HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Aged Care Commissioner

(Case 21HDC01413)

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1. This report is the opinion of Aged Care Commissioner Carolyn Cooper and is made in accordance with the power delegated to her by the Commissioner.

2. The report discusses the care provided to Mr A by multiple providers from January to June 2021.

3. The following issues were identified for investigation:

- *Whether Summerset Group Holdings Limited (trading as Summerset at Wigram) provided an appropriate standard of care to [Mr A] from January to June 2021.*
- *Whether Nurse Maude Association provided an appropriate standard of care to [Mr A] from April to June 2021.*

4. The parties directly involved in the investigation were:

Mrs B	Complainant/daughter
Summerset at Wigram	Aged residential care facility
Nurse Maude Association (Nurse Maude)[1]	Community nursing service

5. Further information was received from:

A medical centre	
Dr C[2]	General practitioner (GP)
Health New Zealand|Te Whatu Ora (Health NZ)[3]	National health agency

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[1] Nurse Maude provides a range of clinical services. This includes specialist wound care services and consultation advice to primary care providers and care homes.
[2] Dr C was an employee of the medical centre and was one of the doctors contracted to provide primary care services to Summerset at Wigram residents. Dr C visited the facility weekly on Tuesday afternoons. Other GPs of the medical centre provided further coverage on Tuesday mornings and Friday mornings.
[3] On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now called Health New Zealand|Te Whatu Ora).

Names (except Summerset Group Holdings Limited (trading as Summerset at Wigram), Health NZ, Nurse Maude, and the advisors on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

6. In-house clinical advice was received from Aged Care Advisor and registered nurse (RN) Jane Ferreira (Appendix A) and GP Dr David Maplesden (Appendix B). Independent clinical advice was received from nurse practitioner Ms Maria Escarlan (Appendix C).

Introduction

7. In June 2021 Mr A, a resident of Summerset Group Holdings Limited (trading as Summerset at Wigram (Summerset)) had a fall. Mr A was transferred to hospital for management of the injury that resulted from the fall. He was found to have critical right leg ischaemia,[4] and surgery was needed to revascularise[5] the right foot. Over July and August 2021 Mr A's condition worsened, and he required amputation of the toes on his right foot.

8. Mr A's daughter, Mrs B, complained to HDC about the services provided to Mr A by Summerset and Nurse Maude, a community nursing service that provided specialist wound care to Mr A. Mrs B was Mr A's Enduring Power of Attorney (EPOA) for Care and Welfare,[6] but at the time of events this had not been activated. Mrs B told HDC that although the EPOA was not activated, the care home was aware that she took care of her father's needs. This was also supported by Summerset's response to the provisional opinion.

9. Mrs B is concerned that Mr A did not receive adequate assessment and treatment of his wounds. In addition, she expressed concern that she was not fully informed about 'the fact that [Mr A's] toes had got worse'.

10. Following receipt of the complaint, this Office was informed that Mr A had passed away. I express my sincere condolences to Mr A's family and friends for his passing.

Background

Clinical history

11. Mr A was a 79-year-old man who was admitted to Summerset in 2017 following a stroke that resulted in left-sided weakness and reduced mobility. He was assessed as needing hospital-level care in 2018. Mr A had multiple comorbidities, including Type 2 diabetes and a history of smoking. In addition, he was prone to urinary infections and constipation and had experienced recent unintentional weight loss.

Long-term care plan

12. Mr A's long-term care plan (LTCP) noted that he required moderate caregiver assistance with activities of daily living and was a medium falls risk and had a mild risk of developing pressure injuries.

[4] Critical limb ischaemia is a severe stage of peripheral artery disease. Significant blockages in the blood flow to the feet occur due to chronic progressive deterioration in tissue perfusion. This differs from acute limb ischaemia, which has a sudden onset.
[5] To surgically improve the blood circulation.
[6] Under the Protection of Personal and Property Rights Act 1988.

13. The LTCP noted that Mr A had pressure injuries on his right leg. It instructed care staff to complete regular repositioning, monitor the injuries for signs of infection, and notify the registered nurse if there were concerns regarding his skin.

14. The LTCP also noted that Mr A had recurrent hip and leg pain, for which he was receiving regular pain relief including paracetamol and codeine, and PRN (as required) medications including morphine.[7] The LTCP noted that while Mr A could verbalise pain, he had a history of not informing others, and therefore staff were instructed to 'observe for non-verbal cues for signs of pain such as grimacing, protective behaviour to affected area and … irritab[ility]'. It was also noted that morphine could impact Mr A's ability to balance on his feet.

15. Summerset said that Mr A elected not to follow many treatment recommendations, including declining to wear open-toed footwear, use a bed cradle, or take pain relief, and he did not want a sensor mat and would mobilise without using the call bell.

Care provided to Mr A

January to February 2021 — identification of wound and initial care given

16. On 31 January 2021 Summerset nursing staff noted a 'small ulcer' on Mr A's right second toe and big toe within an area of an existing pressure injury in the outer aspect of the right ankle (malleolus). On 3 February Mr A was assessed by a registered nurse, who recorded in the wound assessment chart that serum and pus were coming from the wound. The wounds were dressed, and a short-term care plan (STCP) was completed, with instructions to complete wound dressings every two days. However, the wounds were not recorded on an incident report or wound register, and no photos were taken, as per Summerset's Wound Management Policy[8] ('the Policy'). Progress notes and family communication records did not record when Mrs B was first informed of the wound.

17. Mrs B told HDC that it was Mr A who first informed her that he had wounds on his toes.

18. Wound assessments were completed every two days between 31 January and 28 February 2021, except for the period 21 to 25 February 2021. Summerset told HDC that over this period the wound assessments had indicated that the wound was decreasing in size, and that the exudate, which was yellow and serous,[9] had reduced in quantity.

19. Progress notes and the pain monitoring chart showed that Mr A complained of pain on his right ankle on 2, 9, 11, 24, 25 and 26 February 2021. Morphine was administered on three occasions. On other occasions, Mr A refused pain relief because he was concerned about constipation, although initially he refused laxatives as he felt that they were not effective.

20. The Policy notes that pain must be assessed each time a wound is assessed/redressed, and that the effectiveness of pain relief is to be documented on MediMap[10] or in the progress

[7] An opioid medication with a known side effect of constipation.
[8] Dated August 2020.
[9] Clear and watery liquid.
[10] A cloud-based medication management system.

notes. The pain monitoring charts and medication administration records on MediMap show that Mr A's baseline pain and the outcome measures following pain relief were not assessed or recorded consistently.

21. On 23 February, Mr A asked to see his GP, Dr C. Dr C assessed the wound and recorded that there were '[s]ome signs of low-grade infection'. A plan was made for antibiotics,[11] cushioned dressings, and a podiatry review, and nursing staff were advised to keep Mr A shoe free and to request a 'review [as required] if not improving'.

22. Summerset told HDC that the wound was not escalated to the GP prior to 23 February because the wound had been small. Summerset said that nurses did not routinely refer wounds to a GP, and a referral was completed only when wounds showed signs of infection, such as exudate or increased pain. In response to the provisional opinion, Summerset said that wounds are also referred to the GP when they are not healing, which was done in this case.

23. Progress notes show that a podiatrist referral, an incident record, and an STCP for the infection were completed, and that Mrs B was informed about the plan for wound management.

March 2021 — X-ray and referral to Nurse Maude

24. The pain monitoring chart shows that Mr A complained of pain on at least 11 occasions over March (although pain was not monitored from 25 to 31 March) and refused additional pain relief on 3, 6 and 8 March. The medication administration chart shows that Mr A received morphine on 5 and 10 March.

25. In response to the provisional opinion, Summerset stated that Mr A would request pain relief when he was willing to take it and maintained that at times, he refused pain relief. Mrs B told HDC that over March, Mr A increasingly complained of pain on his toes and that her father was 'old fashioned' and 'tough' and would not normally complain of pain. Therefore, to complain of pain would mean that he 'had to be in real pain'.

26. Wound assessment charts show that Mr A's wounds were dressed every 2–4 days over March.

27. On 2 March Dr C completed a further review of Mr A's right foot. Dr C recorded that the '[u]lcerated areas seem[ed] much the same', but she was concerned that Mr A's toes were more swollen/inflamed and not improving on antibiotics. A plan was made to continue with antibiotics, undertake an X-ray of the right foot to check for osteomyelitis,[12] and consider a referral to the specialist wound care service if the wound did not settle in the next couple of weeks or if the X-ray showed osteomyelitis. The X-ray referral was completed on 2 March and a swab of the wound was taken to check for infection. Family communication records

[11] Flucloxacillin, which was administered from 23 to 27 February.
[12] Inflammation of the bone.

show that Mrs B was informed of the planned wound swab, X-ray, and referral to the wound specialist service.

28. On 5 March family communication records show that Mrs B was emailed regarding the X-ray result and the plan of care for the wounds.

29. On 9 March Dr C recorded that the X-ray showed no osteomyelitis, and Mr A had no fever, but the wound swab had tested positive for Staphylococcus bacteria. She noted that the wound was healing slowly, likely because of poor circulation as a result of Mr A's stroke and diabetes. The plan was to complete a referral to the wound care service, to restart antibiotics, trial silver dressings,[13] elevate the foot and keep it shoe free, re-swab the wound on 17 March, and review Mr A again on 23 March.

30. On 9 March Summerset completed a referral to Nurse Maude for specialist wound assessment. The referral noted that the GP had suggested a Doppler ultrasound[14] of the feet. Dr C told HDC that the ultrasound was to check for possible limb ischaemia,[15] and these readings were required when referring to the vascular surgical or nursing team at the hospital. Mrs B was informed that antibiotics had been restarted for Staphylococcus infection of the wound, and that a referral had been made to Nurse Maude.

31. The referral was acknowledged by Nurse Maude on 12 March. Nurse Maude informed Summerset that there was a waiting period of 4–5 weeks and asked Summerset to complete a pre-assessment form. Summerset sent this form to Nurse Maude on 15 March. The form did not mention Mr A's history of Type two diabetes[16] or his baseline blood glucose levels. Dr C told HDC that the Summerset nurses informed her that there was a delay in Mr A being seen by Nurse Maude due to workload pressures.

32. On 24 March a further wound swab showed moderate growth of Pseudomonas (bacteria) and a light growth of Candida (fungi), indicating infection. This was noted by Dr C on 30 March, and she recorded that the toes were reportedly less swollen, red, and painful. Dr C told HDC that antibiotics were not prescribed because the microbiology laboratory report had indicated an opportunistic infection,[17] and when she spoke with the nurses, they said that Mr A's toes were improving and less painful. The plan was to treat the wound, and to re-review if the ulcers were enlarging.

April 2021 — appointment at wound clinic and referral to vascular department

33. Over April, the pain monitoring chart recorded only one assessment completed on 7 April, and the medication administration chart did not show any PRN pain relief having been administered. The progress notes also made minimal reference to pain and wound assessments over this period, but the notes refer to Mr A being comfortable. In response to

[13] These dressings promote wound healing, treat local infection, and prevent systemic spread of the infection.
[14] A test that uses sound waves to show blood flow through the vessels.
[15] A sudden lack of blood flow to a limb, which is a medical emergency.
[16] Diabetes is known to affect wound healing.
[17] An infection caused by bacteria, fungi, viruses, or parasites that normally does not cause disease but may do so if the body's defence system is impaired.

the provisional opinion, Summerset disagreed with this and stated that multiple references were made to Mr A being comfortable and being pain free, and that Mr A's wounds were static and reported in the STCP, therefore not captured within the progress notes.

34. Wound assessment charts showed that Mr A's wounds were dressed every 2–4 days over April.

35. On 12 April Summerset followed up Mr A's referral to Nurse Maude, and on 19 April Mr A was seen in Nurse Maude's wound clinic for an initial assessment with a wound nurse, in the presence of Mrs B. A Doppler pulse assessment showed a diminished foot pulse and that the lower limb pulse was unable to be palpated, with assessment notes reporting likely peripheral vascular disease[18] with limb ischaemia. Mrs B told HDC that Nurse Maude 'assessed the blood flow to the foot'. Mrs B said that Nurse Maude told them that the foot 'was not good' and that 'circulation wasn't flowing to [Mr A's] feet'.

36. The New Zealand Society for the Study of Diabetes Foot Screening Referral Pathways (dated 2017) stipulate that if there is a foot ulcer and/or critical limb ischaemia,[19] the patient should be referred urgently to a multidisciplinary or hospital podiatry clinic and the vascular service. However, this did not happen.

37. A wound care plan was developed, and Nurse Maude told HDC that the wound nurse considered that potentially there was arterial insufficiency[20] and that possibly Mr A should be referred to Health NZ's vascular department. Nurse Maude said that this type of referral is made in consultation with its clinical nurse specialist (CNS) for wound care.

38. Following the appointment on 19 April, Mrs B informed Summerset staff that Mr A had been referred to the vascular clinic,[21] and that Nurse Maude would send a recommendation letter following the appointment. Mrs B told HDC that she was happy that a referral was being made to the vascular clinic and assumed that the referral would go through.

39. On 22 April the Nurse Maude CNS remotely reviewed Mr A with the wound nurse to determine whether a referral should be made to the vascular team. The CNS noted the wound care plan developed by the wound nurse and observed a slow-to-heal ankle site, ulcerated toes, and possible ischaemia. Recommendations were made to implement pressure-relieving strategies to support the wound care plan, which included a review of footwear and equipment use, and to review the wound site in two weeks' time to see if it was improving. Therefore, a referral to the vascular department was not made. In response to the provisional opinion, Summerset stated that Nurse Maude should have confirmed whether the assessment on 19 April identified critical limb ischaemia, along with the Doppler findings and duration of the wound.

[18] A slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel.
[19] Severe blockage of blood flow to the limb.
[20] Reduced blood flow through one or more of the arteries.
[21] This was confirmed by Summerset.

40. Following the CNS review, the wound nurse emailed a copy of the assessment and care plan to Summerset on 22 April. The care plan recommended daily wound care using specified dressings, use of an alternating air mattress, a bed cradle to keep bedding clear of Mr A's feet at night, and liaison with the podiatrist and the GP regarding the outcome of the wound clinic assessment. Summerset said that it followed the instructions to the best of its ability, but Mr A refused some recommended interventions.

41. Summerset said that there was a lack of clarity regarding the referrals process. The care plan recorded that the Nurse Maude wound nurse was 'to refer to Vascular outpatients at [Mr A's] agreeance for further investigation'. However, the email of 22 April advised that a further review would be undertaken in two weeks' time, and that if there was no progress then a referral would be made to the diabetes podiatrist for further investigation and that the podiatrists would 'have a joint Vascular clinic and will be able to liaise further with them if they feel [Mr A] needs further input'.

42. Nurse Maude told HDC that Mr A and his daughter should have been informed of the decisions made following the 22 April review, and it apologised that this did not occur.

43. On 27 April Dr C completed a routine three-monthly medical review. She noted that Nurse Maude had reviewed Mr A's ulcers and was 'referring to vascular'. Dr C told HDC that after speaking with the Summerset nurses, she understood that the plan was for a vascular assessment. Dr C recorded that there were 'not too many complaints of pain recently, still having morphine PRN on occasion', and that the plan was to await the vascular assessment.

May 2021 — deteriorating wounds and ongoing input from Nurse Maude

44. Progress notes through May 2021 continued to make minimal references to pain and wound management. The pain monitoring chart also showed that pain assessment was not completed for most of May.[22] However, when it was completed, Mr A was reported as having severe pain. The medication administration chart showed that morphine was administered on 2, 3, 18, 19 and 27 May. In response to the provisional opinion, Summerset said that Mr A had intermittent pain during May.

45. Wound assessment charts show that Mr A's wounds were assessed and dressed daily. On 10 May Nurse Maude staff followed up with Summerset about Mr A's wound status. Email correspondence indicates that a pressure-relieving air mattress and a bed cradle were provided on 7 May. Photographs of the wound were provided to Nurse Maude, and Nurse Maude advised Summerset that 'the toes [we]re looking as [they] wou[ld] expect them, [and to] continue to keep them dry', that the wound would be slow to heal, and that there was a plan to review the wound in four weeks' time.

46. Nurse Maude's Wound Management Guidelines at the time state that wound photos are to be provided to Nurse Maude every two weeks.

[22] Pain assessments were not completed on 1 May, 4–17 May, 22–26 May, and 28–31 May.

47. On 17 May Mr A asked to see the GP for his painful toes and was seen by Dr C on 18 May. Dr C told HDC that there was no change in Mr A's utilisation of pain relief, or the status of the ulcer reported to her. Dr C advised nursing staff to continue with the same regimen and to re-swab the wound at the next dressing change to ensure resolution of the Pseudomonas and Candida. She also documented that Mr A was still awaiting vascular input.

48. On 18 May Mrs B was informed that Mr A had seen the GP and that the plan was to continue pain relief as he needed it and take wound swabs to rule out infection, and that they were waiting for a vascular clinic appointment. Mrs B complained that the GP was 'getting the care facility to send photos of the toes, and not actually sighting the toes'.

49. Dr C reviewed the results of the wound swab on 25 May 2021. She told HDC that oral antibiotics were not necessary as there was no reported change in the clinical status of the ulcers or other concerns. Dr C said that after giving nearly a month of antibiotics and a resulting opportunistic infection, she was keen to avoid this and advised Summerset to continue routine wound care and cleansing. Mrs B was informed that the wound swab had shown Staphylococcus but this was 'likely part of [Mr A's] normal wound flora and [did] not necessitate treatment'.

50. On 26 May Mrs B told Summerset that she had spoken with the vascular department at Health NZ, and it had asked Summerset to send through photos of Mr A's toes and a copy of the referral sent by Nurse Maude.

51. On 27 May Nurse Maude enquired about the wound, and an update was provided by Summerset along with photos of the wound. However, following this correspondence, no clinical entry was made by Nurse Maude in reference to a review of the photos.

52. On 28 and 31 May Summerset followed up with Health NZ's vascular department and was advised that no referral had been sent to them. Summerset then followed up with Nurse Maude, who advised that as Mr A's wound was looking better and was healing, vascular input had not been sought.

53. Mrs B said that she also spoke to Nurse Maude, and was advised that as the wounds had improved, the vascular referral to Health NZ was not needed. Mrs B then complained and said that 'there [could not] be an improvement, [and] that the pain in [Mr A's] right foot was a lot worse'. Subsequently, Nurse Maude decided to complete a referral to the vascular department.

54. On 31 May a Summerset nurse followed up with Health NZ's vascular department and left a voice message. Summerset also said that it followed up with Nurse Maude, who had informed Summerset that they would provide an update regarding the referral. A Summerset nurse informed Mrs B about the 'plan of care' for Mr A's wounds and said that 'Nurse Maude and Vascular ha[d] now both been involved'. Family communication notes record that Mrs B was '[h]appy to continue'.

June 2021 — elevated blood glucose levels, fall, and transfer to hospital

55. Over June, the pain monitoring chart showed that pain assessments were not recorded on several occasions,[23] even though Mr A had been having 'severe', 'extreme' or 'moderate' pain through June, as per the progress notes. The medication administration chart showed that Mr A also needed an 'increased amount' of morphine (on at least 13 different occasions) and sometimes multiple times a day. Summerset agreed that pain monitoring charts were not completed.

56. In response to the provisional report, Mrs B told HDC that Mr A had complained of increased pain over June and that he had requested pain relief, only to be told that the medications were not due.

57. On 1 June Nurse Maude recorded that the wound had improved but that on discussion with Mrs B, the pain in the toes and feet had increased, with Mr A requiring morphine every night to manage his pain. Mr A was referred to the diabetic podiatry service at Health NZ Waitaha Canterbury for assessment and ongoing care. A Nurse Maude nurse advised Summerset that she had informed Mrs B and completed the referral.

58. On 1 June Nurse Maude sent Summerset a further email advising that Mrs B had informed Nurse Maude that the podiatrist had queried osteomyelitis and asking whether the nurses were aware of this. Summerset advised Nurse Maude that there had been no mention of osteomyelitis within the podiatrist's notes, and that an X-ray for osteomyelitis had been completed and reviewed by the GP, and that Summerset would follow up with the podiatrist the following day. Summerset then shared a copy of the podiatrist notes from 1 June, which did not make any reference to osteomyelitis, and the GP review notes of the X-ray. Further, Summerset advised Nurse Maude that it had received a phone call from Health NZ advising that no referral had been made to the vascular outpatient department.

59. On 2 June the Nurse Maude wound nurse explained to Summerset that Mr A had been referred to the diabetes podiatry team, which works closely with the vascular team and would refer to the vascular team if necessary. The wound nurse also explained that Mr A was not known to the vascular department at this stage. In addition, she advised that the wounds were looking dry, there was no erythema (redness) or swelling, and that she was not particularly concerned about the wounds at this stage.

60. Mr A was discharged from Nurse Maude on 8 June. Nurse Maude told HDC that this was because the diabetes podiatry clinic provides a full wraparound service, including wound care.

61. On 9 June Dr C was contacted (by text) as a Summerset nurse was concerned that Mr A's wounds had not improved despite following the wound care plan and management advice from Nurse Maude. Summerset provided photos of the wound and expressed concern regarding an infection. Dr C was on leave[24] but advised the nurse to complete a wound swab at the next dressing change, and not to commence antibiotics unless the wound became

[23] This includes 2, 4–5, 7–8, and 10–12 June. It is also noted that [Mr A] had been on social leave on some days.
[24] Dr C was on leave from 7 to 13 June 2021.

more red, hot, or swollen or if Mr A developed a fever. This was because Dr C was concerned that there might already be some resistance to antibiotics.

62. On 9 June[25] a wound assessment of the right big toe noted that the wound had increased in size (it is not known whether this was due to swelling), and that there was '[i]ncreased pain' but did not indicate whether there was erythema or what the pain score was.

63. On 11 June Mrs B was informed that the swab results had been positive for *Staphylococcus aureus* and that antibiotics were not necessary for this. The plan of care was discussed, and it was documented that '[Mrs B] agreed [with] the plan'. Dr C was informed of the swab result, and she advised to continue with the cleansing and dressing regimen as per Nurse Maude's care plan and advice, and that she would review the wound on the Tuesday rounds.

64. Dr C told HDC that the wound swab results of June were reflective of wound colonisation,[26] and therefore it was appropriate to deal with the wound topically, rather than any change in the level of deeper infection or status of the toe requiring further oral treatment. She stated that she was not made aware of any reported signs of necrosis (dead tissue) at this point.

65. Summerset said that on 14 June its registered nurses contacted Nurse Maude again because necrotic areas were beginning to develop on Mr A's wound. Nurse Maude advised Summerset to continue to use Betadine solution daily to dry out the wounds, and told Summerset that Nurse Maude could not 'offer anything further at this stage' and to contact the GP if there were more concerns. Nurse Maude also told Summerset:

> 'Due to the potential underlying arterial involvement these wounds are expected to deteriorate and it will be painful, this is why he has been referred through to the [d]iabetes [p]odiatrists [for] review.'

66. At 5.55am on 14 June it was noted that Mr A's blood glucose level was elevated at 17.2mmol.[27] The next blood glucose level was completed at 12.19pm and was noted to be 22.9mmol. Later in the day, Mr A visited Mrs B for dinner. It is not known what instructions had been provided to Mrs B in relation to management of Mr A's blood glucose levels. In response to the provisional report, Mrs B told HDC that she was not informed of Mr A's elevated blood glucose levels.

67. Mrs B told HDC that Mr A ate very little during dinner and was unsteady on his feet and complaining of pain. On arrival at Summerset after dinner, Mrs B asked staff to keep a close eye on Mr A as she was concerned that he was a falls risk. Progress notes indicate that Mr A was more sleepy than usual, and that he would require a GP review the next day. The medication chart shows that Mr A was administered zopiclone for sleep prior to going to

[25] There was no wound assessment record of the wound on the second toe on 9 June.
[26] Bacteria begin to replicate and adhere to the wound site.
[27] Normal blood glucose levels range from 4.0 to 7.5mmol.

bed, which Summerset stated had been requested by Mr A, and that he had been settled in bed at the time the medication was administered.

68. At 4.30am on 15 June Mr A had an unwitnessed fall while mobilising to the toilet. It is recorded that Mr A hit his head and his left shoulder and voiced severe pain in his hip. A registered nurse completed a head-to-foot assessment, including baseline vital signs, and called an ambulance for transfer to hospital. Neurological observations were completed at 4.40am, 5.15am, 5.46am, and 6.15am.

69. Mrs B was informed of the fall by email at 5.02am. She told HDC that when she arrived at Summerset around 7am, she found Mr A 'on his own, lying on the floor', and he was 'clearly in pain and had no recollection of how he had got there, or what he had done to cause the fall'. However, in response to the provisional report, Mrs B said that Mr A had told her that he had fallen because of pain in his toes.

70. Summerset said that a caregiver stayed with Mr A until 6.40am, at which point they left to answer calls bells from other residents but continued to check on Mr A every 20 minutes. However, Mrs B told HDC that after she arrived, no staff had checked Mr A over a period of 20 minutes. Mrs B said that when she sat with Mr A, at no stage did any staff come in to check on him. Summerset stated that given that it was shift handover, and incoming staff were made aware that Mr A was awaiting the ambulance that had been called earlier and Mrs B was with Mr A, it was 'reasonable that staff were satisfied she could assist to orientate and reassure him'.

Subsequent events

71. Mr A was transferred to a public hospital in the morning of 15 June. Health NZ's notes record that Mr A's fall was secondary to the pain caused by the wounds in his foot. On 16 June Mr A underwent a right angioplasty to the posterior tibial artery[28] on his right leg, to improve the blood flow to the limb. In August, Mr A developed gangrene[29] on his right foot, which required surgical debridement and subsequent amputation of his 2nd to 5th toes.

72. On 15 June Mrs B complained to Summerset directly, stating that she was not fully informed of how bad Mr A's wounds were. Mrs B told HDC that '[a] wound should not get to the level that [Mr A's] did before something is done about it' and that families should be informed that wounds are getting worse or better. Further, she stated that on several occasions, Mr A had asked to see the GP, only to be 'told that he had just seen the doctor the previous week', and she failed to 'see why it mattered that [Mr A] had just seen the [GP] the previous week. He knew he was in pain and not feeling right.'

73. In response to the provisional report, Summerset stated that Mrs B was attending Nurse Maude appointments with Mr A, and that Mr A was visited regularly by a GP who was generally aware of his progress.

[28] Opening of the blocked artery in the lower limb.
[29] Tissue death caused by a lack of blood supply.

Further information

74. Dr C told HDC that the process of working as a contracted GP in an aged residential care facility relies heavily on trust, and GPs are dependent to a 'great extent on the nurses' to stay up to date regarding the individual residents' care and wellbeing needs and ask GPs to review in a timely and appropriate manner. In response to the provisional opinion, Summerset stated that while it agrees with this, it is also important for GPs to seek detailed information from the nurses when they raise concerns.

75. Dr C stated that although communication is encouraged to take place via the clinic, messages could be directed to a GP's mobile if urgent. When GPs are on leave, cross-over of care is arranged with other GPs, and this is communicated to the nurses ahead of time.

76. Dr C told HDC that she was not copied into any communication between the nursing team at Summerset and the Nurse Maude team, nor did the Nurse Maude team at any point contact her directly to advise that any alternative process/pathway or referral by her would be needed. In contrast, Summerset stated that Dr C had access to Mr A's integrated clinical record where communication is filed.

Responses to provisional opinion

Mrs B

77. Mrs B was provided with a copy of the 'information gathered' section of the provisional report and given the opportunity to comment on this. Her comments have been integrated throughout the report.

Nurse Maude

78. A copy of the relevant portions of the provisional report was provided to Nurse Maude for comment. Nurse Maude extended its sincere apologies to Mr A's family for any distress it caused, and its condolences for Mr A's passing. Nurse Maude told HDC that it is committed to continuing to address concerns and improve its processes and communications with other providers and families. Other comments have been integrated elsewhere in the report.

Summerset

79. A copy of the relevant portions of the provisional report was provided to Summerset for comment. Summerset considers that the fundamental issue was the lack of timely referral to the vascular clinic, and that this resulted from the failure of clarity and timeliness from Nurse Maude regarding the referrals process. Therefore, Summerset considers that a breach finding is unwarranted in this case. Other comments have been integrated elsewhere in the report.

Dr C

80. A copy of the relevant portions of the provisional report was provided to Dr C for comment. Her comments have been integrated throughout the report.

Opinion: Introduction

81. On 31 January 2021 an ulcer was noted on Mr A's right second toe and big toe. Initially the wounds were managed internally by Summerset staff and then were escalated to Dr C on 23 February and to Nurse Maude on 9 March. Between March and June 2021 Mr A's wounds deteriorated. On 1 June Mr A was referred to the diabetes podiatry team for further management. On 15 June Mr A was transferred to hospital following a fall that was attributed to pain in his foot. Further, it was noted that he had critical limb ischaemia,[30] which required surgical intervention.

82. Mrs B told HDC that when Mr A's toes were becoming more painful, she spoke to him on 'numerous occasions with care facility staff about the pain, and [her] concerns his condition was worsening',[31] but 'very little was done by the care facility'.

83. This report considers whether the care provided to Mr A was of an appropriate standard. I sought responses from Summerset, Dr C, Nurse Maude, my clinical advisors, RN Jane Ferreira (a specialist in aged care) and GP Dr David Maplesden, and an independent clinical advisor and nurse practitioner, Ms Maria Escarlan, to help determine whether the care was appropriate. In my opinion, there were several issues in the care provided by Summerset, Nurse Maude, and Dr C, which leads me to conclude that Mr A received a sub-standard level of care.

Opinion: Summerset Group Holdings Limited — breach

Introduction

84. Mr A was a resident at Summerset at Wigram and received hospital-level care. Between January and June 2021 Mr A was cared for by several caregivers and registered nurses. I have noted several deficiencies in the care provided by Summerset staff, and I address each issue in turn below.

Wound management

85. The Policy stipulates that registered nurses are responsible for the overall management of wounds, including identifying wounds that are responding poorly to the wound care plan, escalating concerns to the primary care provider, and seeking specialist advice. The Policy provides clear guidance on how to manage non-healing wounds; however, RN Ferreira advised that there were several areas of concern regarding Mr A's overall wound management.

86. The wounds were first identified on 31 January and assessed by a Summerset nurse on 3 February. As per the Policy, the wound was recorded in the progress notes, and an STCP and wound assessment chart were started. However, no photographs were taken, no incident

[30] Severe blockage of arteries in the lower extremities, which markedly reduces blood flow.
[31] It is not known when this occurred.

form was completed, and no staging of the wound occurred when the wound was first identified to help guide care planning and interventions, as required by the Policy.

87. Although there is evidence of some wound assessment, RN Ferreira advised that the progress notes contain limited discussion of wound assessment, wound status, delivery of wound care, and the reflected actions. She said that the delivery of wound care to Mr A was inconsistent between January and June 2021 and there were deviations from standard practice in relation to holistic nursing assessment, recognition of decline, and timely advocacy.

88. Summerset told HDC that up to 23 February 2021, the wound assessments had indicated that the wounds were decreasing in size, and the exudate, which was yellow and serous, had reduced in quantity, suggesting improvement. In contrast, RN Ferriera advised that the wound assessments described signs of wound infection, with the presence of purulent exudate over this period, suggesting wound decline. Further, RN Ferreira advised that there were inaccuracies in wound assessments regarding the identification and staging of wounds, descriptions and ratio of slough or granulation tissue, and recognition of decline.

89. Dr C was first notified of the wounds on 23 February, and the issue was escalated to Nurse Maude on 9 March for specialist input. RN Ferreira advised that clinically relevant information, such as Mr A's diagnosis of diabetes and baseline blood sugar levels, were not provided to Nurse Maude at the time of sending the referral, indicating a lack of recognition of the role diabetes plays in wound management. In response to the provisional opinion, Summerset stated that this did not reflect a lack of recognition of the role diabetes played in wound management, but rather an oversight by the nurse when completing the referral form.

90. A wound care plan was developed by Nurse Maude, and on 22 April recommendations were provided to Summerset to implement pressure-relieving strategies to support the wound care plan, including a review of the footwear and equipment use. RN Ferreira advised that although a pressure-relieving air mattress and a bed cradle were provided on 7 May, and there is evidence of footwear review, the progress notes and short-term care plan contain limited discussion about equipment use. In response to this, Summerset stated that there is comment in the progress notes and care plan about Mr A's choice, despite the recommendations made, not to use open-toed shoes, different socks, or a foot cradle in the manner intended.

91. On 14 June Mr A returned to Summerset following social leave, and it was noted that his wound had declined further. RN Ferreira advised that although Summerset staff escalated the issue to Nurse Maude, it is unclear what assessment of the wound occurred, and whether concerns were escalated to the clinical manager or GP for support.

92. RN Ferreira advised that overall, the wound management by Summerset staff was a mild to moderate departure from the accepted standard of care. In contrast, Summerset stated that it considers the wound management to have been of an accepted standard.

93. I accept RN Ferreira's advice. On my review of Mr A's clinical records, it is clear that the wound care delivery was inconsistent. I am therefore concerned about Summerset's wound management practices.

94. I now consider whether the management of Mr A's pain was appropriate.

Pain management

95. Clinical records show that Mr A regularly expressed pain in his right foot. However, there were several deviations in the management of Mr A's pain.

96. Clinical records indicate that Mr A had a chronic history of neuropathic pain,[32] with reports of sudden, intense, stabbing sensations. In addition, the Policy stipulates the need for regular pain assessment, including identification of the pain location, type, and severity of pain each time the wound is assessed and/or redressed. The STCP noted that Mr A's wounds needed daily assessment and daily monitoring of pain. However, Summerset stated that Mr A had a history of refusing pain relief and would rather 'push on' with the pain, and request pain relief when he needed it.

97. RN Ferreira advised that there was limited evidence of registered nurse assessment or reporting of pain assessment scores. This is supported by the inconsistent charting of pain levels within the pain monitoring charts. In April, only one pain assessment was completed and, likewise, it appears that pain assessments were not completed for most of May. Further, in June, when Mr A showed critical signs of deterioration, pain continued to be assessed irregularly. While I acknowledge that progress notes do mention Mr A being 'comfortable', these comments do not evidence formal or objective pain assessments being completed.

98. Mr A's LTCP instructed staff to monitor for non-verbal cues of pain such as grimacing, protective behaviour of the affected area, and irritability, as Mr A was known not to inform staff of his pain levels. However, RN Ferreira's advice indicated an absence of holistic assessment. She said that although the progress notes refer to observed changes in Mr A's mood, it remains unclear whether the care team recognised that this mood change was pain related, and it is unclear whether the nurses considered using the Abbey Pain Scale[33] to inform a holistic (subjective) assessment of pain.

99. The LTCP noted that Mr A was known to refuse pain relief, particularly morphine, as was his right, due to concerns about constipation, which is a known side effect of opioid medications. Although Mr A's LTCP noted the use of non-pharmacological strategies such as heat packs, RN Ferreira advised that it is unclear what non-pharmacological strategies were

[32] Pain caused by damage or injury to the nerves.
[33] An instrument designed to assist in the assessment of pain in residents who are unable to articulate their needs clearly.

used to support Mr A's pain, as there is no discussion on non-pharmacological strategies[34] within the progress notes.

100. Further, Summerset's Wound Management Policy required the effectiveness of pain relief to be documented on MediMap or in the progress notes following administration. However, the outcome from the administration of pain relief was not documented consistently, and, when it was, this was brief and did not use an objective measure. For example, some MediMap entries recorded 'good effect', but it is not known to what degree the pain was relieved and whether further measures were needed to manage Mr A's pain. Summerset acknowledged that a more objective measure may have been preferable but stated that Mr A would advise staff when he wanted more pain relief.

101. RN Ferreira advised that it is not clear whether Mr A's pain management was escalated to the GP, including his refusal of pain relief, or to the clinical manager for discussion and to ensure the effective delivery of coordinated personalised care. This is supported by the absence of such a discussion within the progress notes, and Dr C's statement to HDC that she was unaware of Mr A's increasing pain levels.

102. RN Ferreira advised that overall, Mr A's pain management was a mild departure from the expected standard of care. I accept this advice. In my opinion, there were multiple deviations in Summerset's management of Mr A's pain, including a lack of regular holistic pain assessments, a lack of outcome assessment, a lack of escalation of Mr A's increasing pain levels to Dr C when Mr A asked to see the GP, and a lack of escalation to the clinical manager and a failure to offer non-pharmacological approaches when Mr A declined opioid pain relief. I acknowledge that Mr A was capable of requesting pain relief, but this does not eliminate the need for completing regular, objective assessments and documenting these findings. In my opinion, these assessments are important, particularly in instances where residents have a tendency to under-report pain.

Falls management

103. Mr A's LTCP shows that he was assessed as a medium falls risk on 19 May 2021, due to left-sided weakness from a stroke and the wounds on his leg. The LTCP also noted that Mr A was at risk of losing his balance because he was receiving morphine. RN Ferreira noted several deviations in falls management practices.

104. On the evening of 14 June when Mr A returned to Summerset from social leave, Mrs B informed staff that he was 'sleepy and tired', and she requested a GP review regarding Mr A's level of alertness. RN Ferreira advised that although he was listed on the GP review list for the next day, it is not clear what nursing assessment occurred following the discussion with Mrs B on the evening of 14 June and whether staff recognised the increased risk for falls. Summerset stated that as Mr A was frail and suffering from anaemia, it was not unexpected that he was tired after his social leave. However, RN Ferreira was critical that the clinical records show no evidence of blood glucose monitoring, vital signs monitoring,

[34] Non-pharmacological strategies include massage, physical therapy, and psychological therapy.

an increase in intentional rounding, or a reassessment of Mr A's falls risk. Further, it is not known whether Mrs B's concerns were communicated to the incoming shift.

105. In the evening of 14 June morphine was administered for pain, and zopiclone was given for sleep, which further increased the risk for falls, and, unfortunately, in the early morning of 15 June Mr A experienced an unwitnessed fall. An incident report was completed, which noted that Mr A had hit his head and shoulder and had hip pain, and that a head-to-toe assessment had been completed. Although ultimately Mr A was not moved from the floor, the clinical records state that Mr A had declined to go back to bed, which indicates that staff had considered transferring him following a suspected hip injury at some stage. RN Ferreira advised that this was not in line with accepted falls management practices.

106. An ambulance was called for assistance, and an email was sent to Mrs B advising her of the fall. Mrs B told HDC that on arrival at the care home around 7am, she found Mr A lying on the floor alone and in pain. Summerset said that a caregiver had been sitting with Mr A until 6.40am, when they left to answer another resident's call bell, and the caregiver continued to check on Mr A after answering the call. In contrast, Mrs B told HDC that there were no checks on Mr A between 7am and 7.20am, when the ambulance arrived. RN Ferreira advised that the accepted standard of care would be for a registered nurse or delegated carer to remain with the resident until the ambulance arrived.

107. Summerset initially stated that its expectation was that the caregiver would have remained with Mr A and that other staff members would be allocated to answer residents' call bells. Summerset has reminded staff of this expectation and has also reminded registered nurses of their responsibility to give clear direction to caregivers under these circumstances. In response to the provisional opinion, Summerset stated that whilst it is ideal for staff to remain with the resident, this is not always possible on a night shift when fewer staff are rostered, which may mean that staff need to balance conflicting priorities. Summerset said that it has changed its policy to reflect that it is not always possible to provide constant attendance for the full duration when waiting for an ambulance and that family support can be provided. Although the policy provided by Summerset does not reflect this change, I am concerned by Summerset's new position on this matter.

108. I acknowledge that there is dispute as to whether a caregiver checked on Mr A following his fall, in between care provided to other residents. However, as acknowledged by Summerset, ultimately the caregiver should have stayed with Mr A while he was lying on the floor in a vulnerable state, and I am critical that this did not occur.

109. I acknowledge Summerset's position that staff need to balance conflicting priorities, and that Mrs B was with Mr A. However, in this case, Summerset did not provide evidence that staff were required to attend another emergency, and although Mrs B was staying with Mr A, this did not eliminate staff responsibility to check on him during a critical period; therefore, I prefer Summerset's initial position that a caregiver should have remained with Mr A. In my opinion, there was a lack of holistic care provided to Mr A. The nurses appear not to have recognised Mr A's increased risk of falls due to his ongoing pain or given the

concerns conveyed by Mrs B. This meant that additional safeguarding was not put in place to mitigate the risk of falls.

110. RN Ferreira advised that overall, there was a moderate departure from the accepted standard of care in terms of falls management practices. Summerset maintains that appropriate falls prevention measures were in place and that the response to Mr A's fall on 14 June was reasonable. However, I agree with RN Ferreira that there was a departure from accepted standards of care.

111. Mr A was discharged from hospital on 17 June, and the discharge documentation noted that the pain in his leg had led to the fall. However, RN Ferreira advised that there was no incident investigation, corrective actions, evaluation of care, or quality improvements related to medication safety and falls management processes.

Diabetes management

112. As discussed above, Mr A's diagnosis of diabetes and baseline blood-sugar levels were not provided to Nurse Maude at the time of sending the referral for specialist wound care management. RN Ferreira advised that there were deviations in the care provided to Mr A on 14 June.

113. As per the LTCP, Mr A's blood-glucose levels were checked weekly. Summerset said that this was because Mr A was not on insulin; however, Summerset also told HDC that Mr A was non-compliant with his diabetic diet. On the morning of 14 June, Mr A's blood-glucose levels were found to be elevated at 17.2mmol, and when checked in the afternoon, this increased further to 22.9mmol. However, it appears that his blood-sugar levels were not rechecked.

114. Summerset acknowledged that the care plan stated to report to the GP if Mr A's blood sugar level was high, and that if it was more than 15mmol to monitor the levels closely. Although Mr A's name was added to the GP's review list for the next day, I note that the clinical notes do not record whether his blood-glucose levels were rechecked later in the day or escalated to the clinical manager for further management. RN Ferreira advised that it is unclear whether the nursing team recognised signs of unwellness and the associated impacts on resident care and safety needs. There is no record that when Mr A left for social leave in the evening, Mrs B was told about his elevated blood-glucose readings or given any related care guidance. When Mr A returned to Summerset following his social leave, it appears that the nurses did not recheck his blood-glucose level to see whether it had decreased.

115. RN Ferreira advised that the management of Mr A's elevated glucose levels was a moderate departure from the accepted standard of care. I accept this advice. Whilst Mr A was listed for a GP review the following day and was out on social leave in the evening, there were opportunities to check his blood-glucose levels once he returned from social leave in the evening of 14 June or relay the risks associated with high glucose levels to Mrs B when Mr A was on social leave. In my opinion, this was particularly important given Mr A's deteriorating wound and his non-compliance with a diabetic diet, which subsequently increased his risk for a continued elevation in blood-glucose levels and given that Mrs B had

expressed concern that Mr A was tired, which may have been a sign of a high glucose level. I am critical that this did not occur.

Documentation

116. As discussed above, I have noted several areas of concern in relation to the documentation practices at Summerset.

117. RN Ferreira advised that the progress notes contain limited documentation of wound assessment, wound status, delivery of wound care, and the reflected actions. In addition, there were inconsistencies in wound assessments and pain assessments, no incident form, and no staging of the wound to guide care planning and interventions at the time of the wound identification, as required by Summerset's Wound Care Management Policy. Nursing documentation is a legal record of patient/client care. It is essential for good clinical communication and a core requirement by the Health and Disability Sector Standards 2008.[35] The standards state that care providers are responsible for maintaining clear, concise, timely, and accurate records, but in this case, this did not occur.

118. In response to the provisional opinion, Summerset acknowledged that there were opportunities for improvement but stated that the clinical file is an integrated record, and there should not be a need to document the same information in multiple places.

119. I acknowledge Summerset's comments, and whilst I agree that the same information does not need to be repeated in multiple places, I remain concerned about the inconsistencies in assessments and lack of detail during assessments, and the lack of adherence to policy. The multiple examples of poor documentation reflect poorly on the system at Summerset. Clinical records reflect a clinician's reasoning and are an important source of information regarding the patient's care. Documentation is also a key component of ensuring continuity of care, and in ensuring that the next clinician can understand the rationale behind previous clinical decisions. Clinical documentation is therefore a cornerstone of good care, and a required standard of professional practice. In addition, poor clinical notes hamper later inquiry into what happened — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such inquiry.

Conclusion

120. Individually, some of the deficiencies in the care provided to Mr A may appear minor, but cumulatively they led to a poor overall standard of care for Mr A. In addition, the issues were not isolated incidents involving one or two staff members but rather involved a group of people who cared for Mr A. I consider that ultimately the care home is responsible for such widespread failures of its staff.

[35] https://www.standards.govt.nz/shop/nzs-8134-12008

121. I find that Summerset breached Right 4(1)[36] of the Code of Health and Disability Services Consumers' Rights (the Code) for the following reasons:

- Inadequate wound care management, including the lack of consistent wound care assessment, holistic care delivery, and recognition of decline;
- Inadequate pain management, including the lack of regular holistic pain assessments, the failure to escalate increasing pain levels, and the failure to deliver non-pharmacological approaches;
- Inadequate falls prevention and management, including the lack of recognition of factors that increase the risk of falls, the lack of implementation of necessary precautions to prevent falls, the lack of investigation of Mr A's fall and to make corrective actions, the decision to transfer Mr A following a suspected hip injury, and the decision to leave Mr A on the floor alone following his fall; and
- Inadequate management of Mr A's elevated blood-glucose levels.

122. I also find that Summerset breached Right 4(2)[37] of the Code, for the following reasons:

- The failure to adhere to Summerset's Wound Management Policy, including the failure to document wound care assessments sufficiently and the failure to document the effectiveness of the pain relief administered; and
- The failure to complete documentation sufficiently in accordance with the Health and Disability Sector Standards 2008.

Communication with consumer and family — adverse comment

123. I note three areas of concern regarding the communication that was provided to Mrs B and Mr A about his care.

124. First, Mrs B told HDC that Mr A asked to see the doctor when he was not well, only to be told that he had seen the doctor the previous week. Summerset apologised for this and stated that this was unintentional and advised Mrs B that it had implemented weekly GP visits for her father.

125. Secondly, Mrs B told HDC that she was never informed when Mr A's wounds had deteriorated. Summerset told Mrs B that multiple entries over the months document nursing staff discussions with her regarding Mr A's wounds. However, Summerset acknowledged that in hindsight, it would have been beneficial to provide photos of the wound to Mrs B, although this was not common practice.

126. Thirdly, as discussed above, Mrs B was informed of a critical event by email, despite there being instructions to call her any time. In contrast, Summerset told HDC and Mrs B that there

[36] The right to have services provided with reasonable care and skill.
[37] The right to services that comply with legal, professional, ethical, and other relevant standards.

had been no clear instructions in Mr A's file to direct staff to contact her any time, and Summerset apologised for the way in which staff had contacted her.

127. I acknowledge Summerset's submission that it communicated with Mrs B regularly; however, I am concerned about the quality and effectiveness of the communication that occurred. Further, I note that although Mrs B was Mr A's EPOA, this had not been activated, and although it is good practice to update families on important events, there is no legal requirement. I have carefully reviewed the family communication records, progress notes, and the email correspondence between Mrs B and Summerset, and, in my opinion, the communication does not appear to convey the seriousness of Mr A's wound. While updates were given regarding GP assessments and Nurse Maude's plan of care, these do not appear to convey the deterioration in Mr A's wellbeing over May and June, for example the increase in his pain-relief requirements or the fact that his wound was deteriorating. If greater regard had been paid to Mr A's request for medical review, more appropriate pain relief may have been administered sooner to alleviate Mr A's distress.

128. Likewise, I am concerned about the lack of advocacy for Mr A when he expressed the need to see his GP, and the decision to email Mrs B of a critical event. In my opinion, this demonstrates a lack of commitment towards working in partnership with residents and their families. I remind Summerset that residents have the right to access the information and services they need, and it is Summerset's responsibility to ensure that this is honoured.

Escalation of care to GP — adverse comment

129. My advisors, RN Ferreira and Dr Maplesden, both raised concerns regarding the communication between Summerset staff and Dr C. Further, Dr C told HDC that she was not copied into any communication between the nursing team at Summerset and the Nurse Maude team, nor did the Nurse Maude team at any point contact her directly to advise that any alternative process/pathway or referral by her would be needed. Email communications between Summerset and Nurse Maude do not show that Dr C was copied into the correspondence.

130. As discussed above, there were increasing concerns about Mr A's pain levels, deteriorating wound, and elevated blood-glucose levels. In addition, as Mrs B stated to HDC, Mr A's request for a medical review was not brought to the attention of Dr C. In addition, RN Ferreira advised that Mr A's wound appeared to be showing signs of infection over February, indicating that Summerset staff could have escalated the situation to Dr C earlier.

131. Further to the above, Dr Maplesden was concerned about the lack of information sharing regarding the care provided by Nurse Maude. He advised that Dr C should have been informed about the 4–5-week waitlist for Nurse Maude's wound assessment. In addition, RN Ferreira considered that Dr C should have been updated regarding the transfer of care to the diabetic podiatry service on 1 June 2021, as this would have provided an opportunity for collaboration with the service regarding prioritised care. However, this did not happen.

132. Given the above facts, I consider that there was a lack of collaborative practice between Summerset staff and Dr C. As Dr C is not on site 24/7, it is of utmost importance that nursing staff provide regular updates to her as the primary care physician. As expressly stated by Dr C, contracted GPs rely on the observations made by care-home staff in forming their assessments and developing a plan of care, and, in this case, I am concerned about the lack information provided to Dr C, which ultimately meant that she was not fully made aware of the seriousness of Mr A's wounds.

Opinion: Nurse Maude — breach

Introduction

133. As discussed above, Nurse Maude is a community nursing service that provided specialist wound care to Mr A from April to June 2021. While the initial wound assessment by Nurse Maude met accepted standards, I am critical of several areas of the care provided by multiple individual nurses at Nurse Maude, which I consider reflects a systems issue at Nurse Maude. I address each issue in turn below.

Failure to complete urgent referral to specialist services — breach

134. Nurse Maude's wound care nurse completed an initial wound assessment at its clinic on 19 April following referral from Summerset. Ms Escarlan advised that the assessment was comprehensive and noted Mr A's past medical history, including diabetes, previous smoking history, and family cardiac history. Ms Escarlan noted that this history increased Mr A's risk of ischaemia. In addition, the assessment noted that the pulse on his foot was faint to palpate, while another pulse in the lower limb was unable to be palpated. Further, Mr A was noted as having reduced sensation on his left foot.

135. The wound care nurse then escalated Mr A's assessment findings to the wound CNS at Nurse Maude, who completed a further virtual review on 22 April. The CNS noted possible ischaemia, cramp in the lower legs, a reduced ankle-brachial pressure index (ABPI),[38] and pain in the calf with walking.

136. Ms Escarlan advised that the assessment found an impairment in arterial flow and claudication pain,[39] which are red flag symptoms of critical limb ischaemia and diabetic neuropathy. Ms Escarlan said that in these circumstances, urgent referral should have been made to specialist services, such as diabetes podiatry services or the vascular department, to assist with diagnosis and management. Ms Escarlan advised that not doing so was a severe departure from an accepted standard of care because Mr A was at risk of active and rapid deterioration of his symptoms.

137. I accept this advice. Whilst there is documentation of a referral to the vascular department having been considered, as shown in the information provided by Mrs B, it appears that this

[38] This test compares the blood pressure in the extremities, ie, a calculation of the ratio of the patient's systolic blood pressure at their ankle and the systolic blood pressure in their arm.
[39] Pain that occurs in the limbs with walking, usually as a result of poor blood supply to the limbs.

was not completed until 1 June. The referral pathways for foot screening notes that a referral to vascular services and/or diabetic foot services is required for critical limb ischaemia. I also note that Dr Maplesden and RN Ferreira raised similar concerns about the lack of timely referral to specialist services. Therefore, I agree that an earlier referral was warranted.

Failure to complete in-person assessment — breach

138. Following the initial assessment by Nurse Maude's wound care nurse on 19 April, no further in-person assessments occurred between April and June 2021. Assessments occurred remotely and relied on the images of wounds supplied by Summerset nurses. Nurse Maude did not advise why further in-person assessments did not occur.

139. Ms Escarlan advised that while virtual reviews were helpful during the COVID-19 pandemic and are helpful when access to the patient is difficult, complex wounds such as Mr A's should have been reviewed in person, and not doing so was a severe departure from the accepted standards of care.

140. Ms Escarlan explained that this is because wound photos do not give a holistic view of the patient's experience, or whether the wound is deteriorating. Further, she said that the expertise of the photographer greatly influences the quality of the photos, and this can lead to a misinterpretation of the wound bed[40] characteristics, and consequently the decision-making on the extent and severity of the wound. Ms Escarlan advised that the lack of an in-person review after 19 April 2021 was a severe departure from the accepted standards of care.

141. I accept this advice. I agree that virtual reviews may be helpful where wounds are simple. However, given Mr A's complex clinical history and propensity to deteriorate because of his red flag symptoms, it was essential to complete an in-person review. This was particularly important when Mr A's wounds failed to improve.

Inadequate follow-up — breach

142. Ms Escarlan advised that the management plan by Nurse Maude was poor, and she noted several concerns with this.

143. First, as discussed above, Mr A showed signs of ischaemia during the assessment of 19 April. Ms Escarlan advised that while the wound dressing plan and assessment were appropriate, there was a failure to include a management plan for ischaemic pain, such as ensuring adequate pain relief and advising Mr A to keep his feet on the floor when not on the bed to support symptoms related to arterial insufficiency.

144. Secondly, Ms Escarlan advised that there was a lack of safety-netting advice provided to Summerset and/or Mr A. She said that given Mr A's red flag symptoms, there should have

[40] The base of the wound. Characteristics used to describe the bed include the location, type of tissue, measurements, and the presence of fluid — including its colour, consistency, and odour.

been an active plan in place for Summerset if the wound was persistent or worsening, or if Mr A became systemically unwell. However, this did not occur.

145. Finally, Ms Escarlan advised that when Summerset re-referred Mr A's wounds to Nurse Maude over April and June, the initial treatment plan should have been changed as the wound progressed, and close monitoring and regular follow-up was necessary. Ms Escarlan said that it is the service provider's responsibility to review complex wounds regularly rather than relying on Summerset's nursing staff to report back. This is because a lack of a routine review can lead to losing track of whether the patient is responding to the plan of care, and this affects the ability to escalate to speciality services in a timely manner, which is what happened in Mr A's case. Further, Nurse Maude's wound management policy instructs staff to review digital images at least every two weeks, if not sooner, if there is a change or deterioration. However, correspondence between Summerset and Nurse Maude does not show that this occurred.

146. Ms Escarlan advised that the above failures were a moderate to severe departure from the accepted standards of care. I accept this advice. I agree that there were several shortcomings in the follow-up of Mr A's wounds, including the failure to provide safety-netting advice to Summerset and/or Mr A, the failure to manage Mr A's ischaemic symptoms, and the failure to follow policy and Nurse Maude's documented plan.

Conclusion

147. There were multiple deviations from the accepted standard in the care provided to Mr A by Nurse Maude's nurses. The problems that arose concerned three staff who cared for Mr A. In my opinion, this reflects poorly on the systems at Nurse Maude, for which ultimately it is responsible, rather than the individual staff.

148. I consider that Nurse Maude did not provide a reasonable standard of care to Mr A for the following reasons:

- The failure to complete an urgent referral to either the vascular department and/or diabetic podiatry services;
- The failure to review Mr A's wound in person after 19 April; and
- The failure to follow up on Mr A's care adequately.

149. I therefore find that Nurse Maude breached Right 4(1) of the Code.

Communication regarding referral to vascular department — adverse comment

150. Mrs B told HDC that after Mr A's initial wound assessment on 19 April, Nurse Maude advised her that a referral would be made to Health NZ's vascular department as his foot 'did not look good'. Mrs B then communicated this information to Summerset, who relied on this information to provide further care to Mr A.

151. On 31 May Mrs B was advised by a Nurse Maude nurse that as Mr A's wounds were improving, a vascular referral had not been completed. Likewise, Summerset followed up

with the vascular department, only to learn that a referral had not been completed. Nurse Maude told HDC that usually a referral to the vascular department is completed following assessment with the CNS. However, Nurse Maude did not update Mrs B and Summerset that following the review by Nurse Maude's CNS on 22 April, it was considered that a vascular referral was no longer required. Nurse Maude acknowledged that this should have occurred and apologised to Mrs B for this.

152. I also note Nurse Maude's comments to HDC that it refers patients to the diabetes podiatry clinic rather than the vascular department, when Mrs B's understanding was that a referral would be made to the vascular department rather than the diabetes podiatry clinic. Nurse Maude apologised if the communication about the process was not clear.

153. Further, the documentation provided by Nurse Maude shows conflicting information regarding which service would manage Mr A's wounds. The recommended plan of care sent to Summerset stated that the Nurse Maude nurse would refer Mr A to the vascular department, whilst another part of the documentation stated that if Mr A's wounds deteriorated further, then he would be referred to the diabetes podiatry clinic.

154. I am therefore concerned about the process in place at Nurse Maude for managing deteriorating ulcers, and I recommend that Nurse Maude address this. I discuss this further under the recommendations section below.

Opinion: Dr C — adverse comment

Introduction

155. Dr C provided primary care services to Mr A between January and June 2021. I have noted two areas of concern in the care provided by Dr C.

Lack of vascular assessment — adverse comment

156. Dr C was first made aware of Mr A's wound on 23 February. She assessed the wound and made a plan for antibiotics, cushioned dressings, and a podiatry review and advised nursing staff to keep Mr A shoe free. However, there is no documentation that a vascular assessment was performed.

157. Dr C told HDC that her working diagnosis was one of diabetic ulcers and possible underlying ischaemia/circulatory compromise.

158. As discussed above, Mr A had a history of smoking and Type two diabetes. Dr Maplesden advised that Mr A was at high risk of peripheral vascular disease (PVD) due to this clinical history, and while the overall standard of Dr C's clinical assessments and documentation appeared reasonable, he was mildly critical that there was no apparent assessment of the vascular status of Mr A's foot over this period, including the lack of checking for vascular return and peripheral pulses, or the presence of claudication.[41]

[41] Pain in the legs or arms caused by limited blood flow to the muscles.

159. In response to the provisional opinion, Dr C said that any bedside assessment would have been inferior to the investigations she had requested, and she does not believe that documentation of her bedside findings would have changed the clinical outcome. In addition, she noted that at no point was Mr A reported to have claudication symptoms.

160. I acknowledge Dr C's response to the advice; however, Mr A's outcome is not the focus of my investigation. Rather, my investigation focuses on the standard of care provided to Mr A at the time. Therefore, I concur with Dr Maplesden that a vascular assessment should have been completed due to Mr A's risk for PVD. I acknowledge Dr Maplesden's comments that the risk associated with not completing a vascular assessment was mitigated by Dr C's instruction to nursing staff, in which she advised referral to a specialist wound care service for completion of an ABPI, and other assessments completed by Dr C.

Referral to diabetic podiatry service — educational comment

161. Dr Maplesden advised that given Mr A's risk for PVD, Dr C should have considered a referral to the diabetic podiatry service, as per the health pathways guidance cited by him. However, this did not occur.

162. Dr C told HDC that she felt that Mr A was getting the care and input he needed at the time, and that at no point did Nurse Maude or Summerset nursing staff recommend this option to her. In addition, she said that sending an additional referral to the diabetes foot clinic seemed like 'doubling up' on the wound care he was already receiving.

163. I acknowledge Dr Maplesden's advice and note that RN Ferreira raised similar concerns about a delay in referral to the diabetic podiatry service. In my opinion, an earlier referral was warranted given Mr A's known risks for PVD and slow-healing wounds. However, I do not consider that the responsibility to refer Mr A to the diabetic podiatry service lay solely with Dr C, but also with Summerset and Nurse Maude, which I have discussed above. In my opinion, the lack of an earlier referral stemmed from poor collaboration between Dr C, Summerset staff, and Nurse Maude.

Communication with Summerset during holiday — other comment

164. On 9 June Summerset staff contacted Dr C for advice because Mr A's wounds were not improving. I note that Dr C responded to this request, despite being on holiday at the time.

165. Dr Maplesden advised that it would have been more appropriate for Dr C to have referred Summerset staff to the on-call doctor for further advice.

166. I accept this advice. In my opinion, best practice would have been to redirect Summerset's queries to the on-call doctor; however, ultimately, I consider that Dr C provided reasonable verbal advice.

167. Dr C acknowledged Dr Maplesden's advice and stated that after having given her initial advice, she asked Summerset staff to contact the on-call GP for ongoing issues.

Decision not to commence antibiotic therapy — no breach

168. Mrs B complained to HDC that swabs taken from Mr A's wounds in the week prior to his hospitalisation had indicated an infection, but no antibiotics were started for this. However, when Mr A was transferred to hospital on 15 June, antibiotics were commenced immediately.

169. As discussed above, Summerset staff contacted Dr C for advice due to concerns about wound deterioration. In response to this, Dr C advised nursing staff to complete a wound swab and not to commence antibiotics unless the wound became more red, hot, or swollen or if Mr A developed a fever. This was because Dr C was concerned that there may have been some resistance to antibiotics.

170. On 11 June nursing staff told Dr C that the swabs had come back positive, but they did not state whether Mr A's wounds showed signs of infection or whether the wound was red, hot, or swollen or if there was a fever. Dr C therefore advised not to commence antibiotics and repeated her safety-netting advice in relation to monitoring for infection.

171. Dr Maplesden advised that most localised wound infections do not require systemic antibiotic therapy, and that good wound care was the most important factor. However, given that there were signs of infection, Dr C's decision not to commence antibiotics would be met with mild disapproval.

172. I acknowledge Dr Maplesden's advice and accept that there were signs of infection. However, this information was not conveyed to Dr C. Further, Dr C repeated her safety-netting advice to Summerset staff. Therefore, I am satisfied with Dr C's actions on this occasion.

Reviewing wounds remotely — no breach

173. Mrs B told HDC that Dr C was 'getting the care facility to send photos of the toes', rather than sighting the wounds on Mr A's foot.

174. Clinical records and Dr C's statement to HDC indicate that Dr C reviewed Mr A's wound in person on 23 February, 2 March and 9 March. However, Dr C did not review the wound directly on 30 March, 27 April, or 18 May and appeared to rely on the information provided by nurses. In addition, text messages showed that Summerset staff provided photos of the wound to Dr C due to concerns about wound deterioration. The photos were not requested by Dr C.

175. Dr Maplesden advised that Dr C's management of Mr A's wounds, including the review of the images provided, was reasonable. In addition, he advised that it was reasonable for Dr C to defer to the Nurse Maude nurse, who had specific expertise in wound care management. I accept this advice. In my view, Dr C was in regular contact with Summerset staff and responsive to the concerns raised by them, and as discussed above, it is usual practice for GPs to rely on the information provided by care-home staff to develop a plan of care.

Changes made since events

Summerset

176. Summerset told HDC that it undertook the following actions:

a) Held a meeting with Mrs B, Dr C, and other Summerset staff on 28 June 2021 to discuss Mrs B's concerns and develop a plan going forward regarding Mr A's care. The plan included a change in the GP, weekly reviews by the GP, an increase in Mr A's pain relief, and sharing of the wound photos with Mrs B.

b) Completed a formal review of the concerns raised by Mrs B, which included discussions with staff and a review of Mr A's clinical records.

c) Spoke with staff about Summerset's expectations regarding staying with a consumer who has had a fall. Summerset also reminded registered nurses of their responsibility to give clear direction to caregivers in events such as this.

d) Apologised to Mrs B in relation to its decision to email rather than phone her overnight on 14 June.

Nurse Maude

177. Nurse Maude told HDC that it made the following changes:

a) It completed an internal investigation into the care provided to Mr A and the processes followed, including the processes around communication for care-home patients who have leg ulcers.

b) It now checks the documentation on file relating to an EPOA, and, in doing this, ensures that the correct channels of communication are visible to staff.

c) It made enhancements to the client management system specifically relating to EPOA. This has provided increased visibility of more detailed client-specific EPOA information available to staff.

d) It now attends and actively participates in regular meetings and education sessions with aged residential care facility staff and gerontologists to build relationships and enhance the communication process.

e) It introduced a new referral process for vascular department and diabetic podiatry services via an electronic request management system (ERMS). All wound care nurses are now able to complete and submit a referral directly.

Dr C

178. Dr C told HDC that she made the following changes:

a) As much as possible, she tries not to rely solely on the impressions and reports of the nurses and spends more time seeing and reviewing patients. However, she stated that the system of working in any care home still inherently relies on things being brought

to her attention by nursing staff in the first place and in a timely manner so that action can be taken if needed.

b) She has a low threshold for initiating reviews of patients at Summerset, in terms of follow-up of care, even when nurses have not mentioned that they feel it is warranted.

c) She follows up on referrals made by Summerset more actively, and where possible tries to do them herself.

d) She, along with her GP colleagues, continue to liaise with Summerset to try to improve processes and communication to maximise patient care and safety wherever possible.

e) She has reviewed the 'Choosing Wisely' statement from the Australian Society of Infectious Diseases regarding swabs and antibiotic use for leg ulcers, and the Canterbury HealthPathways guidelines on wound infection, as per the Aged Care Commissioner's provisional recommendations.

f) She has reflected on the findings of this investigation, as per the provisional recommendations.

g) She now refers patients with vascular issues directly to the diabetic podiatry team. She has withdrawn her services with Summerset and will not be undertaking aged residential work again in the future.

Recommendations

Summerset

179. I recommend that Summerset:

a) Provide a written apology to Mrs B for the breaches of the Code and other deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B.

b) Undertake further training sessions on the following topics, using this complaint as the basis for the sessions:

- ISBAR communication tool;[42]
- Stop and Watch tool;[43]
- Pain management;
- Falls prevention and management;
- Wound management — in accordance with Summerset's internal policy, including the role that diabetes plays in wound healing;

[42] https://www.hqsc.govt.nz/assets/ARC/PR/Frailty_care_guides/Modified_SBAR_tool_template_example_FCG_final.docx

[43] https://www.hqsc.govt.nz/resources/resource-library/acute-deterioration-te-tipuheke-taru-frailty-care-guides-2023/#acutedeterioration

- HDC's online training modules.[44]

Evidence of staff completion of this training is to be provided to HDC within three months of the date of this report.

c) Report on the effectiveness of the training sessions, within six months of the date of this report. Effectiveness should be measured via an audit of compliance with Summerset's internal policies on pain and wound management.

Nurse Maude

180. I recommend that Nurse Maude:

a) Provide a written apology to Mrs B for the breaches of the Code and other deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B.

b) Provide a copy of its internal investigation into the care provided to Mr A, including the corrective actions to be implemented and the status of these, within three months of the date of this report.

c) Provide an update on its review of its internal processes around communication with care homes, primary care providers, and consumers and their families regarding the care being provided to residents living within aged residential care facilities. The update should include the corrective actions to be implemented and should be sent to HDC within three months of the date of this report.

d) Review its referrals process for vascular department and diabetic podiatry services in line with the New Zealand Society for the Study of Diabetes Referral Pathways for Foot Screening. Nurse Maude is to provide HDC with an update on this review, including the corrective actions to be implemented, within three months of the date of this report.

e) Review its process for undertaking wound care assessments virtually and in person. Nurse Maude is to provide HDC with an update on this review, including the corrective actions to be implemented, within three months of the date of this report.

f) Complete an education session for its internal staff on its expectations for reviewing wounds and following up with patients, in line with its internal policies and procedures. Evidence of this education session having been completed is to be provided to HDC within three months of the date of this report.

[44] https://www.hdc.org.nz/education/online-learning/

Follow-up actions

181. A copy of this report with details identifying the parties removed, except the advisors on this case, Summerset at Wigram, Health NZ, Summerset Group Holdings Limited, and Nurse Maude, will be sent to Health NZ Waitaha Canterbury and HealthCERT at the Ministry of Health and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following clinical advice was obtained from RN Jane Ferreira:

'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Summerset Wigram Care Home. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Documents reviewed.

- Complaint received 22 June 2021.
- Provider response received 24 September 2021
- Clinical records including nursing assessments, care plans, progress notes, monitoring forms, medication records, medical and allied health records, communication records.
- Organisational policies including EPOA and Supporting Decision-making, Communication, Wound Management, Identification and Management of an Unwell Resident

Complaint

[Mr A's] daughter has expressed concern regarding the clinical oversight and standard of nursing care provided to her father while resident at the care home in 2021. Her concerns relate to falls management, pain management, wound care, and related communication processes.

Review of clinical records

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

<u>Care provided at Summerset Wigram</u>

a) Did the assessment of [Mr A's] wounds and wound care treatment provided by Summerset Wigram meet accepted standards of practice and wound care guidelines?
b) Did [Mr A's] pain level assessment and pain management meet accepted standard of practice and guidelines?
c) Was the monitoring and management of [Mr A's] diabetes within accepted standard practice and guidelines?
d) Were the care interventions provided to [Mr A] following his fall on 15 June within accepted standard practice and falls guidelines?

e) Was the communication between staff at Summerset Wigram and Nurse Maude regarding [Mr A's] wound progress and condition of accepted standard practice?

Care provided at Nurse Maude

a) Did the assessment and treatment of [Mr A's] wounds on his great big toe and second big toe meet accepted practice and guidelines.

Background

[Mr A] was admitted to the care home in 2017 following a stroke event which resulted in a left-sided weakness and reduced mobility. His medical history included Type 2 diabetes, haemorrhagic stroke, gout, hypertension, atrial fibrillation, prostatism, allergic rhinitis, coeliac disease, pancreatic insufficiency, vitamin B12 deficiency and low mood. He was prone to urinary infections and constipation and had experienced recent unintentional weight loss. File information shows that [Mr A] required moderate carer assistance with activities of daily living. He was able to mobilise short distances with a walking stick, and at times used a wheelchair or mobility scooter.

Wounds were identified on [Mr A's] his right toes on 31 January 2021. The sites were slow-healing and following GP assessment, [Mr A] was referred to a wound nurse specialist, diabetic podiatrist, and vascular clinic for further care. During this time [Mr A] was transferred to hospital with a shoulder injury following a fall event on 15 June 2021. During the clinical assessment he was diagnosed with critical right leg ischaemia and underwent a surgical procedure for arterial insufficiency. He returned to the care home for ongoing wound care however the sites continued to decline resulting in amputation of the affected toes.

[Mr A's] daughter has expressed concern regarding the care provided to him between 31 January 2021 when the wounds were identified, and his hospital admission on 15 June 2021.

a) **Did the assessment of [Mr A's] wounds and wound care treatment provided by Summerset Wigram meet accepted standards of practice and wound care guidelines?**

The organisation's wound management policy provides clear guidance about wound care responsibilities, including steps for managing non-healing wounds. The policy refers to contributing factors to slow wound healing such as unintentional weight loss, diabetes, or reduced oral intake, noting the importance of dietitian input if clinically indicated. The policy states that the RN team are responsible for identifying wounds that are responding poorly to the wound care plan, to escalate concerns to the general or nurse practitioner (GP/NP) and seek specialist advice.

Progress notes show that an area of concern was identified on [Mr A's] right second toe on 31 January 2021 during a dressing change for a pre-existing pressure injury to the outer aspect of his right ankle (malleolus). The entry refers to completion of a short-term care plan (STCP) and wound plan in keeping with the wound policy guidelines. It is unclear if an incident report was completed at this time in line with accepted event management processes. It appears the site was reviewed by a registered nurse (RN) on 3 February 2021 with progress notes referring to a treatment plan for a flare up of gout.

Wound care records reflect that wound care interventions were provided between 31 January and 23 February 2021, however progress notes during this timeframe provide very limited discussion of nursing assessment, wound status, or delivery of wound care. The wound assessments describe signs of wound infection with presence of purulent exudate, noting referral to the GP. Progress notes 23 February 2021 state that [Mr A] was seen by the GP regarding "an ulcer on toe, and sore big toe".

An incident report … was logged on 23 February 2021 regarding a suspected infection in the toe, noting a suspected pressure injury to the right great toe (staging is unclear). Nursing information shows that [Mr A] was commenced on antibiotic therapy, a STCP was in place to guide care requirements and referral made to the care home podiatrist which appears to be in line with accepted practice standards.

Interactions regarding delivery of wound care are next discussed in progress notes on 27 February but there is no reference to wound assessment or status considering the prescribed antibiotic therapy.

Entries 2 March 2021 refer to further GP assessment, referral for an x-ray, wound swab, and wound specialist referral. The STCP was updated to reflect a requirement for regular pain assessments and vital sign monitoring per shift for 1 week, however supporting records were not evidenced in the submitted documentation to inform further comment. An entry 3 March 2021 states that [Mr A's] toes appeared "red and macerated" and that antibiotic therapy continued. File information shows that a referral was sent on 9 March 2021 by a care home RN to request wound nurse specialist (WNS) input regarding the slow healing wounds, in line with policy guidelines. I note that a diagnosis of Type2 Diabetes or evidence of baseline blood sugar levels was not reported in the preassessment information which would usually be considered as clinically relevant.

[Mr A] was seen at wound care clinic on 19 April 2021 for an initial assessment of his right great toe, second toe, and ankle site. A specific doppler pulse assessment was completed which showed diminished foot and lower limb pulses, with assessment notes reporting likely peripheral vascular disease with limb

ischaemia. An interim wound care management (WCM) plan was developed for the RN team to follow and the assessing RN reportedly escalated assessment findings to the Clinical Nurse Specialist (CNS) for further guidance in line with their policy processes. Records show that the CNS reviewed [Mr A's] assessment and care plan on 22 April 2021, noting a slow to heal ankle site, ulcerated toes, and possible ischaemia. Recommendations were to implement pressure relieving strategies to support the wound care plan, which included a review of footwear and equipment use, and review the sites in two weeks. [Mr A's] plan of care indicated that an agreed wound plan was in place for a two-week period and that vascular referral was pending follow-up WNS assessment. Nursing documentation shows that three goals were developed for [Mr A's] wound care: *to provide comfort, * to reduce infection, * to refer to vascular clinic if no improvement (no timeframe is noted). The WNS provider has advised that referrals to the vascular outpatient team occur as clinically indicated following CNS review.

File information shows that on 10 May 2021 the provider followed up with the care home about [Mr A's] wound status. Email communications state that a pressure-relieving air mattress and a bed cradle were implemented 7 May 2021, however progress notes and the short-term care plan provide limited discussion of equipment use. Progress notes indicate that use of appropriate footwear had been discussed with [Mr A], his daughter, and the physiotherapist with alternatives considered.

Reviewed wound photos 4 May and 27 May and wound records indicate that [Mr A's] wounds were showing increasing signs of necrosis, and progress notes describe increasing reports of pain. It is unclear from nursing notes if the RN team informed the GP of pain assessment findings, the use of as-required (PRN) prescribed pain relief, or [Mr A's] refusal of pain relief due to his concerns with constipation.

WNS records show that following discussion with the RN team regarding the hard to heal wounds, [Mr A] was referred to the diabetic podiatry services on 1 June 2021 for assessment and ongoing care. Care statements indicate that the service worked in partnership with the vascular team and would be better suited to support [Mr A] at that time. Given [Mr A's] diabetic status and regular podiatry input, as outlined in his care plan, it is unclear why a referral to this specialist service was not considered earlier by the care home team or discussed with the WNS at the time of referral. It is unclear whether the GP was updated of this by the nursing team, which may have indicated an opportunity for GP consultation with the WNS and/or vascular team regarding prioritised care.

Email communication with WNS 14 June 2021 refers to wound decline following social leave with reports of increased pain, use of additional medications, delayed wound care and challenges with suitable footwear. It is unclear what nursing

assessment occurred on [Mr A's] return to the care home or if concerns were escalated to the clinical manager or GP for support which would be considered accepted practice in the circumstances.

The Wound Management policy refers to professional responsibilities regarding documentation and reporting requirements. On review of the submitted information it appears that delivery of resident wound care was not consistently evidenced in RN progress note entries with minimal discussion of wound assessment, wound status or related actions reflected. There also appear to be inaccuracies in wound assessments regarding the identification and staging of wounds and pressure injuries, descriptions and ratio of slough or granulation tissue, and recognition of decline which presents an improvement opportunity. It is unclear whether the Clinical Manager and RN team reviewed [Mr A's] wound status during their monthly RN meetings in keeping with clinical and quality management processes as outlined in the wound management policy, however, meeting minutes were not provided to inform further comment.

In summary, it appears that the care home's management of [Mr A's] wound care was provided in line with health specialist guidance at the time. However, there are deviations from practice related to holistic nursing assessment, recognition of decline and timely advocacy, including communication and documentation standards which would be viewed similarly by my peers.

- Departure from accepted practice: Mild to moderate

b) Did [Mr A's] pain level assessment and pain management meet accepted standard of practice and guidelines?

The wound management policy refers to RN responsibilities to pain assessment (2.5) with discussion of pain assessment tools (Abbey and IOWA) used to identify pain location, type, and severity. The care record reports that [Mr A] regularly expressed reports of pain in his right foot. Reviewed pain assessments, medication administration records and progress note entries indicate that [Mr A] reported pain but there is limited evidence of RN assessment or reporting of pain assessment scores. RN and carer progress notes refer to observed changes in [Mr A's] mood however it is unclear whether the team considered signs of verbal distress were pain-related cues. Health information indicates that [Mr A] had a chronic history of neuropathic pain, with reports of sudden, intense, stabbing sensations. While [Mr A] was able to inform the care team of pain, it is unclear whether the RNs considered using the Abbey pain scale to inform a holistic (subjective and objective) assessment and guide nursing actions.

From the evidence reviewed to respond to this question there appear to be mild departures from accepted approaches to practice regarding pain management. File information indicates that [Mr A] was known to refuse pain relief as he was concerned about the effects of the prescribed medication on bowel function.

From the information reviewed it is unclear what health education was provided to [Mr A], including non-pharmacological strategies, to support his knowledge and understanding. Progress notes provide limited evidence of RN actions or further assessment of pain across shifts. It is unclear whether concerns with pain management were escalated to the GP for review or clinical manager for discussion at weekly RN meetings to ensure effective delivery of coordinated personalised care, in line with recommended approaches to practice.

- Departure from accepted practice: Mild

c) **Was the monitoring and management of [Mr A's] diabetes within accepted standard practice and guidelines?**

[Mr A's] care plan appears to provide comprehensive guidance regarding the management of his health requirements. File information indicates that the GP was aware of his health status with clinical notes acknowledging the impact of diabetes on wound healing. The care record provides evidence of Dietitian involvement in care with commencement of a nutritional supplement, and a dietary review to increase servings of protein to support wound healing. There is evidence that a podiatrist was involved in [Mr A's] podiatry requirements at the care home.

File evidence shows [Mr A's] blood glucose levels were regularly checked weekly. Records show that levels were elevated above his baseline on the morning of 14 June 2021 (17.2mmol/22.9mmol) but do not appear to have been rechecked on the afternoon or night shift. Progress notes do not provide discussion of any related care interventions in line with care plan guidance. I note that [Mr A] went out with his daughter that day, however there is no record of communication informing her of the elevated readings or any related care guidance documented at the time. I note from the provider response that the duty RN added [Mr A] to the GP list for review the next day. It is unclear whether the RN team recognised signs of unwellness and the associated impacts to resident care and safety needs, with minimal evidence of a holistic nursing assessment being completed, or escalation of raised recordings to the clinical manager or GP, which would be considered accepted practice. Based on my review of the submitted evidence I consider there are moderate deviations from accepted practice standards in the management of this episode of care which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

d) Were the care interventions provided to [Mr A] following his fall on 15 June within accepted standard practice and falls guidelines?

Nursing information reflects that [Mr A] was assessed as a medium falls risk on 19 May 2021. The long-term care plan is comprehensive and provides clear guidance regarding agreed care and safety interventions. The care record shows that [Mr

A] attended weekly physiotherapy sessions with supporting entries discussing assessed levels of mobility and exercise plans. [Mr A's] care plan stated that he was at risk of falls due to a left-sided weakness. It also stated that he received prescribed doses of controlled drug medication (Morphine) and was at risk of losing his balance. File information shows that [Mr A] was informed of safety interventions, such as the use of hip protectors or a sensor mat but declined to include these in his plan of care. Carer progress note entries refer to call bell access, hazard minimisation and intentional rounding to support safety needs which appears to be in line with care plan guidance.

On 15 June 2021 [Mr A] experienced an unwitnessed fall event in his bedroom which resulted in hospital transfer for further assessment. The incident report … states that a carer reportedly heard [Mr A] calling out at 0430hrs and found him lying on the floor, however there is no supporting entry outlining the event reported in carer progress notes. The incident report and RN progress note state that [Mr A] reported hitting his head, with shoulder and hip pain. He was reportedly assessed from head to toe by the duty RN who suspected a hip fracture and called an ambulance for assistance. The provider has advised that vital signs and neurological observations were recorded, however there is no evidence with the submitted evidence. The nursing entry states that [Mr A] reported a pain score of (4), indicating severe pain but declined prescribed pain relief. The entry also states that [Mr A] declined to go back to bed. It is concerning that the RN considered transferring a resident with a suspected hip injury, which is not in line with accepted falls management practices (HQSC, 2019; HQSC, 2023).

It is unclear whether the duty RN was familiar with the post-fall assessment process at the time. The Falls Management policy was not sighted in the evidence bundle, however the Management of an Unwell Resident policy states that if a resident becomes unwell or sustains an injury, the resident will be assessed by an RN. The policy states that first aid trained members will be on duty, with additional RN support available from on-duty or on-call nurses, and GP/NPs or ambulance services. The policy discusses the resident transfer to hospital process, including communication and documentation requirements, noting expectations to inform the resident's nominated representative.

Care records state to call [Mr A's] daughter at any time if there was a change in his condition. It is unclear why the duty RN chose to email rather than telephone his nominated representative, however the provider has provided rationale, and acknowledged that a telephone call would have been a more appropriate means of communication in the circumstances, in line with organisational policy. [Mr A's] daughter has described finding her father in his bedroom alone post-fall. Accepted falls management practice is for an RN or delegated carer to remain with the resident until further assistance arrives. It is unclear from the provider response and file evidence what corrective actions have occurred in response to this feedback.

The discharge summary 17 June 2021 refers to relocation of [Mr A's] dislocated shoulder sustained in a fall event, with mention of high doses of morphine and pain leading to the fall. However, evidence of incident investigation, event evaluation, including corrective actions or quality improvements related to medication safety and falls management processes was not provided.

The event history shows that on 14 June 2021 [Mr A's] blood glucose levels (BGL) were elevated; 0555hrs (17.2mmol) and 1219hrs (22.9mmol). He was given his prescribed oral metformin, however there is no evidence that further checks occurred or that the RN team considered signs of infection, or potential adverse health effects from a raised BGL. Medication records show that [Mr A] was given two PRN doses of Morphine for pain relief at 0606hrs and 0838hrs. He then left the care home on social leave, returning at 1930hrs. File information shows that his daughter reported on his return to the care home that he was "sleepy and tired" and requested a GP review regarding the level of alertness. It is unclear what nursing assessment occurred based on this information. There is no evidence of note to indicate that BGLs and vital signs were checked by an RN. Medication administration records show that [Mr A] was given prescribed Morphine for reported pain and Zopiclone (for insomnia) at 2041hrs. It is unclear whether the RN and care teams recognised that [Mr A] was at increased risk of falls at this time. It does not appear that the frequency of intentional rounding was increased to ensure his safety needs were maintained, or wellbeing concerns communicated to the incoming shift.

As a comment, it is unclear from the submitted evidence whether [Mr A's] fall risk was reassessed on his return to the care home from hospital or if falls minimisation strategies were reviewed, in line with accepted practice standards (HQSC, 2019; HQSC, 2023).

On review of the submitted evidence I consider there are moderate practice deviations relating to nursing assessment, medication management, falls prevention and management, post-fall assessment processes, and incident management responsibilities which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate.

e) Was the communication between staff at Summerset Wigram and Nurse Maude regarding [Mr A's] wound progress and condition of an accepted standard of practice?

Further to commentary in Question (a), following GP assessment, the care home sent a referral to Nurse Maude for WNS assessment on 9 March 2022 in line with policy guidelines. Email communication from Nurse Maude acknowledged receipt of the referral noting a wait list period of 4–5 weeks, which is reflected in care home documentation. The external provider sent an aged care specific form to the care home on 12 March 2021 to request further information. Care home

records show the completed preassessment form was emailed to the WNS on 15 March 2021. Content discusses a chronic stage 2 pressure injury on [Mr A's] ankle (2 November 2020), with identified pressure injuries on the right great toe and second toe (staging not noted). Nursing information states that [Mr A] had received two courses of antibiotics however wound swabs indicated persistent presence of staphylococcus. X-Ray results reported no signs of osteomyelitis. The document states that [Mr A] experienced intermittent pain when walking or touched, with a pain assessment score of 7/10. The document reported unintentional weight loss of 3kg between November 2020 and January 2021. Health history and activities of daily living are discussed, however as outlined in question (a), [Mr A's] diagnosis of Type2 Diabetes and related health data was not reported in the preassessment information.

On 12 April 2021 a follow-up email was sent to the care home by the provider querying a need for input as there had reportedly been no communication received from the RN team. File information 14 April 2021 indicated that the referral had been received by Nurse Maude, with email feedback complimenting the level of information provided by the care home RN. [Mr A] was seen by the WNS team on 19 April 2021 which still appears to be within the forecasted 4–5-week timeframe. File information provides evidence of regular email communications between the care home RN and WNS team regarding [Mr A's] wound status and management plan which appears to be acceptable in the circumstances.

Care provided at Nurse Maude

f) Did the assessment and treatment of [Mr A's] wounds on his great big toe and second big toe meet accepted practice and guidelines.

I am unable to provide comment as this is outside my scope of practice.

Clinical advice

Based on this review I recommend the care home team complete additional education about the Stop and Watch tool to support recognition of resident deterioration and prompt escalation to a registered nurse. I also recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the care team and family/whānau in the resident's clinical record. To support this action, I recommend implementing the ISBAR communication tool to better inform clinical assessments, nursing actions, and safe, evidence-based decision-making.

I also recommend that the care home team complete the HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/.

Jane Ferreira, RN, PGDipHC, MHlth

Nurse Advisor (Aged Care)
Health and Disability Commissioner

References

Health and Disability Commissioner. (2022). Online Learning. https://www.hdc.org.nz/education/online-learning/

Health Quality and Safety Commission. (2019; 2023). Frailty Care Guides. http://www.hqsc.govt.nz/'

Names (except the advisors on this case, Summerset at Wigram, Health NZ, Summerset Group Holdings Limited, and Nurse Maude) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: In-house clinical advice to Commissioner

The following clinical advice was obtained from Dr David Maplesden:

'1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner with current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide a clinical steer in relation to the complaint from [Mrs B] about the care provided to her late father, [Mr A], by [Dr C]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Mrs B]
- Response and care notes Summerset at Wigram (SW)
- Response and clinical notes Nurse Maude (NM)
- Clinical notes [a public hospital]
- **Addendum 20 February 2024:**
  - **Response and clinical notes from [Dr C] received 17 June 2023**

3. I have been asked to provide a steer on [Dr C's] role in the management of [Mr A's] [right] toe ulcers between February and June 2021 including the decision by [Dr C] not to prescribe [Mr A] antibiotics when a wound swab dated 9 June 2021 was positive for Staphylococcus aureus.

4. I have reviewed the information on file. I am not particularly concerned about the GP's decision not to prescribe antibiotics when a wound swab (9 June 2021) grew staph aureus unless there were obvious clinical signs of infection at that time **[see addendum s 7(iv)]**. The Australasian Society for Infectious Diseases noted in a "Choosing Wisely" statement in 2016[1]: *Lower leg ulcers, most commonly venous ulcers are often treated with oral antibiotics, even in the absence of evidence of clinical infection. There is no evidence to support this use, except if screening for carriage of multi-resistant organisms. Also a swab for microscopy and culture, in the absence of signs of infection is not recommended. Unnecessary antibiotics and swabbing will add to healthcare costs, antimicrobial resistance and patient allergy*. Local HealthPathways guidance on wound infection[2] advises swabbing of the wound and treatment with oral antibiotics if there are systemic signs of infection (spreading erythema around wound; induration or discolouration

[1] https://www.choosingwisely.org.au/recommendations/asid2 Accessed 7 February 2023
[2] Canterbury Community HealthPathways. Biofilm and Wound Infection. https://canterbury.communityhealthpathways.org/ Accessed 7 February 2023

spreading into peri-wound; lymphangitis; red streak following blood vessel; malaise, or other nonspecific deterioration in general health; fever; raised pulse).

5. However, it appears [Mr A] had "high risk" diabetic foot disease and active disease (non-healing ulcers) from the start of 2021 and it is perhaps of some concern there was not an earlier referral to the Christchurch Diabetes Centre — Active Foot Disease Clinic (AFDC) as recommended in relevant local guidance[3]. It is also relevant that [Mr A] was requiring increasing doses of analgesia for foot pain at rest in the weeks prior to his hospital admission on 15 June 2021 which, noting it was associated with active foot ulceration in a patient with diabetes and confirmed peripheral vascular disease (ABPI performed by Nurse Maude (NM) staff on 19 April 2021 (R leg 0.69)), required consideration of underlying critical limb ischaemia. I note [Mr A] was being reviewed by both a podiatrist and NM wound management specialists over this period, and there was an eventual referral to the AFDC by NM staff on 1 June 2021 (review scheduled for 22 June 2021). It is unclear to what extent [Dr C] was relying on information from the podiatrist and NM staff regarding appropriate management of [Mr A's] foot disease (and competent and appropriate professional advice would be expected from these sources), or whether she may have been under the impression (as care home staff were apparently) that NM staff had made an earlier referral to the hospital vascular service.

6. I recommend [Dr C] is asked to provide a response and GP notes for the period January to July 2021 **[response and notes received 17 June 2023 and incorporated below]**. The response should include comment on the following:

7. *Her working diagnosis as to the cause of [Mr A's] chronic foot ulcers and, in particular, whether critical limb ischaemia was considered and/or assessment undertaken in this regard particularly when [Mr A] was requiring increasing doses of analgesia for foot pain*

(i) [Mr A's] co-morbidities are noted including hemiparesis following a haemorrhagic stroke (2016), type 2 diabetes, gout, prostatism with recurrent UTI, hypertension, low mood, B12 deficiency, osteoporosis, pancreatic insufficiency, coeliac disease, atrial fibrillation, ex-heavy smoker, long standing finger and lateral ankle (L) ulcers, weight loss and anaemia. Review was undertaken by a physician on 4 May 2021 in response to a referral from [Dr C] with conservative approach to weight loss and anaemia agreed. [Dr C] was first asked to review a wound on [Mr A's] right big and second toes on 23 February 2021. Flucloxacillin was prescribed for signs of infection with additional podiatry input requested (unclear who was providing this service) and review as directed by nursing staff. At review on 2 March 2021 the wounds were stable rather than significantly improved and [Dr C] arranged blood count, X-ray (to exclude underlying bony

[3] Canterbury Community HealthPathways. Foot Disease in Diabetes. https://canterbury.communityhealthpathways.org/ Accessed 7 February 2023

involvement) and wound swab. Antibiotics were continued with swab growing S Aureus sensitive to the flucloxacillin prescribed. X-ray and blood count were unremarkable. At further review on 9 March 2021 there was some mild improvement in the toe ulcers noted with the comment noted: *Healing slowly, likely poor circulation post-stroke and diabetes doesn't help … Woundcare referral has been sent but in the meantime trial silver dressing.* [Dr C] states in her response: *At this stage I requested nurse Maude wound care input to be initiated also and it was my understanding on checking with the nursing team that this would include an initial vascular assessment for detailed pulse checks and ankle brachial pressure index (ABPI) measurements as the potential for limb ischaemia/poor blood supply was part of my ongoing considerations, and it was my understanding at the time that this information would be required in order for any input to be requested from the Vascular surgical or nursing teams at the hospital if needed. Summerset nursing staff were to initiate the Nurse Maude referral at my request.* On file is an e-mail from NM to SW dated 9 March 2021 accepting the referral but noting there was currently a 4–5 week wait for review. It is unclear if [Dr C] was made aware of this wait.

Comment: [Mr A] was at high risk of peripheral vascular disease given his smoking history and diabetes. While the overall standard of [Dr C's] clinical assessments and documentation appears very reasonable, I am mildly critical there was apparently no assessment of the vascular status of [Mr A's] foot over this period (vascular return, peripheral pulses) although I note a more accurate assessment (ABPi) was planned following involvement of the wound care nursing service. [Mr A's] analgesia requirement over this period was somewhat variable and there is no reference to presence or absence of claudication.

(ii) Wound swab was repeated on 23 March 2022 to determine if there was evidence of wound colonisation (Candida and Pseudomonas grown consistent with colonisation) and [Dr C] notes: *Overall, the toes were reported to me to be improving and less painful.* Wound management advice was apparently being provided remotely to SW staff by NM while awaiting formal assessment by the NM wound care specialist. The NM specialist assessment was undertaken on 19 April 2021 (see s 2). Report includes: *Possible ischaemia with history of heavy smoker, CVA, ulcerated toes and malleolus failing to heal. Cramp in lower legs at night several times a week. Able to get back to sleep after change of position. ABPI reduced at 0.69. Pedal pulse palpated. Pain on calf when walking with physio …* The detailed report includes, in the management plan, the comment *This RN to refer to vascular outpatients at* [Mr A's] *agreeance for further investigation.* In a follow-up e-mail from NM to SW staff dated 22 April 2021 management advice is provided and *we will review in 2 weeks to ensure progress is being made. If progress isn't made then we will need to consider referral to diabetes podiatrist for further investigation. The podiatrists have a joint Vascular clinic and will be able to liaise further with them if they feel he needs further input.*

Comment: The NM wound care specialist findings were consistent with [Mr A] suffering from significant left lower limb peripheral vascular disease but not (at this stage) critical limb ischaemia. I believe it was reasonable for [Dr C] to defer to the nurse specialist who had specific expertise in wound care management, and the documentation reviewed suggests the nurse specialist was able to liaise with relevant secondary care services and would do so if she felt the clinical situation warranted MDT review. The SW response provides further detail of contact between themselves and NM staff in May and June 2021 which appears to support this premise.

(iii) [Dr C] saw [Mr A] on 27 April 2021 for routine 3-monthly review and notes *it was my understanding at this stage from the nursing staff that Nurse Maude had referred* [Mr A] *to the Vascular team* (see above). The foot wounds appeared stable and current management was to continue while awaiting the expected vascular service review. Notes include: *Not too many complaints of pain recently, still having morphine PRN on occasions … Await vasc assessment.* [Dr C] reviewed [Mr A] again on 18 May 2021 prior to him travelling … for a holiday. She was asked to view some nasal and hand skin lesions and *wanting to check in about toes as still sore — is under nurse maude and getting regular dressings and care, awaiting vasc input also but likely will be a while for this.* [Dr C] notes in her response: *There was no change in his utilisation of analgesia, or the status of the ulcers reported to me by the nurses however at this point. I do not recall if the dressings were taken down on this occasion or if photos (taken regularly and documented by the nursing staff as part of their routine practice) were sighted by me instead, but I advised to continue the same regime for his ulcer care and re-swab at his next dressing change to ensure resolution of the pseudomonas and candida.*

Comment: I believe [Dr C's] management of [Mr A] was reasonable at this point provided there were no obvious signs of infection or wound deterioration on viewing the toes or current images of the toes, and it does not appear concerns in this regard were raised with [Dr C] by SW staff. As stated previously, I believe it was a reasonable assumption by [Dr C] that specialist NM staff were liaising with the podiatry/vascular service as implied in the NM report referred to in s (ii) above.

(iv) Wound swab dated 20 May 2021 grew S aureus which [Dr C] felt was likely to be a coloniser given absence of any reported signs of wound infection, and no antibiotics were prescribed (see general comments in s1). On 1 June 2021 NM staff referred [Mr A] verbally and in writing to the Diabetes Podiatry team and he was discharged from NM care on 7 June 2021 in anticipation of this handover. [Dr C] was on medical leave from 7–13 June 2021. On 9 June 2021 SW staff contacted [Dr C] via text including images of [Mr A's] ulcers (images viewed — ulcers appear clean and dry but there is some erythema involving the whole of the second toe and distal phalanx of the big toe). There was a preceding message which included: *We've done our wound dressings with input from the wound specialist but by the*

look of how the wounds are, we might need to start him on antibiotics with your advice. Also, … query would it be okay to check for osteomyelitis once more. I'll be sending photos of the wounds … [Dr C] responded: *I am happy to restart Abs and we can put him in my list for review next week … can we reswab him before deciding on Abs and please ask him to keep his shoes off and leg elevated.* A swab was taken that afternoon and result grew S aureus sensitive to flucloxacillin but resistant to penicillin as previously. On 11 June 2021 (Friday) SW staff messaged [Dr C] with the result, noting [Mr A's] daughter was querying about him starting antibiotics. [Dr C] responded (per text): *Plse advise NOK that Abs are not necessarily required and in fact not advised always for this. His swab often come back positive and it is concerning there is already some resistance which I don't want to worsen. I will reassess wounds on tues on my ward round and decide then. Plse continue with the cleansing and dressing regime as per Nurse Maude and keep foot elevated/shoe off. If toe becomes markedly swollen or hot in the interim or if fever we will of course start Abs.* Blood tests taken on 11 June 2021 showed a borderline neutrophilia. [Dr C] notes usual practice would be for the GP providing cover in her absence to have been contacted regarding the results or concerns regarding [Mr A]. She does not recall being informed of any further concerns regarding [Mr A] prior to the review scheduled for 15 June 2021. Prior to the review taking place [Mr A] was admitted to [hospital] following a fall in which he dislocated his shoulder. There was an incidental observation of dry gangrene/critical ischaemia involving his right first and second toes and [Mr A] underwent a right lower limb angioplasty (further procedure required over subsequent weeks). [Dr C] had no further input into [Mr A's] management. … discharge summary dated 17 June 2022 note [Mr A] had normal vital signs on admission and *dry gangrene 1st and 2nd toe, erythema to base of these toes, foot warm.*

Comment: In hindsight, it would have been most appropriate for [Dr C] to have referred SW staff to the on-call doctor for the facility when she was approached while on leave with their concerns regarding [Mr A]. There were some signs consistent with infection in the images reviewed (erythema — although I am not sure if this was a new finding) but the wounds were dry and did not appear particularly sloughy. Best practice would be to confirm there were no systemic signs of infection present (elevated temperature, pulse etc) although it might be expected nursing staff would provide such information proactively if they were concerned. I believe it was reasonable to order a wound swab on this occasion given possible signs of infection (I do not believe there is a sound clinical rationale for ordering swabs when there are no signs of infection) with the result being used to direct appropriate antibiotic therapy. Given there were apparently some signs of infection (spreading erythema — if this was the case) and a positive wound swab (albeit the same organism and sensitivities recorded on previous swabs including those when there were no overt signs of infection) I believe [Dr C's] decision not to commence antibiotics would be met with mild disapproval by my peers with a significant mitigating factor being the safety netting advice provided

for SW staff to report any further deterioration in the wound in which case antibiotics would be considered. If the presence of erythema was not new (ie no evidence of spreading infection) the decision to withhold antibiotics and keep the wound under close review could be consistent with accepted practice (eg Auckland Region HealthPathways[4] comment: *Practice Point: Limit antibiotics for localised infections. Most localised wound infections do not require systemic antibiotic therapy in the first instance. Good wound care is the most important factor.* The [hospital] notes refer to [Mr A] being commenced on IV antibiotics but it appears the main cause for his wound deterioration and non-healing was ischaemia rather than infection.

8. *Whether she is aware of the Canterbury HealthPathway "Foot Disease in Diabetes" and, if so, whether she believes her management of [Mr A] reflected this advice*

[Dr C] cannot recall if she reviewed the cited guidance but she emphasises she was under the impression the NM specialist staff would liaise with relevant MDT members as they saw fit and as discussed previously, I believe this was a reasonable assumption. However, if [Dr C] has not consulted the cited pathway I recommend she familiarise herself with this resource.

9. *Her understanding of the role Nurse Maude had in management of [Mr A's] foot disease, including interdisciplinary referrals*

As per the discussion in the body of this advice, [Dr C] was under the reasonable impression NM staff would liaise with MDT clinicians as indicated and that a vascular referral had been made by them shortly after their preliminary review of [Mr A]. [Dr C] had no direct contact with NM staff.

10. *Any change in her clinical practice or in clinical processes at Summerset at Wigram as a result of the complaint*

[Dr C] refers to changes in her practice relating mainly to improved communication and collaboration with SW staff and I believe these changes are appropriate. I recommend [Dr C] review the references cited in section 4 and additionally the Canterbury Health Pathway on peripheral vascular disease[5] if she has not done so already.'

[4] Auckland Region HealthPathways. *Wound Infections.* https://aucklandregion.communityhealthpathways.org/ Accessed 20 February 2024
[5] Canterbury Community HealthPathways. *Peripheral Vascular Disease.* https://canterbury.communityhealthpathways.org/ Accessed 20 February 2024

Appendix C: Independent clinical advice to Commissioner

The following clinical advice was obtained from Ms Maria Escarlan:

'I have been asked to provide clinical advice to HDC on case number 21HDC01413. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint. I am aware that my report should use simple and clear language and explain complex or technical medical terms.

I am currently registered as a nurse practitioner in older people's health. I have a subspecialty in wound care. I have a total of 17 years' nursing experience. Between 2013 and 2020, I was managing aged residential care (ARC) facilities providing rest home-level care, hospital-level care, dementia care, and psychogeriatric care. Then I got employed in the hospital in 2020 in a clinical nursing specialist nursing role to provide clinical support to ARC facilities across Taranaki, including (but not limited to) wound care management. This role includes provision of expert clinical advice and management of patients with complex wounds across aged residential services, provision of training and education to upskill RNs, and liaison between secondary experts, i.e., wound CNS, vascular service, and foot podiatry service, to support best practice and improve patient outcomes.

In 2022, I registered as a nurse practitioner and have continued working in a clinical support role and providing more advanced practice in the scope of a nurse practitioner. My professional qualifications include registration as a registered nurse in the Philippines, a general and obstetric registered nurse in New Zealand (NZ), and a nurse practitioner in NZ.

My academic qualifications include a Bachelor of Science in Nursing (Philippines), a Competency Assessment Programme (NZ), a Certificate (Nursing-Gerontology), a Postgraduate Diploma (Nursing-Clinical), a Master of Health Sciences (Nursing-Clinical), a Postgraduate Certificate of Proficiency in Therapeutics: Knowledge and Integration, and a Postgraduate Certificate of Proficiency in Nurse Practitioner Prescribing Practicum.

Brief summary of clinical events:
[Mr A] was referred to Nurse Maude for his ulcers on his right great and 2nd toes. [Mr A] attended the Nurse Maude Wound Clinic on 19/4/2021 for an assessment and treatment plan. He was accompanied by [Mrs B], his daughter/EPOA/ complainant, on this appointment. An ulcer on the right lateral malleolus was also noted during this appointment. [Mrs B] reports that she was informed that a referral to the vascular department at the hospital would be made, but when she contacted the hospital, this referral has not been made. [Mrs B] followed up with Nurse Maude due to pain in toes increasing and wounds not improving, prompting referral to a diabetic foot podiatrist by Nurse Maude on 1/6/2024. This referral was requested by [Mrs B].

On 15/6/2021, [Mr A] presented to the hospital following a fall. [Mr A] was noted to have an increasing toe pain with a significant morphine requirement. While inpatient, vascular assessment revealed ischemia to the foot; amputation was considered but not pursued due to comorbidities and frailty.

Nurse Maude's staff who were involved on [Mr A's] case were wound care registered nurses (RN 1), (RN 2) and a wound clinical nurse specialist (Wound CNS). When [Mr A] and [Mrs B] attended the Nurse Maude wound clinic, this assessment was done by the wound care registered nurse (RN 1). During this appointment, the wound care registered nurse (RN 1) considered there may be a potential arterial insufficiency and discussed with [Mr A] and his daughter a referral to the vascular department. A referral to the vascular specialists at Canterbury DHB is always made in consultation with the Nurse Maude clinical nurse specialist (Wound CNS) as per Nurse Maude statement. The wound care registered nurse (RN 1) internally escalated [Mr A] to Nurse Maude's wound CNS.

The wound CNS (did not assess [Mr A] in person) in discussion with the wound care registered nurse (RN 1) provided a treatment plan and documented that the plan was to be followed up in two weeks.

On 10 May 2024, aged care facility provided an update to Nurse Maude via email with the recent photo of [Mr A's] wounds. The photographs appeared worse. The wound care registered nurse (RN 2) remotely reviewed this wound and there was no documentation that the wound CNS was informed. During this remote review, it was noted on the progress notes by the RN 2 that the wounds would continue to be slow to heal until pressure relieving equipment was put in place and the plan of care remained unchanged.

No further input from Nurse Maude from 10 May, until on 1 June 2021, [Mrs B] phoned Nurse Maude and requested the referral. Hence, a referral has been made to the Diabetes Podiatry Clinic.

Question 1: Whether the assessment and treatment of [Mr A's] wounds by Nurse Maude met accepted standards of care

List of sources of information:

Lippincott Procedures on Wound assessment

Management of the diabetic foot — New Zealand Society for the Study of Diabetes (nzssd.org.nz)

https://t2dm.nzssd.org.nz/Section-108-Management-of-the-diabetic-foot

https://www.woundscanada.ca/docman/public/wound-care-canada-magazine/wcc-2019-v17-no1/1404-wcc-spring-2019-v17n1-final-p-22-24-abpi-how-to-tool-pdf/file

In my opinion, the wound assessment conducted by the Nurse Maude wound care registered nurse (RN 1) on 19 April 2021 met the standards of care. It was done comprehensively. On their documentation, they noted:

- An ABPI assessment was done, which revealed 0.69 with monophasic sounds.
- Past medical history and comorbidities of CVA, HTN, diabetes, ex heavy smoker, family cardiac history was considered that increased [Mr A's] risk of ischaemia.
- Pain in wounds in bed at night.
- Pain on walking was noted.
- Dorsalis Pedis pulses faintly palpated and unable to palpate posterior tibial pulses.
- Cramp-like pain.
- Reduced sensation with monofilament test and incomprehensible artery on left foot.

The wound dressing plan provided was appropriate.

The wound care registered nurse (RN 1) followed their policy by escalating [Mr A] to their wound CNS. The wound CNS documented below based on the discussion with the wound care registered nurse (RN 1):

"*On discussion:*

- *Possible ischemia with history of heavy smoker, CVA, ulcerated toes and malleolus failing to heal*
- *Cramp in lower legs at night several times a week. Able to get back to sleep after change of position. ABPI reduced at 0.69. Pedal pulse palpated*
- *Pain in calf when walking with physio*
- *I recommend in the first instance he has pressure relief and wound management plan and review in two weeks to determine if wounds improve. Also, to have footwear checked for possible cause.*

If the problem continues to be referred to the Diabetes Pod team."

I noted that there is an inconsistency of the documentation of the assessments. Wound CNS wrote pedal pulses palpated; however, this was not what RN 1 documented which was a faintly palpated dorsalis pedis and unable to palpate posterior tibial pulses. This assessment is vital in determining urgency in seeking a vascular input.

Moreover, the follow-up plan is not clear.

The wound CNS noted that [Mr A] would be followed up in 2 weeks. But the documentation by the wound care registered nurse (RN 1) on the progress notes stated 4 weeks. Neither occurred which I believe a poor practice in care.

I believe the gaps are:

- There were red flags symptoms of critical limb ischaemia and diabetic neuropathy. The above assessments showed that [Mr A] had an impairment in arterial flow and claudication pain, which can likely be due to critical limb ischemia, but the treatment plan did not include managing these, and [Mr A] was not referred to the secondary specialist service urgently despite the abnormal findings on the assessment.
- No provision for safety netting in the event that the wound declines.
- There is no provision or plan of what symptoms are to be monitored by staff to indicate worsening of the condition of the wound for the staff to escalate to the secondary specialist service.
- The wound plan relied on pressure-relieving equipment, although helpful to prevent further decline; however, [Mr A's] risks and symptoms required a more aggressive approach i.e., referral to vascular specialist or a diabetes foot services.
- Inadequacy of management plan on his pain that is likely neuropathic due to diabetic neuropathy.
- Inconsistencies of the timeline for the follow-up plan as per their documentation.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

For the assessment, when a patient presents with lower leg problems, such as pain, oedema, an ulcer, or other skin breakdown, one of the first tasks is to identify what the cause or causes might be, and which factors could affect treatment strategies.

After taking a thorough patient history, an ankle-brachial pressure index (ABPI, or ABI) assessment is to be considered to be done, a common test to determine any impairment to the arterial blood flow to the lower extremities.

The assessment of [Mr A's] wounds by Nurse Maude met accepted standards of care.

For the treatment plan, the recommended wound dressing plan and pressure relieving equipment were appropriate and acceptable; however, a management plan on ischaemic pain was not included such as a recommendation of neuropathic pain management i.e. a neuropathic pain medication, putting the legs down to relieve pain when in bed which is known to alleviate pain due to arterial insufficiencies, and an urgent referral to the vascular service/diabetes foot specialist. Although documentation on goals of treatment wrote a vascular referral and diabetes podiatry team; however, this had not been followed through.

Sources as above.

Was there a departure from the standard of care or accepted practice?

Moderate departure

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

Consultation with the wound CNS in the hospital where I am working, she viewed the wound assessment and initial treatment plan were appropriate; however, the follow up management plan was done poorly as the treatment plan may evolve to accommodate the progression of the ulcers. As shown on the wound photos, the initial treatment plan may need to be changed as the wound progressed. Hence, close monitoring and regular follow up needed to be in place.

Due to the underlying unknown/unseen risks in patients with diabetes, any diabetic foot ulcer requires a timely referral to the specialist service, such as diabetes foot podiatry or vascular, who have expertise on managing this type of complex wound.

Please outline any factors that may limit your assessment of the events.

The region where I am working has different pathways in referral of complex wounds. I am not working in a region where there is a service provider like Nurse Maude as the middle provider in between primary and secondary care. Although my understanding does not limit my assessment of the events, but it is good to take note that in the region I am working, the primary care i.e., ARC facilities/primary medical provider can refer directly to the secondary care in managing complex wounds.

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

The assessment showed red flags of ischaemia, it would have been beneficial if the wound CNS in Nurse Maude had seen the wound in-person rather than a remote review/or in discussion with the RN to avoid inconsistencies in assessment i.e. pedal pulses palpated vs faint/no pulses noted and since the wound CNS was the only staff in Nurse Maude who could do the vascular referral at that time, the wound CNS should have taken over the management and follow up plan of [Mr A].

Question 2: Whether the referral to the diabetes podiatry service should have been made earlier by Nurse Maude.

List any sources of information reviewed other than the documents provided by HDC:

Updated foot screening referral pathways 2017 — Management of the diabetic foot - New Zealand Society for the Study of Diabetes

In my opinion, the referral to the diabetes podiatry service should have been made earlier by Nurse Maude.

[Mr A] was considered as an active risk who may deteriorate rapidly. He had foot ulcers and symptoms of critical limb ischaemia as documented on their wound assessment. An urgent referral to diabetes podiatry service or to vascular service for critical limb ischaemia should have been made on the day of the first encounter.

Nurse Maude wound assessment outcome could have aided triage decision making to urgently refer [Mr A] to either vascular or diabetes foot podiatry service.

Alternative plan of an emergency admission if rapidly deteriorating i.e., persistent/ worsening pain or systemically unwell should have been put in place in the event that there was a delay of the referral.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

All patients with active foot disease, as below, should be urgently referred to specialist services and should be seen by specialist diabetes foot services with vascular surgery:

- Foot ulcer (if otherwise well likely able to be seen as outpatient)
- Spreading infection
- Critical limb ischaemia
- Gangrene
- Possible active Charcot foot (e.g. hot swollen foot with or without pain)
- Deterioration in postoperative tissue/wound

[Mr A] had an active foot ulcer at the time of the event with symptoms of critical limb ischemia on the day of his appointment in the wound clinic.

Sources as above.

Was there a departure from the standard of care or accepted practice?

Severe departure.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

Discussion with the current wound CNS in the hospital where I am working, she viewed this as below standard of care due to significant active risk of patient with diabetic foot ulcers.

Please outline any factors that may limit your assessment of the events.

None

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

To integrate the Management of the diabetic foot — NZZSD guidelines into Nurse Maude's policy and procedures.

Question 3: The appropriateness of reviewing [Mr A's] wounds using photos, rather than in-person.

In my opinion, an in-person review would have been more appropriate for [Mr A's] case.

On this case, even a digital review was not even followed through. Nurse Maude's policy on Wound Management noted that "Digital images should be updated at least every two weeks or sooner if there is significant change/deterioration in the wound. If not improving, review the assessment to determine if any possible factors may delay healing remain. Adjust plan of care accordingly." There is no evidence that the digital photos were done every 2 weeks. Their policy was not followed through.

Inconsistencies of the follow up plan would be considered as a departure in standards of care. Wound CNS documented that "... *wound management plan and review in two weeks to determine if wounds improve … If the problem continues to be referred to the Diabetes Pod team.*" However, there is no evidence that the two-week follow up by wound CNS occurred. Which could be likely a factor in why the referral was not made.

This would be considered a departure from current standards of practice. The reason for this is lack of following through the recommended management can cause a gap of care and delay in provision of specialist management i.e. vascular input.

In some practices, a digital review is needed to be done. This was commonly used and advantageous during the Covid pandemic.

Despite the fact that photos are now being used for evaluating wounds, they are not a consistently reliable tool and cannot take the place of in-person wound review, particularly when it comes to ischemic wounds. This is because the expertise of the one who took the photograph greatly influences the quality of the photos, which can alter the wound bed characteristics, and lead to a misrepresentation of the kind of tissue in the wound and, consequently, decision-making on the extent and severity of the wound.

The wound photo does not give the holistic view of the patient's experience. The patient's worsening of pain could indicate deterioration, 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.

When a patient is actively under your service (Nurse Maude in this instance), it is the service provider's responsibility to regularly review complex wounds rather than relying on the facility's nursing staff. Lack of timely and routine review can lead to losing 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 can be hugely impacted like what happened in [Mr A's] case. [Mr A] was referred to a secondary service due to the perseverance of [Mr A's] family, [Mrs B]. I believe that a referral would have been further delayed or wouldn't have occurred if [Mrs B] had not followed up Nurse Maude.

In summary, the gaps that I noted that did not meet standards of care:

1. Two-weekly follow up did not occur either in-person or virtual.
2. When the facility's RN notified Nurse Maude of deterioration on 10 May 2021, Nurse Maude RN2 did not escalate this to the wound CNS, which could have prompted the wound CNS to refer to vascular/diabetes podiatry service.
3. Overall, there was no urgency in their treatment plan that could alleviate [Mr A's] issues.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

A virtual review of wound is generally used as a mechanism when distance or access is a problem between clinician and patient, or the wound is stable/healing.

Was there a departure from the standard of care or accepted practice?

Severe departure.

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

Digital review of wounds can be case to case, but complex wounds require in-person review.

Please outline any factors that may limit your assessment of the events.

None

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

Staff education on their Wound Management policy to ensure staff follow them through.

Development of processes that clarify when wounds are reviewed including guidelines for use of digital vs face to face review.

Question 4: The adequacy of the policies and processes in place at Nurse Maude.

Nurse Maude has adequate policies and processes in place. Although, I believe that the wound CNS should view the complex wounds in person particularly when there are red flag symptoms such as in [Mr A's] case.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.

Yes

Was there a departure from the standard of care or accepted practice?

No departure

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.

Acceptable

Please outline any factors that may limit your assessment of the events.

None.

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

As above, I do recommend the integration of the Management of the diabetic foot — NZZSD guidelines into Nurse Maude's policy and procedures may be beneficial in improving their service in managing diabetic foot ulcers and a clear guideline on when should wound CNS be required to view the wounds in-person.

Question 5: Any other comments you wish to make about the care provided by Nurse Maude in relation to the wounds.

No further comments.'