mrs A's] legs and wounds gave her significant neuropathic pain related to her diabetes. Neuropathic pain can be very difficult to treat with medication reducing but not eliminating pain in up to 50% of patients. Gabapentin in her pain relief regime on admission and the increase of the dose on the 4th [Month2] shows that her degree of pain was noted and actioned early on. Other resources such as the Pain Clinic and/or Diabetic Clinic/NP may have been able to offer further options, advice, and experience in order to manage [Mrs A's] pain. Due to her continuing pain further medications were added.

[Mrs A] was given regular pain relief but without knowing the timing of dressings it is difficult to determine if pain relief was administered in a timely fashion prior to dressing

completion. EMLA cream (topical anaesthesia) was applied sometimes for the dressings though is not prescribed.

Pain relief guidelines were followed, and pain documented and treated for the most part. This included her regular medication — gabapentin and paracetamol as well as PRN medication codeine, tramadol, ibuprofen, and later oxycodone. The PRN medication did not appear to be given with any particular rationale for the choice by the RN.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information provided I would consider that there is no departure from the accepted standard of care. Pain relief was regularly given, and review was undertaken.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree that due to the difficulty in treating neuropathic pain that the care given meets the accepted standard.

d. *Recommendations for improvement to prevent a similar occurrence in the future.*

If patients present with or develop neuropathic pain advice from a Pain Clinic may be useful such as in the case of [Mrs A] to ensure that analgesic options have been considered.

It would be useful for staff to have some guidance around the analgesia to administer when so many options are available to ensure consistency and to provide the most appropriate analgesic available to fit the needs of the patient.

9. The timeliness of the escalation to GP/specialist/hospital.

a. What is the standard of care/accepted practice?

As discussed above there was consultation with the [wound clinic] on the 26th [Month1] regarding the ongoing management of the non-healing ulcers which appears to have been long term by the time of admission to [the care home].

Current protocols indicate that with monthly reassessment there should be noted a 25% reduction in ulcer size and that failing to heal within 12 weeks recommends referral to a specialist. There is no indication in the notes that there was regular noting of the direction of wound healing. The measurements are the same consistently in the wound chart for the R) leg. The wounds on the R) leg were "seen" (the photos were poor) by the NP wound specialist at the beginning of [Month2] with a recommendation to follow up in 2 weeks. There is no indication if follow up at the [wound clinic] occurred.

Urgent referral was sent to the surgical team on the 15th [Month3]. The photographs taken by [the public hospital] on the 25th [Month3] show advanced ulcer formation with the wounds appearing far larger than indicated in the wound chart from [the care home]. Both legs have extensive involvement on the posterior aspect with sloughy and

necrotic patches. I am surprised at the extent of the ulcer on the L) leg which originated from a skin tear that occurred while in [the care home] on the 23rd [Month2]. For a wound to deteriorate to this extent without follow up is not acceptable practice.

The wounds have been noted as "bedsores" in the [public hospital] admission notes though this does not appear to be the case and may have led the family to believe that [Mrs A] was not cared for while in [the care home].

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

From the information provided I would consider that there is a moderate departure from the accepted standard of care. The main reason for this is that once it was established that there was no improvement of the wounds on [Mrs A's] R) leg and they were not making any positive progression a further referral should have been initiated this time to surgical services. The rapid deterioration of the skin tear that occurred on the 23rd [Month2] over the four weeks until it was assessed by the [public hospital] team also indicated that the [the care home] capacity had been reached in the management of [Mrs A's] wounds and referral earlier should have occurred.

c. How would it be viewed by my peers?

I believe that my peers in practice and education would agree with my assessment that the time of referral does not meet the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.

It is essential the limitations and staff capability are realised in the case of wound management. This should be an RN initiated conversation with the medical team with the evidence such as notes and photographs to provide rationale for referral.

10. Reasonableness of the communication with the family

a. What is the standard of care/accepted practice?

It would be expected that the family is notified of any changes to normal routines and patterns such as increased pain over time, falls, alterations to care plans, follow up from doctor visits, need for urgent treatment. If this is a sudden change this should be communicated by telephone as soon as possible. Other changes could be notified in person or via other agreed methods of communication such as email. Visits by family to site may be documented in progress notes and record of conversations documented as necessary.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?

c. How would it be viewed by my peers?

From the information provided I would consider that there is no departure from the accepted standard of care. Regular contact was maintained where appropriate with the family.

d. Recommendations for improvement to prevent a similar occurrence in the future.

Follow up may be needed with family if there is no reply to email, this could be a phone call and message.

Review completed by:

Associate Professor Karole Hogarth JP, RN, BSc, PhD

References

ACC. 2017. Guiding principles for pressure injury prevention and management in New Zealand

BPAC NZ. 2016. Managing patients with neuropathic pain. Issue 75, 20–31. https://bpac.org.nz/BPJ/2016/May/docs/BPJ75-pain.pdf

Diabetic Foot Australia. 2017. National plan to end avoidable amputations within a generation.

Health Quality & Safety Commission. 2019. Frailty Care Guides. NZ Government.

Koh, J.H., Miller, C., McKenzie, G., & McGuiness, W. The relationship between periwound skin condition and venous leg ulcer chronicity. Wound Practice and Research. 92–89.

Ministry of Health. 2016. Designated Auditing Agency Handbook: Ministry of Health Auditor Handbook (revised 2017). Wellington: Ministry of Health.

Pagan, M., Trip, H., Burrell, B., & Gillon, D. 2015. Wound programmes in residential aged care: A systemic review. Wound practice and Research. 52–60

Prevention and treatment of pressure ulcers/injuries: Clinical practice guideline. 2019.

The Australian Wound Management Association Inc. and the New Zealand Wound Care Society Inc. 2011. Australian and New Zealand Clinical Practice Guideline for Prevention and Management of Venous Leg Ulcers.

https://www.nzwcs.org.nz/resources/publications/10-guidelines-and-protocols'

The following further clinical advice was received from RN Hogarth on 17 August 2022:

'I have been asked to provide further advice on the above case following the responses from [the care home] (BUPA).

Background

[Mrs A] (aged [in her eighties] at the time of the events) had a history of dementia, ischaemic heart disease, insulin dependent diabetes, hypertension and gastro-oesophageal reflux disease. On 21 [Month1], [Mrs A] was admitted into [the care home]. [Mrs A] was noted to have a chronic ulcer on her right lower leg and stage 4 pressure injury on her right heel. On 23 [Month2], [Mrs A] fell and suffered a skin tear to her left leg. On 23 [Month3], [Mrs A] was admitted to [the public hospital] presenting with a cough. [Mrs A] was discovered to have developed chronic bed sores on both legs.

Expert advice requested

Please review the response to your previous expert advice, provided by [the care home], and advise whether this response causes you to change or amend any of your previous advice.

In particular, please comment on:

1. In your previous advice, you identified a mild departure in relation to the subsequent wound plan, particularly around the ongoing documentation and the amount of detail included in the notes. Please advise whether any of the further information or clarification provided by [the care home] causes you to change or amend this advice.
2. In your previous advice, you identified a moderate departure in relation to the timeliness of escalation to GP/specialist/hospital. Please advise whether any of the further information or clarification provided by [the care home] causes you to change or amend this advice.
3. I note that [the care home] have also provided further information and answers/clarification on several other matters raised in your original expert advice. Can you please also advise whether this causes you to make any additional comments about the care provided by [the care home] or amend any of your original advice.
4. Any comments you wish to make on the changes made by [the care home] since these events, particularly in relation to updated policies/processes.
5. Anything else that you wish to comment on.

For each question, I have been asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?
c. How would it be viewed by your peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

1. In your previous advice, you identified a mild departure in relation to the subsequent wound plan, particularly around the ongoing documentation and the amount of detail included in the notes. Please advise whether any of the further information or clarification provided by [the care home] causes you to change or amend this advice.

a. What is the standard of care/accepted practice?

As per [the care home's] response it is the responsibility of registered staff i.e., Enrolled Nurse or Registered Nurse (depending on staffing) to ensure that assessment and documentation meets requirements and to follow up on issues that are longstanding by regular checking and referral as needed. The direction and delegation of wound management needs should reflect the skills, training, and capacity of the care team.

The training of staff using appropriate frameworks and increasing the capacity in the management of complex wound needs should be ongoing.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be? In the response provided there is no new information due to the time since the complaint, therefore there is no change to the mild departure from accepted practice (at that time).

I disagree with the point regarding the subjectivity of wound assessment as "measurement" is quantifiable using a consistent tool. Determining the progression of wound healing can be trickier especially where there are different staff involved in care on a daily basis. Understanding the wound healing process and the barriers to this especially for those with chronic wounds alongside comorbidities are important aspects as is when to refer to specialist services.

From the response provided it is clear that [the care home] has reviewed and developed their practices in regard to chronic wound management.

c. How would it be viewed by your peers?

I believe that my peers in practice and education would agree that at the time the ongoing wound assessment could have been strengthened. They would be reassured by the changes and improvements made since the initial report.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

I have previously suggested that photographs are a useful way to track wound healing, it is also useful when making referrals. Easy to use wound care charts alongside a plan to track and monitor wound progress with objective information including the timings included for referral and follow up with wound clinic, or wound NP are a useful one stop tool. Ongoing education of staff around wound assessment, care and when to escalate (as undertaken by [the care home]).

2. In your previous advice, you identified a moderate departure in relation to the timeliness of escalation to GP/specialist/hospital. Please advise whether any of the further information or clarification provided by [the care home] causes you to change or amend this advice.

a. What is the standard of care/accepted practice?

Complex long-standing wounds can be very difficult to manage especially in older adults with contributing pathology. As per my previous advice the accepted standard is for escalation of care in a timely manner that meets the current protocols if there is no evidence of wound healing. In the case of the chronic wounds already present on [Mrs A's] legs on admission an assessment by a wound care NP or clinic would have been advised early on when it was clear that there was little progression to healing. The development of a further non healing wound following a skin tear should have also

triggered further assessment as it became obvious that it was not on a healing trajectory.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?

I believe that my original advice stands though I would consider reducing the departure from accepted practice to a mild to moderate departure, there was a referral to services though no evidence of follow up after the initial referral and a gap of seven weeks until the next urgent referral.

[The care home] have reinforced in their response that a referral was made to the wound clinic on the 26th [Month1], five days following admission with chronic wounds, this was acknowledged in my original advice. This was an indication that there was an understanding of the support that they would need in the management of [Mrs A's] already extensive wounds (it is not clear if this was followed up from the information provided). There is then a gap until the 15th [Month3] when a further urgent referral is made. [Mrs A] was seen by [NP C] on the 23rd [Month3]. By this time the new skin tear received on the 23rd [Month2] had evolved into a further ulcer on [Mrs A's] L) leg. NP Betts noted that there did not appear to be an understanding of the process for referral to specialist wound care services and this was also evident to me.

It is also noted by [the care home's] response that chronic wounds such as these may never heal however this assessment needs to be made by a wound care expert to address the ongoing need to reduce further deterioration, risk of infection and provide comfort.

c. How would it be viewed by your peers?

I believe that my peers in practice and education would agree with my assessment that there could have been some further action taken in between the time points above to escalate care to wound specialists.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

Ensuring that staff understand and can follow guidelines and recommendations for wound care management, with clear pathways for following up referrals.

3. I note that [the care home] have also provided further information and answers/clarification on several other matters raised in your original expert advice. Can you please also advise whether this causes you to make any additional comments about the care provided by [the care home], or amend any of your original advice.

[The care home] have provided clarification commentary on aspects of pain relief, dressing changes, wound assessment pattern of healing as well as some statements from staff regarding [Mrs A's] care.

I have no further comment on the information provided.

4. Any comments you wish to make on the changes made by [the care home] since these events, particularly in relation to updated policies/processes.

a. What is the standard of care/accepted practice?

Regular review and the implementation of change to ensure that care is of current best practice is the standard in health care. Evidence based decision making and using resources developed by experts in the field are an important part of this.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure (mild, moderate, or severe) do you consider this to be?

Changes to policy and procedure have been implemented and processes changed and adapted. There is no departure from accepted standard of care.

c. How would it be viewed by your peers?

I believe that my colleagues in practice and education would agree that [the care home] have provided opportunities for their staff to upskill or maintain currency in the assessment and management of wounds including:

- Staff completion of Ko Awatea modules
- Wound management sessions by [the wound care product company]
- Virtual wound care education — ongoing
- Resources from this learning are available to staff to access as needed
- Other opportunities have been provided as described in their response

Other initiatives include:

- Communication sessions — clinical communication and ISBAR
- How and when to escalate care
- Clinical documentation

Tools and policies:

- WI CHR Med — 5.1.2 Staff role, responsibilities and delegations
- Pain Assessment
- Stop and watch tool — early warning assessment

The tools and policies are logical and easy to follow and the education opportunities are ongoing and appropriate. This is all indicative of a facility that is responsive to feedback, is considerate of the needs of staff education and is able to implement change.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

No recommendations, continue with offering ongoing education.

Associate Professor KJ Hogarth'

Appendix C: Bupa Policy: Wounds — Management of

Accessing specialist advice

- Registered Nurses are responsible for completing referrals for specialist advise which is readily available through appropriate channels (see below)
- Referrals should occur promptly if there is little evidence of improvement in a wound, where interventions appear not to be achieving the desired healing outcome or:
  - whenever there is rapid deterioration
  - complex or non healing wounds
  - any concern re skin malignancy
  - possible osteomyelitis
  - arterial insufficiency
  - evidence of vasculitis
  - highly exudating wounds
- Some Care Homes are aligned with DHB outreach programmes where Gerontology Nurse Specialist can offer advice on wound management and Wound Nurse specialists can be accessed through DHBs. (Contact the Quality and Risk team if problems / delays in accessing specialist advice)
- Wound product advice can also be obtained via wound product supplier (eg product specialist)