Care Home

Registered Nurse, RN C

General Practitioner, Dr F

A Report by the
Aged Care Commissioner

(Case 20HDC00726)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to the care provided to an elderly woman at a care home in 2019, in particular the management of her leg wounds.

Findings

2. The Aged Care Commissioner found deficiencies in the woman's care. Weekly photographs of the woman's wounds were not taken, as required by the Wound Care policy; the records were confusing regarding the foot being referred to and the treatment provided; and the referral system was insufficiently clear, resulting in delayed treatment. The Aged Care Commissioner considered that the care home's systems were inadequate to support timely care, intervention, and referral of the woman to more specialised care. The Aged Care Commissioner found the care home in breach of Right 4(1) of the Code.

3. The Aged Care Commissioner considered that a registered nurse, as the person responsible for the overall care and direction of all residents and staff at the care home, did not manage the woman's referral to the wound clinic satisfactorily; the nurse's record-keeping was deficient with respect to the woman's wounds, leg pain and ongoing management; and the nurse did not follow the care home's Wound Care policy. The Aged Care Commissioner found the nurse in breach of Right 4(1) of the Code.

4. The Aged Care Commissioner also had concerns about the care provided by two general practitioners. The Aged Care Commissioner considered that although their actions did not amount to a breach of the Code, a breakdown in communication between the medical and nursing staff resulted in the woman's referral being overlooked and her treatment delayed.

Recommendations

5. The Aged Care Commissioner recommended that the care home, the nurse, and a general practitioner provide a written apology to the woman's family for the deficiencies identified in this report. The Aged Care Commissioner recommended that the care home evaluate the changes made since these events and report back to HDC on the outcome. The Aged Care Commissioner also recommended that the nurse reflect on her standard of record-keeping and the GP review the level of detail in his clinical records.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his mother, Mrs A (dec), at the care home. The following issues were identified for investigation:

- *Whether the care home provided Mrs A with an appropriate standard of care from Month1[1] to Month4 (inclusive).*
- *Whether RN C provided Mrs A with an appropriate standard of care from Month1 to Month4 (inclusive).*
- *Whether Dr F provided Mrs A with an appropriate standard of care in Month2 and Month3.*

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

8. The parties directly involved in the investigation were:

Mr B	Consumer's son/complainant
Care home	Provider
RN C	Registered nurse/provider
CNS D	Clinical nurse specialist/provider
Ms E	Healthcare assistant/provider
Dr F	General practitioner (GP)/provider
Dr G	GP/provider

9. Further information was received from Te Whatu Ora.

10. In-house clinical advice was obtained from GP Dr David Maplesden (Appendix A). Independent advice was obtained from RN Associate Professor Karole Hogarth (Appendix B).

Information gathered during investigation

Introduction

11. Mrs A, then aged in her seventies, was admitted to the care home in 2016. She was a rest-home level resident living in a single room.

12. Mrs A had a complex medical history. Her GP, Dr F, told HDC that her medical history included anxiety and depression (for which she was on long-term escitalopram and lorazepam), hypertension (high blood pressure), and cerebrovascular disease (the brain has been affected by bleeding or a blood clot). Her medical history also included a stroke, carotid artery stenosis (narrowing of the blood vessels in the neck), severe peripheral vascular disease (narrowed blood vessels reducing blood flow to the limbs), an aorto-femoral bypass (a graft to bypass diseased large blood vessels in the abdomen and groin), a left great toe

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

amputation, gout, and mild cognitive impairment. Mrs A was a heavy smoker prior to being admitted to the care home but her family said she did not smoke thereafter.

13. Mrs A's son, Mr B, complained about the management of his mother's ischaemic[2] right foot in the weeks prior to her death on 12 Month4, including her inadequate pain relief, the diagnosis of gout as the cause of her pain, the delayed recognition of sepsis, and the inadequate monitoring for side effects of naproxen[3] after it was commenced on 3 Month2 by a doctor at an emergency medical clinic.

Care home

14. The care home's rest-home wing is comprised of single rooms, each with an en suite. The care home had a registered nurse on duty during working hours. After hours, an on-call roster of registered nurses provided 24-hour cover in conjunction with another care home (Care Home 2). At the time of these events, the care home nurse was RN C.[4]

Care home management

15. RN C told HDC that she had overall responsibility for the care and direction of all residents and staff. She said that each shift had a healthcare assistant (HCA) leader who was responsible for immediate oversight of resident care, work/staff allocations, medication administration, interventions due, and GP liaison. The HCA leaders reported daily to RN C or the registered nurse on call and sought their input as needed. The HCA leaders also consulted with RN C or the registered nurse on call before calling in a GP.

16. RN C said that HCA leader and registered nurse meetings were held monthly to review all aspects of care delivery and associated policies, both on a general and an individual basis. She said that she joined in staff handover between shifts regularly (and always after the doctor's rounds) to ensure that information was delivered. Paper handover charts were completed each shift to highlight residents' activities and changes, issues, GP directives, incidents, and accidents.

17. RN C stated that the registered nurse, enrolled nurse, or HCA leader who was present during a GP appointment would communicate information about the consultation via written progress notes, handovers, and verbally to incoming staff. She said that there was a whiteboard in the nursing office that listed upcoming appointments and the reason for the appointment, and she followed up on all events, changes, and residents' requests and observations daily.

Wound management documentation

18. RN C told HDC that every wound assessment and dressing change for Mrs A was recorded in detail using the Vcare Resident File Computer programme in use at the care home. This allowed the clinician to record details of the wound size; its dimensions; the type; the longevity; the condition of the wound, skin, and surrounding tissue, exudate and other

[2] Reduced blood flow.

[3] Naproxen is used for pain relief in several conditions, including gout. It is a non-steroidal anti-inflammatory drug (NSAID).

[4] RN C commenced her employment at the care home in 2019. She no longer works at the care home.

factors; the presence of infection; any pain associated with the wound; the primary, secondary, and securing dressing material used; the medication associated with the wound; and the date for the next wound review.

19. RN C said that the staff could access all the information regarding the history of every wound, and any alerts, treatments, and recordings. The HCA leader opened the Vcare programme on each shift, and the dashboard of resident folders highlighted events scheduled, in order to notify staff if a dressing was due. If a new wound was discovered, the HCA leader on duty entered it into the system to alert oncoming staff, and it would also be noted on the daily handover sheet.

20. RN C said that there was also a dressing folder in paper format that contained the most current photograph of the wound and the dressing history. She said that photographs were not taken on a regular schedule.

Referrals

21. RN C told HDC that when a GP gave a directive for a referral it would be discussed at the time, and it would be decided who would communicate with the service required. Most often, the GP would make a direct referral, or alternatively the GP would write an accompanying medical note for the facility to make the referral, or the Clinical Manager could refer directly using the then DHB referral form.

Ulcer on right leg

22. In May 2018, Mrs A developed a chronic ulcer on her right leg. On 15 May 2018, Dr F saw Mrs A regarding the ulcer, and on 10 July 2018 he noted that she was to have a punch biopsy of her right lower shin.

23. On 18 September 2018, Dr F saw Mrs A and recorded: 'Vascular consideration ulcer in leg … biopsy Result.' The results, received on 19 July 2018, showed no evidence of dysplasia (abnormal cells) or malignancy. A referral to the wound clinic was made on 28 September 2018.

24. On 16 October 2018, Mr B emailed the then facility manager, expressing his disappointment that his mother had not been referred to the vascular clinic. The facility manager responded that she had discussed the matter with a Dr F's locum at that time. She said that the care home had followed up the matter twice, and Dr F's nurse was to contact the wound clinic to arrange a follow-up. The facility manager emailed: 'Unfortunately it has to come from the GP I am unable to refer to the wound clinic … I will follow up with the doctor's nurse tomorrow to ensure that the referral has been made.'

25. Mrs A was assessed at the vascular clinic on 5 November 2018 and the findings included an ankle brachial pressure index (ABPI)[5] of 0.61 on the right and 0.58 on the left, but the reliability was questioned as it was difficult to hear the pulses. No pedal pulses (on top of

[5] The ankle-brachial index test compares the blood pressure measured at the ankle with the blood pressure measured at the arm. A low ankle-brachial index number can indicate narrowing or blockage of the arteries in the legs.

the foot or on the ankle bone) were palpable, and significant signs of venous hypertension (increased pressure in the veins of the lower legs) were noted. Wound dressing advice was provided. Dr F said that the full vascular report with recommendations on management of the ulcer was received in early November, and there was no recommendation for further vascular assessment.

26. On 8 December 2018, Mrs A had an overnight admission to the public hospital, where she was diagnosed with heart failure and ischaemic heart disease. A follow-up echocardiogram on 29 Month1 showed preserved ejection fraction[6] and no major valvular disease.

Issues in feet

27. RN C told HDC that a red diffuse area on Mrs A's right foot was first noticed on 23 Month1. She said that this was marked with a pen and monitored for any increase in area, intensity, pain, and impact on mobility. The affected area remained unchanged until 28 Month1, when a similar small red area appeared on the outer aspect of Mrs A's foot.

28. On 29 Month1, Mrs A was seen by a GP locum with her daughter present. The locum's notes include: 'Dusky, pulses absent, improved with elevation. Necrotic breakdown 2 & 3 toes.' The management was to optimise limb positioning, avoid using a compression stocking, and keep the limb warm. Codeine was available as analgesia.

29. Blood tests on 31 Month1 showed that Mrs A had mild anaemia, normal C-reactive protein (CRP),[7] and normal renal function. Mrs A was prescribed regular paracetamol 1g QID (four times a day) and PRN (as required) codeine 15–30mg up to QID. The PRN administration records do not indicate escalating use of analgesia, and the response to the PRN codeine administered is consistently recorded as being good.

30. On 3 Month2, Mrs A was taken by her family to an emergency medical clinic because, as recollected by Mr B, Mrs A had 'call[ed] in tears due to the pain' in her foot. She was seen by a doctor, who noted that she had pain in the toes of her right foot. He recorded that she was somewhat confused and that she had 'good circulation and sensation in [right] foot — CRT [capillary refill time] < 2 [seconds]'. She had normal foot pulses and small pressure sores on the balls of her 2nd, 3rd, and 4th toes. Her right foot was tender, swollen, and red, but not warm. The doctor's impression was that Mrs A had gout. He prescribed naproxen and recommended a GP review and a blood test in a week's time. In response to the provisional opinion, Mr B told HDC that he observed that Mrs A's foot was 'black and rotting before this appointment'.

31. On 8 Month2, RN C recorded that the pain in Mrs A's left foot had subsided, the redness was decreasing, and she was walking as usual. In response to the provisional opinion, Mr B

[6] A form of heart failure in which the ejection fraction — the percentage of the volume of blood ejected from the left ventricle with each heartbeat divided by the volume of blood when the left ventricle is maximally filled — is normal, defined as greater than 50%.

[7] A blood test used to check for the presence of inflammation or infection in the body.

disputed this and stated that when he saw Mrs A on 7 Month2, he observed that her foot was 'black, obviously ulcerated, and intense and painful'.

32. On 14 Month2, RN C recorded in the progress notes that Mrs A was comfortable so long as her affected left foot was not touched or she was not weight bearing. Her feet had equal warmth and colour. The notes state:

> 'Pedal pulses present but faint (as per usual) no further discoloration to spots under 2 _3 _5 toes. Areas marked to monitor symptoms. Area previously sore on bunion area returned to previous state. No further necrotic or red spots seen.'

33. The only photograph of Mrs A's legs in the records was taken on 17 Month2. The photograph shows her right foot with a lesion on the little toe. Thereafter, the question in the wound care plans about photographs is not answered, and that section is left blank.

34. On 18 Month2, RN C recorded that Mrs A had pain on putting her left leg on the floor, described as 'shooting star pain'. The areas of redness had not extended, but breakdown of tissue was evident on the outer aspect of her little toe and under the second and third toes. RN C noted that she had a discussion with one of Mrs A's sons, followed by emails with Mr B, and that the family were very concerned because Mrs A had reported to them that she had extreme pain. RN C also noted that the PRN analgesia report indicated minimal use of codeine and that the full course of naproxen had been administered as prescribed. She queried whether Mrs A's symptoms had worsened after the course had been completed.

Review by Dr G

35. A GP review was requested, and on 18 Month2 Mrs A was reviewed by locum GP Dr G, who considered that the pain had improved with the naproxen and worsened when it had been stopped, so he restarted it. He did not document any assessment of her foot. However, RN C made an entry in the progress notes dated 18 Month2 summarising Dr G's assessment:

> 'OE blackened areas, broken skin on outer aspect little toe and under 2 _3 toes noted, pulsed evident.
>
> Plan — continue current nursing interventions. Blood tests tomorrow as prearranged. Restart NSAID medication and review after course finished and test results back.'

36. Dr G told HDC that he saw Mrs A in person on that day, and his notes record that her son was present during the consultation. Dr G said that his usual practice would be to examine the patient, and the rest-home notes record that 'on examination' he agreed that the likely diagnosis was gout. He noted: '[I]f evidence of gout to start allopurinol [gout prevention medication].' However, Dr G acknowledged the absence of these examination findings in the notes. Dr G requested 'routine bloods [including] uric acid'. He said that his recollection of the ordering process at the care home was that a doctor would request the bloods either verbally or as a written entry in the notes, and the nursing staff would arrange the forms and collection of samples.

Review by Dr F

37. On 19 Month2, Dr F saw Mrs A for a clinical review. He noted that gout was an ongoing issue and that she was taking naproxen. He recorded that she 'could benefit from Doppler'. Dr F told HDC that the need for further vascular assessment was discussed with RN C.

38. RN C told HDC that referral was suggested as an avenue of further investigation that could be pursued at a later juncture, rather than an instruction to refer. She said that if it had been an instruction, the referral would have been done immediately. In any event, no referral was made at that time. There is no record of any of Mrs A's family having been present at this appointment.

39. On 22 Month2, Mrs A had an assessment by a podiatrist, who noted that Mrs A had an infection around some of her right toenails. Dr F was informed by fax, and he charted the antibiotic flucloxacillin.

40. In an email to Mr B dated 27 Month2, RN C indicated that Dr F had reviewed the uric acid result, which showed a slight elevation, but had decided that no long-term prophylactic treatment for gout was warranted. RN C recorded: 'Please continue to monitor. [Left] Foot much less painful, no redness present.'

41. The wound care plans dated 27 and 29 Month2 and 4, 6 and 9 Month3 state: '[I]nfected 1st and 2nd toes on [left] foot.' However, Mrs A's first toe on her left foot had been amputated previously. All wound care plans state the size of the wound as depth 1mm x width 6mm x length 5mm.

42. In early Month3, the records indicate that Mrs A's condition remained stable. She was mobilising satisfactorily, and her foot pain responded to treatment. The pain assessment of 2 Month3 noted a marked increase in pain. On 6 Month3 the progress notes state: 'Mobilising well — sore toes do not impact on step or weight bearing. Looking cleaner around nail beds and not inflamed.' The wound care plan of 6 Month3 refers to the wound bed being 'yellow/sloughy black/necrotic'.

43. On 9 Month3 it is noted that the wound bed was 'black/necrotic' but that the pain was 'much better'. The notes on 16 Month3 indicate that Mrs A's intermittent pain was relieved by PRN medication. In response to the provisional opinion, Mr B told HDC that Mrs A was actually declining and in terrible pain.

44. Mrs A was reviewed by Dr F on 10 Month3 and her vital signs were documented as normal. Dr F recorded: 'Uric acid … poor toenails infection … very "wobbly" … nails leave alone, poor circulation, protect nails.' No antibiotics were prescribed. Dr F did not record which foot he referred to. In response to the provisional opinion, Mr B stated that there was no correspondence with the family about this review. The progress notes on 10 Month3 noted, '[Son] informed of Drs visit,' although no family members were documented as having been present at this appointment.

45. The wound care plan on 11 Month3 again refers to 'infected 1st and 2nd toes on L foot', as do all subsequent wound care plans.

46. On 14 Month3, RN C recorded that Mrs A was stable and mobilising well despite ongoing pain in her left foot.

Deterioration

47. On 19 Month3, Mrs A's condition deteriorated. RN C recorded that Mrs A complained of sharp pains in her shin and calf area. RN C did not record which leg was affected. She recorded that no redness, swelling, or altered circulation was seen and that Mrs A was fully weight bearing and her gait was as usual. Mrs A was given codeine with 'mild effect'. RN C noted that Mrs A appeared 'pale and vague', and after lunch she was taken to her room in a wheelchair to rest on her bed. RN C recorded: 'Pain acute at times? more cramp like as seemed to be relieved when moving foot towards then away from body.' No updated wound care plan or short-term care plan was completed that day. RN C decided that GP review was not necessary, but close monitoring was required.

48. Mrs A's family became increasingly concerned about her level of pain. In response to the provisional opinion, Mr B stated that Mrs A was 'in complete agony and severe pain' to the point of vomiting when she attended a family event on 22 Month3. He said that when Mrs A was returned to the care home, she was 'denied/prolonged pain relief upon her arrival'.

49. The progress notes from 22 Month3 state that Mrs A returned to the care home at 3pm and her daughter asked for Mrs A to be administered codeine as she was experiencing pain in her legs. Mrs A was given codeine at 3.07pm. It was also noted that Mrs A had vomited (although it is unclear whether this was during the family event or when she returned to the care home), but that she had had no further episodes of vomiting that day.

50. A pain assessment on 23 Month3 noted that Mrs A had intermittent pain that was relieved by repositioning.

51. On 23 Month3 Mr B emailed RN C expressing concern that 'the current strategies [were] not working for whatever reason'. RN C responded:

> 'I agree her pain management at present is not effective enough. Unfortunately, nerve pain is the toughest to ever get on top [of] — I will suggest referral to a Pain Specialist tomorrow as well as total medication review.'

52. The wound care plan of 23 Month3 refers to the wound bed being 'yellow/sloughy black/necrotic'. On 24 Month3, Dr F reviewed Mrs A and noted:

> 'Circulation [Right] leg & necrotic wound … Blood circ check the wound clinic. On codeine … is quite anxious currently and need to balance pain relief … could have Doppler also PRN.'

53. In response to the provisional opinion, Mr B stated that Mrs A had the necrotic wound before it was documented at the appointment on 24 Month3.

54. Dr F increased Mrs A's analgesia to regular codeine 15mg BD (twice a day) together with the PRN doses (as noted in paragraph 29). No antibiotics were prescribed.

55. Dr F said that the need for further vascular assessment was again discussed with RN C, as had been discussed previously on 19 Month2, and he advised that specialist nursing input was needed.

56. That day, RN C recorded:

> '[Seen by] [Dr F] today — [son] present. History of pain, circulatory issues and anxiety — general well being discussed. [Dr F] requested Doppler studies be conducted by the wound clinic technicians early 2020 — referral sent. Pedal pulses present, foot warm and perfused …'

57. The care home did not formulate a wound care plan relating to a wound on Mrs A's right leg, although it was noted that photographs were to be taken at the next dressing change to judge progress.

58. Despite RN C having recorded that a referral was sent, the wound clinic records do not contain a referral sent that day. There is also no copy of a referral in care home records.

59. RN C also recorded:

> 'Please always double check if [Mrs A] needs PRN meds — she often waits til[l] pain is severe before asking for same. Management of pain vs anxiety and achieving correct medication balance for this is our goal.'

60. The care home said that RN C sent a referral to the wound clinic on 27 Month3 requesting Doppler studies. The care home told HDC that the referral was not made until that date because Mrs A had responded well to treatments, and her wounds had been sighted in the preceding eight weeks by Dr F, two locum GPs, an after-hours GP, and two registered nurses. As stated above, the wound clinic has no record of this referral.

61. RN C stated that it was not usual practice to refer residents to district nursing, as usually the district nurses do not attend rest home residents. She said that she had collegial discussions about Mrs A with a nurse who worked at the care home regularly, and with the Clinical Manager at Care Home 2.

62. Dr F saw Mrs A on 31 Month3. He noted that she was very anxious and had pain in her left foot. He recorded: 'Needs referral to [the wound clinic].' He prescribed a short course of prednisone as an alternative to naproxen for the gout, and nortriptyline 10mg nocte (at night) for pain management. There is no specific reference to Dr F having assessed Mrs A's right foot. Dr F said that the need for referral for vascular assessment and specialist nursing was again discussed that day, and the referral to the wound clinic was expedited by RN C.

63. Dr F said that when deciding on the necessity for hospital admission at both the 24 Month3 and the 31 Month3 appointments, he took into account Mrs A's co-morbidities and the likelihood of being offered major surgery to improve her circulation over the public holiday, together with her desire to be with her family. He said that having the results of the Doppler

studies would strengthen this referral. However, there is no indication that he discussed these factors with Mrs A and her family member who was present.

64. That day, RN C recorded that there had been minimal impact from the recent medication changes, and that Mrs A was a little quieter. RN C also documented: '[S]lightly less PRN only. Wounds static and painful episodes of no obvious trigger still occurring.'

65. On 3 Month4, RN C faxed the referral and the need for an urgent appointment. The referral states: '*Urgent — marked deterioration in lower [right] leg circulation. Necrotic areas. Pain intensifying.' The referral is dated 3 Month4 in the body of the document.

66. The referral has handwritten on it: 'Urgent [name] ?7 [Month4] or 9 [Month4].' This is the first and only note in the wound clinic records relating to this referral.

67. The wound care plan of 3 Month4 again refers to 'infected 1st and 2nd toes on L foot' and states that Mrs A's pain level was 2/10, the wound bed was necrotic, and the wound was deteriorating. This is the final wound care plan.

68. On 4 Month4, RN C recorded that Mrs A had reported feeling better, and she had less pain and improved sensation in the shin and thigh areas of her right leg. That is the first reference to the right leg in the progress notes.

Wound clinic review 7 Month4

69. An appointment was made for Mrs A to attend the wound clinic on 7 Month4. Mr B said that he received an email stating that his mother had an appointment at the wound clinic and asking whether someone could please come to pick her up.

70. Healthcare assistant (HCA) Ms E stated that Mrs A washed and dressed herself as usual on 7 Month4 and was mobilising independently with her walking frame. Ms E does not recall having emailed Mr B but, as she made a diary entry that he was going to collect his mother for the appointment, she thinks she may have spoken to him on the telephone prior to the appointment.

71. In response to the provisional opinion, Mr B said that the email for this appointment 'came out of the blue' and when he collected Mrs A to take her to the appointment, he was accompanied by his two young sons, as he had 'no idea of her condition or the state she was in'. Mr B told HDC:

> 'When I picked her up, she needed to be put into a wheelchair … On the way to [the wound clinic], mum screamed uncontrollably — stating she didn't want to live like this … in front of my sons in the back seat … After we lifted her out of the car in the carpark at [the wound clinic] we took her inside screaming — they took one look at her and rushed her into a room, appalled at her condition, I was told to take her directly to surgery, expect amputation and was given a letter to take directly with me to emergency.'

72. The wound clinic clinical nurse specialist (CNS) CNS D found that Mrs A's right foot was cold and cyanosed. There was ulceration and necrosis on her fourth and third toes, and CNS D was unable to palpate pedal pulses. Her impression was that Mrs A had critical limb ischaemia (lack of blood flow to the limb).

73. That same day, CNS D referred Mrs A to the vascular surgeons at the public hospital.

Public hospital

74. Mrs A was admitted to the public hospital on 7 Month4. Her pain was assessed as being 4.5/5 at times.

75. In response to the provisional opinion, Mr B told HDC that Mrs A lost the ability to speak on the way to the hospital and 'continued to cry and scream'. He stated that he met quickly with the surgeon while he assumed that Mrs A was subdued on medication.

76. On 10 Month4, while Mrs A was being prepared for revascularisation surgery, she suffered a stroke on the ward. She was placed on palliative care that day and, sadly, she died on 12 Month4. The death certificate states the cause of death as 'sepsis — days; R lower limb ischaemia — hours to days; peripheral vascular disease — years'.

Pain relief

77. Mr B told HDC that between Month1 until the time of her death, Mrs A's pain became excruciating, which he expressed to the care home on many occasions.

78. RN C told HDC that Mrs A's pain assessments were completed weekly. RN C said that Mrs A was articulate and explicit in her description of her pain, but she relayed more extreme comments and emotion to her sons. RN C said that frequently the pain was associated with Mrs A's long-term anxiety and depression.

79. In response to the provisional opinion, Mr B told HDC that Mrs A was fearful of the doctor's visits, and her comments were not answered because of the presence of the care home staff, so he began to accompany her to the appointments, which gave her the confidence to speak up.

80. The care home said that pain relief was administered as required. Mrs A's pain scores are documented, but pain is not always mentioned in the progress notes. The care home stated that Mrs A often scored her pain at low levels, and her acute episodes of pain were managed by the care home staff with PRN pain relief or other support.

81. Dr F told HDC that Mrs A's pain management was considered and discussed at every consultation, and each time she complained of having pain, the pain was in her foot. He said that she had regular codeine 15mg twice daily charted, and PRN medication of codeine 15mg one to two tabs was available up to four times daily, giving a combined codeine dose up to 150mg if needed daily for pain. She was also prescribed paracetamol 1000mg four times a day and lorazepam 1mg in the morning and 0.5mg later in the day (twice daily and as needed) for her severe ongoing anxiety.

82. Dr F said that initially Mrs A was charted naproxen, which was noted to be effective to treat her gout, but subsequently this was changed to prednisone due to the potential side effects of naproxen in the elderly.

83. Dr F stated that he discussed Mrs A's pain with care home staff and RN C, and they reported that at times Mrs A appeared distressed with pain but it settled quickly with lorazepam, personal input, and/or codeine. Dr F said that Mrs A's ongoing anxiety made objective assessment very difficult, and RN C reported to him that right up until Mrs A's last day at the care home, she attended activities, often walked without apparent discomfort and, on 7 Month4 when leaving for her wound clinic appointment, she appeared cheerful and had no difficulty with mobility.

84. In response to the provisional opinion, Mr B disputed the fact that Mrs A was 'in good spirits and mobile' when she left the care home. He reiterated that Mrs A left the care home for her wound clinic appointment in a wheelchair, crying and screaming. He stated: 'Rushing her to [the wound clinic] out of the blue, the look on their face, when they viewed her condition, was horrendous.'

85. Dr F recalled that during one appointment in Month3, Mrs A came into the clinic seeming to be in no distress, but her demeanour changed as soon as a family member appeared. Dr F said that after the appointment, he discussed with RN C the difficulty of objectively assessing Mrs A's gout, peripheral vascular disease, and associated pain with such variable presentations due to her anxiety.

Confusion in records

86. Care home notes are unclear regarding the wounds and the feet involved. The progress notes on 27 Month2, 1 Month3, 6 Month3, and 9 Month3 state that the infected first and second toe on the left foot were assessed that day. However, Mrs A had no left first toe due to a previous amputation. The wound care plans all refer to the first and second toes on the left foot. The short-term care plan prepared by RN C on 31 Month1 and the subsequent updates refer to necrotic gout nodules on the second, third, and fifth toes on the left foot.

87. A note by RN C on 20 Month3 refers to a large historic ulcer on the right lower leg and notes that half a toe was missing on the right foot. The medical notes indicate that Mrs A had wounds on her right foot and that ischaemia had been diagnosed in her right leg.

Policies

88. The Pain Relief policy (applicable at the time of the events) provides the following:

> '• The RN/EN/Care Lead (CL) will assess all residents' pain levels using the pain assessment in VCare within 48 hrs of admission to the facility and then every six months and as required when the resident experiences any new pain.
>
> • The sites of pain and interventions on how to manage the pain will be clearly documented in the long term care plan (LTCP) in VCare under the pain section. The LTCP shall be developed by the RN or EN (under the direction of an RN) in

consultation with the resident/representative, their medical practitioner and other staff.

- If the resident experiences pain, an assessment in VCare will be completed.
- The reason for administering PRN pain relief is to be recorded on 1 Chart and the effectiveness of the pain relief recorded in 1 chart. Both the reason for [being] given and effectiveness needs to be recorded in the resident's progress notes and put on the handover sheet for the next shift.
- If the resident has pain that is not relieved by pain relief, has no pain relief prescribed or has severe pain, then the GP must review the resident.
- The RN is responsible for ensuring the resident has sufficient pain relief prescribed both regularly and PRN that is required to keep the resident as pain free as possible.'

89. The Wound Care policy (applicable at the time of the events) provides:

'For all wounds complete the **Wound Assessment treatment and evaluation** in VCare. This will record details about the wound and what treatments are to be completed. It also allows for the documentation of ongoing treatments.

An electronic wound register will be available in VCare, which will show all the residents who have current wounds. This is automatically created from the data in the **wound assessment, treatment and evaluation.**

When a wound has healed, you need to go into the wound assessment, and answer YES to the question that says is this wound now healed, and this will then take it off the wound register.

The Clinical Manager or Registered Nurse assess all wounds and will determine what the treatment will be. **NO-ONE** is to alter this unless they have consulted with the Clinical Manager.

The Clinical Manager or Senior Registered Nurse will liaise with a Wound Care Nurse Specialist or a doctor if necessary. Resident GPs are to be informed of all wounds.

…

It is the responsibility of the Clinical Manager/RN on consultation with the resident's doctor to decide on a planned choice of treatment for each resident dressing according to the stage of healing reached. Where possible the resident is also consulted and consideration for their comfort given.

…

Wounds and pressure areas are to be photographed using a facility device at least weekly and stored in the correspondence area in VCare. It will be dated and be able to be identified easily. This will ensure there is documented evidence of the wound and its progress (or otherwise). It will also assist when the GP visits, as it may remove the

necessity to remove the dressings to view the wound. Document in the progress notes when this has occurred.'

Responses to provisional opinion

Mr B/Mrs A's family

90. Mr B was given an opportunity to respond to the information gathered during this investigation. Mr B's comments have been incorporated into the opinion where relevant and appropriate.

91. Mr B told HDC that his family spent considerable time and diligence to ensure that Mrs A was in the right hands in her twilight years. He stated that Mrs A's documented medical history was provided to the care home and he was always transparent in his communication to the care home.

92. Mr B stated that Mrs A died in agony, which was very upsetting to deal with, and that no one deserves what Mrs A was put through and what she endured. Furthermore, elderly people in the care home should never be put through such a shocking lack of urgency concern, practice, and follow-up.

93. Mrs A's family believe that an 'assumption' was made that Mrs A was suffering from gout, and stated that this was 'based purely on external physical conditions, such as tightness and swelling of the skin, skin colour, sensitivity to touch etc. … which could be found across a variety of different ailments, not just gout'.

94. Mrs A's family stated that Mrs A was treated for gout 'for some time without success before belatedly deciding to test for uric acid levels, only to then find out they weren't overly elevated'. They further stated that treating Mrs A for gout (when she was not suffering from this particular condition) took the focus away from the real issues causing her discomfort, and, in doing so, valuable time that could have been critical to her recovery and/or pain levels was lost.

RN C

95. RN C was given the opportunity to respond to the provisional opinion but had nothing further to add.

Dr F

96. Dr F was given the opportunity to respond to the provisional opinion but had nothing further to add except that he will comply with the Aged Care Commissioner's proposed recommendations.

Dr G

97. Dr G was given the opportunity to respond to the provisional opinion. He stated that he agreed with Dr Maplesden that documentation of clinical findings is important.

Care home

98. The care home was given the opportunity to respond to the provisional opinion. The care home's response has been incorporated into this report where relevant and appropriate.

99. The care home said that it regrets the management of this case and stated that it is dedicated to learning from this experience and continuously improving to ensure that it does not happen again. The care home stated that the wellbeing of its residents is of utmost priority.

Opinion: Introduction

100. This opinion considers the care provided to Mrs A by the care home, RN C, Dr F, and Dr G. I acknowledge the distressing impact of Mrs A's condition on Mrs A and her family and express my sincere condolences to Mrs A's family for their loss. Their diligence in advocating for her health and wellbeing should be commended.

101. Mrs A was a rest-home resident at the care home. She had a complex medical history that included hypertension, heart failure, ischaemic heart disease, cerebrovascular disease, severe peripheral vascular disease, gout, and a toe amputation.

102. In Month1, an inflamed area was noted on Mrs A's right foot. The condition of her foot worsened and a referral was made to the wound clinic on 3 Month4. Mrs A was seen at the wound clinic on 7 Month4 and diagnosed with an ischaemic right foot and referred to the public hospital.

Opinion: Care home — breach

Introduction

103. The care home had a duty to provide services to Mrs A with reasonable care and skill. This included responsibility for the actions of its staff, and an organisational duty to facilitate reasonable care.

104. The care home also had a duty to comply with the New Zealand Health and Disability Services (Core) Standards,[8] which state:

> 'Service Management Standard 2.2: The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.'

105. The Health and Disability (Core) Standards also include:

> 'a) Consumers receive safe services of an appropriate standard that complies with consumer rights legislation;

[8] NZS 8134.1.3:2008 current at the time of events. This has since been replaced.

b) Consumers receive timely services, which are planned, coordinated, and delivered in an appropriate manner;'

106. Standard 2.9 requires that consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required. It states:

'*Criteria*

…

2.9.9: All records are legible and the name and designation of the service provider is identifiable.

2.9.10: All records pertaining to individual consumer service delivery are integrated.'

107. In my view, there were deficiencies in the care provided to Mrs A by staff at the care home, and these were systemic issues for which the care home bears responsibility. These are outlined below.

Wound care

108. My independent nursing advisor, Associate Professor Karole Hogarth, stated that the accepted standard of care involves the continued assessment and management of all wounds from any cause, beginning with a comprehensive wound care plan based on the policy of the facility.

109. The care home's Wound Care policy required photographs of wounds weekly. However, there is only one photograph of Mrs A's wounds in the records. That photograph was taken on 17 Month2 and shows a lesion on the little toe of her right foot. Consequently, there was no visual record of changes in the wounds over time.

110. The policy also required: '[Fo]r all wounds complete the Wound Assessment treatment and evaluation in VCare. This will record details about the wound and what treatments are to be completed.' However, there is no wound/dressing chart and the measurements of the wounds were unchanged over time. All the wound care plans state the size of the wound as depth 1mm x width 6mm x length 5mm.

111. As stated above, the records are unclear about which foot was being treated. There are repeated references to the great left toe when that toe had been amputated. Associate Professor Hogarth said that it appears that Mrs A had issues with both feet and legs, which the staff were aware and supportive of, though their treatment is difficult to follow from the notes, as it was not always noted which foot was being written about in the progress notes.

112. In addition, the information is at times contradictory. For example, on 3 Month4, RN C faxed a referral to the wound clinic that states: '*Urgent — marked deterioration in lower [right] leg circulation. Necrotic areas. Pain intensifying.' However, the wound care plan of 3 Month4 again refers to 'infected 1st and 2nd toes on L foot' and states that Mrs A's pain level was 2/10.

113. Furthermore, there is some inconsistency about how the wounds were described. For example, on 30 Month3, the wounds on the left foot are described as 'yellow/slough; black/necrotic' and on 1 Month4, they are described as 'pink; epithelising', and back to 'yellow/slough; black/necrotic' on 2 Month4. I also acknowledge Mr B's recollection of Mrs A's foot being 'black and rotting' in early Month2, as discussed in paragraphs 30 and 31.

114. Associate Professor Hogarth advised that long-standing ulcers are very difficult to treat, especially when combined with long-term conditions such as Mrs A's, and healing can be very difficult to manage without intervention. She said that recognising when a chronic wound and/or ulcer is beyond the scope of staff is essential for the outcome of the patient.

115. Mrs A was reviewed and reassessed regularly by registered nurses and her GP from mid-Month2 until her hospital admission in Month4. Mrs A's progress notes indicate that there had been no progression towards healing in this time, and there were signs of infection. From the notes and GP review, Mrs A did not show the classic signs of ongoing limb perfusion issues; she still had palpable pedal pulses, and colour and warmth did not indicate vascular impairment up until late Month3.

116. Associate Professor Hogarth said that the wounds appear to have been dressed regularly as documented in the daily notes, although the dressing type is unclear. She noted that Mrs A was regularly reminded to uncross her legs and elevate them when sitting, and that antibiotics were administered as prescribed. Associate Professor Hogarth considers that there was a departure from accepted practice and care of Mrs A in the assessment and ongoing treatment of her wounds, due to the inconsistency in how the wounds were described, there being no ongoing photographs, and the confusion about which foot was referred to in the notes. I agree. Given the importance of accurate record-keeping and, in particular, photographs of wounds to ensure that any deterioration is identified quickly and escalated appropriately, I am particularly concerned about the care of Mrs A's wounds, and have discussed this in further detail below (see paragraphs 131 to 136).

Referral process

117. The referral process at the care home was that when the GP gave a directive for a referral, the GP would discuss his requirement with the staff member present at the time, and it would be decided between them who would communicate with the service required. Most often the GP would make a direct referral, but alternatively the GP might write an accompanying medical note for the facility to make the referral, or the registered nurse/Clinical Manager might refer directly using the then DHB referral form. There was no written guideline or policy on referrals, so it is not clear whether the GP should have made a written directive or whether an oral directive was sufficient. In my view, this process ran the risk of miscommunication, as happened in this case.

118. Associate Professor Hogarth advised that although the wounds were relatively small, the lack of healing and further progression should have prompted a referral to the complex wound clinic sooner, and this may have triggered the move to specialist wound management services sooner if indicated. However, Associate Professor Hogarth acknowledged the difficulty for nursing staff in making the referral, as Mrs A was reviewed

several times by Dr F, and therefore the staff had confidence in him regarding the decision to contact external services. This is also confirmed in the Wound Care policy, which advises nursing staff to '[r]efer to GP in first instance and follow his instructions'.

119. Dr F recorded on 19 Month2 that Mrs A 'could benefit from Doppler'. RN C thought Doppler was suggested as an avenue of further investigation that could be pursued at a later juncture, rather than an instruction to refer. She said that if it had been an instruction, the referral would have been done immediately. The expectation of Dr F and the care home staff as to who would undertake the referral was unclear. In any event, no referral was made at that time. I am concerned that the system was insufficiently clear and allowed this failure of communication with Dr F thinking he had instructed RN C to make the referral and RN C being unaware that this was required of her. However, I consider that it was RN C's responsibility to clarify Dr F's intention.

120. Dr F said that when he saw Mrs A on 10 Month3 he was unaware that a referral for Mrs A's assessment had not been made. Subsequently, following the review by Dr F on 24 Month3, RN C documented that Dr F had requested Doppler studies to be conducted by the wound clinic in early 2020. She recorded 'referral sent'. The care home told HDC that RN C did not send the referral until 27 Month3 because Mrs A had responded well to treatments. On 31 Month3, Dr F again said that Mrs A needed a referral to the wound clinic. However, the wound clinic records show that RN C made the referral to the wound clinic on 3 Month4. The referral is dated that day, so it could not have been a re-referral of an earlier referral.

121. I find that a referral was not sent until 3 Month4. In my view, this was unsatisfactory and resulted in a delay before Mrs A was reviewed by the wound clinic.

Conclusion

122. The care home had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code).

123. In my view, there were deficiencies in the care provided to Mrs A for the following reasons:

- Weekly photographs of Mrs A's wounds were not taken as required by the Wound Care policy.
- The records were confusing regarding which foot was referred to and the treatment provided.
- The referral system was insufficiently clear, and although Dr F intended a referral to be made to the wound clinic on 19 Month2 and requested a referral to the wound clinic on 24 Month3, the referral was not made until 3 Month4.

Overall, the care home's systems were inadequate to support Mrs A's timely care, intervention, and referral to more specialised care. I find that the care home failed to provide services to Mrs A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Opinion: RN C — breach

Introduction

124. RN C had overall responsibility for the care of all care home residents and the direction of the staff. Each shift had an HCA leader who was responsible for immediate oversight of resident care, work/staff allocations, medication administration, interventions due, and GP liaison. The HCA leaders reported daily to RN C or the registered nurse on call, and sought their input as needed.

Pain management and documentation

125. RN C was aware that Mrs A's family were concerned about her pain levels and that she reported more severe pain to her family than to care home staff.

126. Associate Professor Hogarth advised that adequate pain relief is a right for all persons in care, and the assessment of this in conjunction with carers and family is essential to ensuring that the appropriate medication, at the appropriate level, is administered regularly as needed. She stated that the accepted standard of care related to pain management includes assessment of pain, regular pain medication as prescribed, and minimal breakthrough pain, and that the resident would state that they have minimal or no pain and that pain does not impact on their ability to undertake normal activities, as defined by the resident. Associate Professor Hogarth said that the documentation should be thorough and pain charts used to determine the resident's stated levels of pain. This should be recorded along with the drug given and the resident's response following administration.

127. Mrs A was on regular paracetamol for pain relief, and regular codeine was added on 24 Month3. The PRN administration records do not show escalating use of analgesia, and Mrs A's response to the PRN codeine administered is consistently recorded as being good.

128. Mrs A often scored her pain at low levels, but she also had acute episodes of pain that were managed by staff with pain relief or other support. Mrs A's pain was also frequently associated with her long-term anxiety and depression. From Month1 into early Month2, she described breakthrough pain as being shooting and lasting seconds. There was also a change to the pain pattern with shin pain added to Mrs A's discomfort. Thereafter, she was relatively stable until her pain worsened around 19 Month3.

129. Associate Professor Hogarth advised that Mrs A's pain was assessed regularly, pain relief was administered as required, and pain scores were documented, and the treatment appears appropriate to the level of pain reported by Mrs A. However, it is not clear whether the changes to the pain pattern in mid-Month2 were communicated to the GP. I accept this advice.

130. Associate Professor Hogarth also noted that pain is not always mentioned in the summary in the progress notes, and some of the daily notes are brief. She said that it would be useful for staff to be reminded that documentation of chronic pain issues needs to be consistent, and the progress notes need to be concise but have enough detail of the resident's status over a shift, including dressings and pain. I agree and I am concerned about the standards

of the records maintained by RN C regarding Mrs A's pain. In reaching this conclusion, I have taken into account usual practice, as well as patient interests and community expectations. In addition, there were other deficiencies in RN C's record-keeping, as discussed below.

Wound care

131. Associate Professor Hogarth stated that the accepted standard of care involves the continued assessment and management of all wounds from any cause, beginning with a comprehensive wound care plan based on the policy of the facility.

132. The Wound Care policy required photographs of wounds weekly, but there is only one photograph of Mrs A's wounds in the records. That photograph was taken on 17 Month2. Consequently, there was no visual record of changes in the wounds over time.

133. The policy also required: 'For all wounds complete the **Wound Assessment treatment and evaluation** in VCare. This will record details about the wound and what treatments are to be completed.' However, there is no wound/dressing chart, and the measurements of the wounds were unchanged.

134. The Wound Care policy provides that it was the responsibility of the Clinical Manager or registered nurse to assess all wounds and determine what the treatment would be. As stated above, the records are unclear about which foot was being treated. There are repeated references to the great left toe when that toe had been amputated. Associate Professor Hogarth said that it appears that Mrs A had issues with both feet and legs, although the treatment of her feet and legs is difficult to follow from the notes, and RN C did not always note which foot was referred to in the progress notes.

135. In addition, the information recorded is at times contradictory. For example, on 3 Month4, RN C faxed a referral to the wound clinic that states: '*Urgent — marked deterioration in lower [right] leg circulation. Necrotic areas. Pain intensifying.' However, the wound care plan of 3 Month4 refers to 'infected 1st and 2nd toes on L foot' and states that Mrs A's pain level was 2/10. In my view, it was RN C's responsibility to oversee the care home staff and ensure that the records were accurate. As stated above, she had overall responsibility for the care of all residents and the direction of the staff.

136. Associate Professor Hogarth said that the wounds appear to have been dressed regularly as is documented in the daily notes, although the dressing type is unclear. She is of the view that there was a departure from accepted practice and care of Mrs A in the assessment and ongoing treatment of her wounds. Associate Professor Hogarth noted that there is inconsistency about how the wounds were described, there are no ongoing photographs, and there is confusion in the notes about which foot was referred to. She said that the documentation of the wounds and Mrs A's leg pain and her ongoing management are confusing. I acknowledge my advisor's advice, and I am particularly concerned about the failure to photograph the wounds, the size of the wound being recorded as unchanged over time, and the obvious inaccuracies in the records.

Referral

137. The referral process at the care home was that when the GP gave a directive for a referral, it would be discussed at the time and decided who would communicate with the service required. Most often the GP would make a direct referral, but alternatively the GP might write an accompanying medical note for the facility to make the referral, or the Clinical Manager might refer directly using the then DHB referral form. Furthermore, the Wound Care policy states, 'Referral to Wound Nurse Specialist (if not healed within four weeks)', but advises GP input in the first instance and to 'follow his instructions'.

138. Dr F recorded on 19 Month2 that Mrs A 'could benefit from Doppler'. RN C thought Doppler was suggested as an avenue of further investigation that could be pursued at a later juncture, rather than an instruction to refer. She said that if it had been an instruction, it would have been done immediately. Dr F said that he had asked for a Doppler referral for vascular assessment, and it was his expectation that this would have been arranged on 19 Month2. Given that Dr F had indicated that Mrs A would benefit from Doppler assessment, I consider that he had indicated that this was his immediate intention. If RN C was unsure whether this was an instruction, she should have clarified with Dr F what his intentions were.

139. Dr F further stated that when he saw Mrs A on 10 Month3, he was unaware that a referral for Mrs A's assessment had not been made. Although either RN C or Dr F could have made the referral, neither did so. Dr F said that the need for further vascular assessment was again discussed with RN C at Mrs A's appointment on 24 Month3, and RN C recorded: '[Dr F] requested Doppler studies be conducted by the wound clinic technicians early 2020 — referral sent.' However, there is no record that RN C sent a referral to the wound clinic on 24 or 27 Month3 requesting Doppler studies. The only referral in the care home and the wound clinic records was prepared and sent on 3 Month4. Associate Professor Hogarth was mildly critical of the documentation of the GP visits from a nursing perspective to show what was discussed and to ensure that issues raised were addressed. I agree and I am of the view that if the documentation had been better and, preferably, RN C had arranged for it to be reviewed by Dr F for accuracy or discussed with him whether he intended that a referral should be made, then this breakdown in communication could have been avoided.

140. In my view, it is concerning that the first referral in the wound clinic records is dated 3 Month4 in the body of the document. I have considered whether RN C may have faxed a referral on either 24 or 27 Month3, but I consider this is unlikely given that the care home records do not contain the original referral and the 3 Month4 referral is the only one in the wound clinic records. Associate Professor Hogarth said that the referral could have been followed up sooner, as this would have allowed time prior to the service reduction over the public holiday. Furthermore, a quicker referral may have provided an opportunity for a further set of eyes over Mrs A's condition with the possibility of earlier intervention, which may or may not have altered the care or trajectory of deterioration and outcome. I agree that if RN C thought she had sent a referral on 24 Month3 and she had followed it up, she would have ascertained that no referral had been received by the wound clinic. Overall, I consider that RN C's management of Mrs A's referral was unsatisfactory.

141. In my view, RN C should have clarified the instruction from Dr F, particularly regarding who would make the referral if it was required, and, in Month3, she should have followed up with the wound clinic to check that the referral she thought she had sent had been received.

Conclusion

142. RN C did not provide services to Mrs A with reasonable care and skill with regard to:

- the assessment and ongoing treatment of her wounds;
- the deviations from policy; and
- the documentation of the wounds, leg pain, and ongoing management.

143. RN C also failed to clarify the requirements regarding Mrs A's referral to the wound clinic and ensure that a referral was received by the wound clinic in Month3. Accordingly, I find that RN C breached Right 4(1) of the Code.

Opinion: Dr F — adverse comment

144. Dr F was the care home's medical practitioner. He saw Mrs A for regular three-monthly reviews and also when requested by care home staff.

Necrotic wound — adverse comment

145. By 24 Month3, Dr F was aware of Mrs A's necrotic wound in her right foot. Dr Maplesden advised that appropriate management included reassessment of the peripheral pulses and consideration of an acute referral if pulses were absent. He said that referral was still warranted even if an acute Doppler assessment of the pulses could not be undertaken, unless the pulses could be palpated digitally.

146. Dr Maplesden advised that if Mrs A's right foot pulses remained palpable, even if diminished, then Dr F's intended management on 24 Month3, which was for prompt referral for assessment of the pulses by the wound clinic, was reasonable taking into account the mitigating factors. However, if the peripheral pulses were not palpable, Dr Maplesden would be mildly to moderately critical of Dr F's management, primarily in relation to not offering Mrs A the option of an acute vascular surgical referral.

147. There is no indication in Dr F's records that he assessed Mrs A's pedal pulses during this visit, although RN C recorded in the progress notes: 'Pedal pulses present, foot warm and perfused …' It is not specified whether that was her assessment or a report of an assessment by Dr F. However, I acknowledge that RN C and Dr F were assessing Mrs A jointly, and I accept that the impression was that pedal pulses were present at that time. Dr Maplesden said that if Mrs A had palpable peripheral pulses in her right foot, it was reasonable to defer vascular surgeon referral until formal assessment of the pulses had been undertaken.

148. Dr F said that when advising a conservative approach while awaiting the wound clinic review, he took into account Mrs A's co-morbidities and the likelihood of her being offered surgery to improve her circulation, together with her desire to attend a family event. In my view, Dr F should have discussed this approach with Mrs A and her family.

Referral — adverse comment

149. The referral process at the care home was that when the GP gave a directive for a referral it would be discussed at the time and decided who would communicate with the service required. Most often the GP would make a direct referral, but alternatively the GP might write an accompanying medical note for the facility to make the referral, or the Clinical Manager might refer directly using the then DHB referral form.

150. On 19 Month2, Dr F suspected that there might have been a deterioration in the vascular status of Mrs A's right foot, and he told HDC that he considered a referral to the wound clinic for ABPI. Dr F said that he had asked for a Doppler referral for vascular assessment, and it was his expectation that this would have been arranged on 19 Month2.

151. However, RN C thought that a Doppler assessment was suggested as an avenue of further investigation that could be pursued at a later juncture, rather than an instruction to refer. She said that if it had been an instruction, it would have been done immediately. However, she did not seek clarification from Dr F. In any event, no referral was made at that time.

152. My in-house clinical advisor, GP Dr David Maplesden, noted that the expectation of Dr F and care home staff regarding the referral process was unclear. He said that it would have been appropriate for either RN C or Dr F to have made the referral, but it appears that neither did. Dr F said that when he saw Mrs A on 10 Month3, he was not aware that a referral for Mrs A's vascular assessment had not been made.

153. Dr Maplesden advised that if Dr F had a definite intention to make the referral on 19 Month2, he would be mildly to moderately critical of the breakdown in communication or processes that resulted in the referral being overlooked. I agree. In my view, Dr F had a responsibility to ensure that when he decided on a referral, he communicated his decision clearly. He should have recorded his intention in the medical notes to avoid any doubt.

154. The process in place allowed Mrs A to 'fall between the cracks' as Dr F believed he instructed RN C to make the referral, while RN C interpreted the conversation and Dr F's notes as a suggestion of a possible referral in future.

155. This was even more likely in this case because Dr F recorded vague requests such as on 19 Month2 that Mrs A 'could benefit from Doppler', and on 24 Month3 that she 'could have Doppler'.

Treatment of pain — no breach

156. Mrs A was on background analgesia of paracetamol 1g QID, and regular codeine 15mg BD was charted on 24 Month3. Dr F said that Mrs A's pain management was considered and

discussed at every consultation, and staff reported that she appeared distressed with pain at times, but it settled quickly with lorazepam, personal input, and/or codeine.

157. Dr F said that Mrs A's ongoing anxiety made objective assessment of her pain very difficult, and he noted that her demeanour changed when family members were present at consultations.

158. Dr Maplesden said that had Dr F been notified at any stage that Mrs A's use of PRN analgesia was escalating or was proving inadequate to control her pain, he would have expected there to have been a formal review of the analgesia prescribed, with appropriate changes made, such as an increase in regular analgesia and close monitoring of the response. Dr Maplesden noted that regular codeine had been charted from 24 Month3, and no additional PRN codeine was administered until 31 Month3, which suggested that rapidly increasing pain was not an overriding issue.

159. I accept this advice and consider that Dr F's management of Mrs A's pain was within acceptable standards.

Treatment of gout — educational comment

160. On 19 Month2, Dr F reviewed Mrs A and noted that gout was an ongoing issue. He restarted naproxen and noted that he was waiting for the results of the blood test to ascertain the uric acid levels. Dr F did not commence treatment with allopurinol to reduce uric acid levels for gout prevention, and he said that normally he would not do so until the current attack had subsided.

161. Dr Maplesden advised:

> 'While this was previously regarded as accepted practice, recent advice includes: Allopurinol can be initiated during an acute flare of gout; there is little evidence supporting delaying treatment until the flare has settled.'

162. After Dr F reviewed the uric acid result, which showed elevated levels supporting the diagnosis of gout, he decided that no long-term prophylactic treatment was warranted. Dr Maplesden said that this would not be in keeping with best practice, although issues such as co-morbidities and polypharmacy required consideration in this case. I accept this advice.

163. Dr F acknowledged that best practice would have been to commence prophylactic treatment, and that with the benefit of hindsight, in light of Mrs A's ongoing foot pain, 'it could reasonably be argued that initiation of Allopurinol would have been beneficial'. However, I note that Dr Maplesden did not advise that failure to do so was below accepted standards. I agree and I am not critical of Dr F's care in this respect.

Opinion: Dr G — adverse comment

164. Care home staff noted that there were some necrotic areas on Mrs A's toes on 13 Month2 and that she had increased pain on 16 Month2. A GP review was requested on 18 Month2 after further deterioration, and Mrs A was reviewed that day by locum Dr G.

165. Dr G noted that Mrs A's pain had improved while she was on naproxen and worsened when it was stopped. Dr G's plan was to restart naproxen and order blood tests, including testing the uric acid level, and if there was evidence of gout to start allopurinol. Dr Maplesden advised that improvement with naproxen was consistent with the diagnosis of gout, and the blood tests planned by Dr G were appropriate. However, Dr G did not document that he had undertaken an assessment of Mrs A's feet.

166. Dr Maplesden advised that if Dr G assessed Mrs A's foot, the findings should have been documented. Dr G said that he did examine Mrs A's foot, but he acknowledged the absence of these examination findings in the notes. He agreed that documentation of clinical findings is important.

167. RN C made an entry in the progress notes dated 18 Month2 that confirms Dr G's attendance and summarises his assessment. Dr Maplesden said that he believes the failure by Dr G to record his findings in relation to his examination of Mrs A's foot was a mild departure from accepted standards of clinical documentation, noting that the foot was the cause of Mrs A's concerning symptoms. However, Dr Maplesden noted that Dr G did record some notes in relation to Mrs A's management, and RN C described the assessment findings in the progress notes. Dr Maplesden noted that it is not clear that the documented findings specifically represented the results of Dr G's assessment.

168. Dr Maplesden also noted that there was intention to perform appropriate blood tests, but he recommended that Dr G provide more specific instructions to nursing staff in future regarding the tests required.

169. I accept Dr Maplesden's advice, and I am concerned about Dr G's standard of record-keeping, particularly as he did not record his assessment in the medical notes or review the record made by RN C to ensure that it reflected his assessment accurately. I am also critical that Dr G did not provide specific instructions to nursing staff at the care home regarding the blood tests required.

Changes made

170. The care home said that having reviewed these events, it undertook the following:

- Reminded the registered nurse and Care Lead staff to follow the wound policy;
- Reviewed with staff the consistent use of language to describe observations; and

- Built a closer working relationship with a complex wound care specialist from the public hospital and discussed the process for escalation of referrals.

171. The care home advised that the following changes were made to the service it provides:

Improvements to GP communication and documentation

- The care home provided education to registered nurses and other staff regarding the use of ISBAR when communicating information to the GP to ensure that accurate clinical information is provided so that decisions about resident care are timely and proactive.
- Education was provided on the escalation of care and clear delegation and documentation of tasks following GP rounds. The follow-up is diarised with notes kept. The recording of GP reviews has been improved, especially discussions, planning, and responsibilities for any actions recommended.
- There is now clear documentation of when family have attended GP reviews.

Clinical actions

- There has been education across the care home and Care Home 2 promoting the use of the 'STOP AND WATCH' reporting tool for HCA staff in daily reporting.

Referrals

- The care home has defined the process when referrals occur during GP rounds. Until November 2020, wound care referrals continued to be sent through the Care Coordination Centre, and staff set follow-up dates if the referrals were not responded to.
- From November 2020, registered nurses have been able to refer directly to the complex wound care team by email. This is discussed with the GP when completed, and education for staff on the referral process has been completed.
- Since 2020, care home staff have established links and good relationships with the complex wound team and CNS D, and care home staff are able to telephone for advice and support to guide the care team.

Internal audits

- Internal audits are completed six monthly by the quality adviser to ensure that documentation, including wound care records, is accurate and timely and that long- and short-term monitoring is correct.

Education with care team

- The care home has provided ongoing education to upskill the care team.

Recommendations

172. I recommend that the care home, Dr F, and RN C each separately apologise to Mrs A's family for the deficiencies identified in this report. The apologies are to be sent to HDC within three weeks of the date of this report, for forwarding.

173. The care home has implemented several changes since these events. I recommend that within six weeks of the date of this report, the care home evaluate the changes made and report back to HDC on the outcome and any further changes proposed as a result of the evaluation.

174. I recommend that within six weeks of the date of this report, Dr F review the level of detail in his clinical records and report to HDC on the outcome.

175. I recommend that within six weeks of the date of this report, RN C reflect on the standard of her record-keeping with regard to the level of detail required, and report back to HDC on the outcome and any changes she has made as a result.

Follow-up actions

176. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's name.

177. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to the Medical Council of New Zealand, and it will be advised of Dr F's name.

178. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to HealthCERT and Te Whatu Ora|Health New Zealand, and they will be advised of the name of the care home.

179. A copy of this report with details identifying the parties removed, except the advisors on this case, will be sent to the Royal New Zealand College of General Practitioners 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 advice was obtained from GP Dr David Maplesden:

'**CLINICAL ADVICE — MEDICAL + Addenda**

TO: INV

FROM: David Maplesden

CONSUMER: [Mrs A] (dec)

PROVIDER: [Dr F]; [Care home]

FILE NUMBER: C20HDC00726

DATE: 14 December 2020, **Addenda 15 March 2023 (bold)**

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1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr B] about the care provided to his late mother, [Mrs A], by [Dr F] and staff of [the 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. I have reviewed the following information:

- Complaint from [Mr B]
- Response and care documentation [the care home]
- Response and clinical notes [Dr F]
- [Wound clinic] notes
- Clinical notes [DHB]
- **Addendum 15 March 2023: Additional information reviewed includes: further responses and documentation from [the care home]; response to my initial advice from [Dr F]; transcripts of handwritten clinical notes; response from [Dr G]; health navigator file review.**

2. [Mr B's] complaint relates to the care of his late mother by [Dr F] at [the care home] between [Month1] and her admission to [the public hospital] in [Month4]. [Mrs A] died in [the public hospital] on 12 [Month4] with death certificate stating cause of death as *sepsis — days; R lower limb ischaemia — hours to days; peripheral vascular disease — years.* [Mr B] is concerned at the management of his mother's ischaemic right foot in the weeks prior to her death including:

- inadequate pain relief
- misdiagnosis of gout
- delayed recognition of sepsis

- delay in monitoring for side effects of NSAIDs after these were commenced by the [emergency medical] clinic

3. [Dr F] notes in his response that [Mrs A] (aged [in her seventies]) was admitted to [the care home] in [2016] and her medical history at that time included: anxiety and depression (on escitalopram and lorazepam long-term); hypertension; cerebrovascular disease (previous stroke, carotid artery stenosis); severe peripheral vascular disease (PVD) with aorto-femoral bypass 1995 and previous left great toe amputation; gout; mild cognitive impairment; heavy smoker. In May 2018 [Mrs A] developed a chronic ulcer on her right leg and was referred for vascular assessment ([the wound clinic]) in September 2018. Assessment was undertaken on 5 November 2018 with findings including ankle brachial pressure index (ABPI) of 0.61 on the right and 0.58[1] on the left (reliability questioned as difficult to hear pulses). There were no pedal pulses palpable and significant signs of venous hypertension noted. Wound dressing advice was provided. [Mrs A] had an overnight admission to [the public hospital] where she was diagnosed with heart failure and ischaemic heart disease in December 2018 with follow-up echocardiogram on 29 [Month1] showing preserved ejection fraction and no major valvular disease.

4. On 23 [Month1] an inflamed area was noted on [Mrs A's] right foot. On 29 [Month1] [Mrs A] was reviewed by [a locum] in relation to painful toes on her right foot. Notes include: *Dusky, pulses absent, improved with elevation. Necrotic breakdown 2 & 3 toes.* Management was to optimise limb positioning, avoid compression stocking and keep limb warm. Codeine was available as analgesia. Blood tests on 31 [Month1] showed mild anaemia, normal CRP, normal renal function. On review of medication charts, at this time [Mrs A] was prescribed regular paracetamol 1g QID and PRN codeine 15–30mg up to QID.

Comment: There are no medication administration charts on file to determine frequency of PRN analgesia administration. I am unable to determine how well [Mrs A's] pain was monitored or managed over this period, or why family felt it necessary to take [Mrs A] to an after-hours provider (see below) for assistance with management of her condition (no daily record on file from [the care home]). This documentation should be obtained if nursing review is to be sought (daily record, pain reporting documentation, PRN medication administration records and drug charts). I note comments from [the care home] and [Dr F] that [Mrs A's] established anxiety problem made interpretation of her pain levels difficult to interpret at times. The capacity to administer up to 120mg codeine per day on top of [Mrs A's] regular paracetamol appears a reasonable pain management strategy.

Addendum 15 March 2023: PRN administration records have been reviewed in relation to analgesia and are tabulated in Appendix 2. There was no pattern of escalating use of analgesia, and response to PRN analgesia administered (codeine) is consistently recorded as good. [Mrs A] was on background analgesia of paracetamol

[1] See Appendix 1 for interpretation

1g QID and regular codeine 15mg BD was charted on 24 [Month3]. Had [Dr F] been notified at any stage that [Mrs A's] use of PRN analgesia was escalating or was proving inadequate to control her pain, I would expect there to have been a formal review of her analgesia prescribing with appropriate changes made (increase in regular analgesia and close monitoring of response).

5. On 3 [Month2] [Mrs A's] family took her to the [emergency medical] centre for review of her foot, apparently because of increasing pain. Notes include: *Pain in R big toe (and other toes) last 1m or so, worse over w/e. No recent injury … hasn't seen the GP for a while …* [Mrs A] was noted to be responsive but somewhat confused. Assessment findings include: *Good circulation and sensation in R foot — CRT<2 secs, pulses N. Small pressure sores on balls of 2nd, 3rd and 4th toes … somewhat tender along all toes, not tender in midfoot or MTPJs. Tender swollen R foot 1st IPJ, red, not warm.* It appears a diagnosis of gout was considered with short course of Naproxen prescribed ([Mrs A] was taking omeprazole 20mg BD as gut protection) and check renal function and uric acid levels in two weeks with GP review recommended. The [care home's] spreadsheet suggests there was an initial improvement in [Mrs A's] condition and pain levels and she was walking normally on 8 [Month2].

Comment: The findings of "good circulation" and "normal pulses" in the right foot is somewhat surprising given the vascular assessment findings from November 2018 and no revascularisation procedure performed in the interim. Nevertheless, if the GP's impression was of a good circulation, the diagnosis of gout was reasonable and the management provided was appropriate for this diagnosis. Gout and limb ischaemia can co-exist and in that situation it could be difficult to differentiate which pathology was causing the increase in pain.

6. The [care home] spreadsheet notes observation of some necrosis areas on [Mrs A's] toes on 13 [Month2] and increased pain on 16 [Month2]. GP review was requested on 18 [Month2] after further deterioration over the weekend and [Mrs A] was reviewed that day by locum [Dr G]. The recent review at [the emergency medical] centre is noted together with diagnosis of gout and follow-up blood tests required. Notes include: *Pain improved on NSAID and worsened when medication stopped.* Plan was: *restart Naproxen … bloods inc uric acid tomorrow … If evidence of gout to start allopurinol.*

Comment: There are no assessment findings documented. I would be mildly critical if [Dr G] did not assess [Mrs A's] foot given the increase in pain, but noting the recent findings at the [emergency] clinic of likely gout and "good" circulation. If the foot was assessed, findings should have been documented. Improvement with NSAID was consistent with the diagnosis of gout and the blood tests planned by [Dr G] were appropriate. It appears blood tests were undertaken the next day as planned (19 [Month2]) but only uric acid was requested. Best practice would be to re-check renal function if NSAIDs were to continue although I note [Mrs A] had normal renal function in [Month1]. Serum uric acid was elevated at 0.41 mmol/L, supporting the gout diagnosis.

Addendum 15 March 2023: **[Dr G] provided a response dated 2 February 2022 in which he confirms he examined [Mrs A's] foot although he acknowledges absence of clinical documentation in relation to the assessment. [Dr G] states:**

My usual practice in this situation would be to examine the patient and the rest home notes record that "on examination" I agreed the likely diagnosis was gout. Therefore I consider Dr Maplesden can be reassured that I did examine [Mrs A] … I acknowledge the absence of these examination findings in the notes and I agree with him that documentation of clinical findings is important … I requested "routine bloods inc uric acid". My recollection of the ordering process at [the care home] was that a doctor would request the bloods either verbally or as a written entry in the notes and the nursing staff would arrange the forms and collection of samples. Routine bloods was taken to mean renal function & CBC. **On review of [care home] [nursing] notes there is an entry dated 18 [Month2] which confirms [Dr G's] attendance and includes:** ***OE blackened areas, broken skin on outer aspect little toe and under 2, 3 toes noted, pulses evident. Plan — continue current nursing interventions. Blood tests tomorrow as prearranged. Restart NSAID medication and review after course finished and test results back.*** **I believe the failure by [Dr G] to record his findings in relation to his examination of [Mrs A's] foot to represent a mild departure from expected standards of clinical documentation noting the foot was the cause of [Mrs A's] concerning symptoms, but the fact some notes had been recorded by him in relation to [Mrs A's] management, and it appears the [nurse] had described the assessment findings (although it is not clear that the documented findings specifically represented the results of [Dr G's] assessment). There was intention to perform appropriate blood tests and I recommend [Dr G] provide more specific instructions to nursing staff in future regarding the tests required.**

7. On 19 [Month2] [Dr F] reviewed [Mrs A] at what appears to be a routine review. Notes include: *gout an ongoing issue. Restarted on Naproxen → gout levels awaited. Pulses could benefit from Doppler.* [Dr F] notes in his response that he *suggested during the consultation that a further doppler assessment should be carried out.*

Comment: The uric acid level may not have been available at this point. [Dr F] observes in his response that treatment with allopurinol to reduce uric acid levels (gout prevention) would normally not commence until the current attack had subsided. While this was previously regarded as accepted practice, recent advice[2] includes: *Allopurinol can be initiated during an acute flare of gout; there is little evidence supporting delaying treatment until the flare has settled.* In an e-mail to [Mrs A's] son dated 27 [Month2], [the care home] [nurse] [RN C] indicates [Dr F] has reviewed the uric acid result and decided no long-term prophylactic treatment was warranted. This would not be in keeping with best practice although issues such as co-morbidities and polypharmacy required consideration in this case. It appears [Dr F] suspected there may have been a deterioration in the vascular status of [Mrs A's] right foot and referral for ABPI was

[2] BPAC. Managing gout in primary care. 2018. https://bpac.org.nz/2018/gout-part1.aspx Accessed 14 December 2020

considered. The expectation of [Dr F] and [care home] staff regarding the referral process is unclear. It would be appropriate for either the facility RN or [Dr F] to make the referral but it appears neither did. If there was a definite intention to make the referral at this point, I am mildly to moderately critical of the breakdown in communication or processes which resulted in the referral being overlooked and I recommend the facility review its processes in this regard.

8. On 22 [Month2] [Mrs A] had an assessment by the podiatrist with infection around some of the right toenails noted. [Dr F] was informed by fax and flucloxacillin charted. Her condition remained stable and she was reviewed by [Dr F] on 10 [Month3] where vital signs were documented (normal) and *Uric acid … poor toenails infection … very "wobbly" … nails leave alone, poor circulation, protect nails.*

Comment: The [care home] spreadsheet indicates [Mrs A] was stabilising and mobilising satisfactorily in the first half of [Month3]. Her wounds were stable and intermittent complaints of foot pain were apparently responsive to treatment. I am unable to determine what actions [Dr F] took on noting [Mrs A's] elevated uric acid but see previous discussion regarding delay in instituting prophylactic treatment with allopurinol. I would not regard the delay as being a departure from common practice but recommend [Dr F] review the cited BPAC guidance on gout management. It is unclear if [Dr F] was aware there was no current referral in place for [Mrs A's] vascular assessment but given her apparent stability currently (and assuming there was no obvious necrotic ulceration), there was no apparent urgency for the assessment.

Addendum 15 March 2023: The Health Navigator review raises the potential issue of whether [Dr F's] review on 19 [Month2] might have raised suspicion of infection given the podiatrist observations only three days later. I do not think it is possible to make a definitive statement in this regard as infection could have developed or become obvious at any point in the preceding three days, particularly in a poorly vascularised foot. However, if regular nursing review of the foot had led to concern regarding possible evolving infection over the three-day period, I would expect this concern to have been relayed to [Dr F] and consideration given to commencing antibiotics. There is also the issue of variation between observers regarding whether or not a clinically significant infection might be present. A 2019 systemic review[3] concluded: *Currently, there is insufficient evidence to inform the diagnosis of bacterial skin infections in older adults in the community; clinicians should therefore rely upon their clinical judgement and experience. Evidence from high quality primary care studies in older adults, including studies assessing symptoms traditionally associated with bacterial skin infections (e.g. erythema and warmth), is urgently needed to guide practice.* There was further concern regarding whether or not further antibiotics might have been prescribed on 10 [Month3] when GP notes referred to *poor toenails infection …* There is nothing in the notes to suggest [Mrs A] had obvious progressive infection between 10 and 24 [Month3] and it does not appear there were any concerns raised

[3] Gbinigie O, Ordóñez-Mena J, Fanshawe T et al Limited evidence for diagnosing bacterial skin infections in older adults in primary care: systematic review. BMC Geriatr. 2019 Feb 18;19(1):45

with [Dr F] by nursing staff regarding that possibility. Topical treatment (betadine) of localised peri-nail infection may have been appropriate if this was controlling any minor infections. [Dr F] notes in his later response that he was not aware at the visit on 10 [Month3] that a referral had yet to be made for [Mrs A's] vascular assessment.

9. Between 10 and 24 [Month3] [the care home] spreadsheet records [Mrs A] as being stable, mobilising satisfactorily and attending out of facility family events. There was a complaint of leg pain, and associated vomiting, after a family event on 22 [Month3]. On 24 [Month3] [Dr F] reviewed [Mrs A] noting: *Circulation R leg & necrotic wound … Blood circ check [the wound clinic]. On codeine … is quite anxious currently and need to balance pain relief … could have Doppler also PRN.* [Dr F] notes in his response: *The need for further vascular assessment was again discussed with the nurse in charge, as it had been previously on 19 [Month2] and the recommendation that specialist nursing input was needed.* Regular codeine was initiated at 15mg BD with PRN doses available as previously described. The adequacy of this management depends on [Mrs A's] average dose of PRN codeine required over the previous week or so (not evident from available documentation). The [care home's] response notes: *Referral was made to [the] wound clinic. Initial referral was made 27th [Month3] following GP review on 24th [Month3]. Due to [public holiday] closures, referral was followed up, refaxed and confirmed for urgent appointment. [Mrs A] was seen at [the wound clinic] on 7th [Month4] … Referral was not made until this date as [Mrs A] had responded well to treatments and her wounds had been sighted in the preceding 8 weeks by GP, 2 locum GPs, an After-Hours GP and 2 Registered Nurses*.

Comment: It appears [Dr F] had increasing concerns regarding the vascular status of [Mrs A's] right foot. [Dr F] states in his response that he took into consideration [Mrs A's] co-morbidities and her desire to spend time with family over the [public holiday] when deciding on necessity for hospital admission although management options were not discussed in detail with family. It is difficult to ascertain how long [Mrs A's] necrotic foot wound had been evident but local guidance[4] suggests requesting acute vascular assessment in patients with suspected critical limb ischaemia (*Absent peripheral pulses with: persistently recurring rest pain requiring analgesia for more than 2 weeks, or ulceration, or gangrene of the foot or toes*). Once the necrotic wound was observed by [Dr F], I believe appropriate management included reassessment of peripheral pulses (noting these had been reported as 'normal' on 3 [Month2] although in hindsight it appears unlikely this was the case) and consideration of acute referral if pulses were absent noting the criteria discussed above. If acute Doppler assessment of the pulses could not be undertaken, I believe referral was still warranted unless the pulses could be palpated digitally. Referral required [Mrs A's] consent but it is not evident there was any discussion of this option. Under the circumstances, I am mildly to moderately critical of [Dr F's] management of [Mrs A] on this occasion. Mitigating factors include: the co-morbidity of gout which may have obscured the source of [Mrs A's] pain; the finding of "normal" foot pulses a few weeks' previously; the overall stability of [Mrs A's] condition including her ability to mobilise; the challenges of assessing [Mrs A's] pain

[4] Community Health Pathways section titled '*Peripheral vascular disease*'.

levels when influenced by anxiety; the fact referral for Doppler assessment of pulses had been requested by [Dr F] on 19 [Month2] and was again suggested following the current assessment. If acute specialist review was to be deferred, the Doppler assessment needed to be undertaken with some urgency and it is not clear this was adequately communicated to nursing staff who were making the referral. I would be mildly to moderately critical if the referral was not requested urgently. The referral was not made until 27 [Month3] and was then delayed because of the [public holiday]. I recommend the facility treat the delay in referral (from the time it was requested by [Dr F] on 19 [Month2]) as a serious event and review the current process for facilitating such referrals.

Addendum 15 March 2023: [Dr F] reiterates in his later response his expectation the referral for vascular assessment had already been made as previously directed and on learning it was not in place, his emphasis that Doppler assessment of pulses was urgently required and the referral should be completed to reflect this. There remains confusion over when a referral was actually completed. I would expect this to have been same day completion and the [nursing] notes reviewed dated 24 [Month3] include: *S/B [Dr F] today — [son] present. History of pain, circulatory issues and anxiety — general well being discussed. [Dr F] requested Doppler studies be conducted by [wound clinic] technicians early 2020 — referral sent. Pedal pulses present, foot warm and perfused …* However, the only completed referral form I have viewed (and which is marked urgent) is dated 3 [Month4] (adjacent to the referrer's signature rather than at the top of the form). The [nursing] notes also refer to presence of peripheral pulses (although unclear whether this was reported by [Dr F] or relates to the [nurse]'s assessment) and the accuracy of this reported finding might be in question based on the overall sequence of events. [Dr F] emphasizes he took into account [Mrs A's] co-morbidities and likelihood of being offered major surgery to improve her circulation together with her desire to be [at a family event] when advising a conservative approach while awaiting NM review. The [nursing] notes do complicate the picture somewhat. If the notes are accurate with respect to the impression [Mrs A] had palpable peripheral pulses in her right foot, I believe it was reasonable to defer vascular surgeon referral until formal assessment of the pulses had been undertaken. If the pulses were not palpable (implying a situation of critical limb ischaemia as previously discussed) I believe the option of acute vascular surgical assessment needed to be presented to [Mrs A] and the possible sequelae of deferring such assessment. The degree to which the NM referral was to be regarded as urgent is unclear. The referral viewed is marked urgent but the [nursing] note implies [Dr F] requested the assessment be completed in *early 2020* which implies a lesser degree of urgency but was likely to reflect reality even if the referral was sent promptly. In the scenario that there was confidence [Mrs A's] right foot pulses remained palpable even if diminished, I believe [Dr F's] intended management on 24 [Month3] (prompt referral for NM assessment of pulses) was reasonable taking into account the mitigating factors previously discussed. If the peripheral pulses were not palpable, I remain mildly to moderately critical of [Dr F's] management, primarily in relation to not offering [Mrs A] the option of acute vascular surgical referral.

10. [Dr F] reviewed [Mrs A] for the last time on 31 [Month3]. Notes include: *Seems v anxious currently. Also L foot pain joint, tender joint … needs referral to [the wound clinic] for circulation.* Prescribed short course prednisone (accepted management as alternative to NSAID for acute gout), nortriptyline 10mg nocte (accepted adjunctive pain management). There is no specific reference to assessment of vascular status of the right foot. [Dr F] states in his response: *The need for referral for vascular assessment and specialist nursing was again discussed on 31 [Month3] and expedited at that point by the nurse [].*

Comment: I am moderately critical that acute (rather than urgent) vascular assessment was not considered at this point, particularly if there were to be delays in gaining Doppler assessment of the pulses, given documented difficulties in controlling [Mrs A's] pain and apparent persistence of a necrotic wound on her right foot ie fulfilling criteria for critical limb ischaemia. If a more conservative approach was to be taken (which might have been reasonable given [Mrs A's] co-morbidities), this required explicit discussion with [Mrs A] and her family. It is not apparent there were signs of sepsis at this point, or that any concerns regarding [Mrs A's] vital signs were conveyed to [Dr F] on this date. I recommend [Dr F] review the cited local guidance on peripheral vascular disease.

Addendum 15 March 2023: ***[nursing] notes dated 31 [Month3] read: Minimal impact from recent medication changes noted — a little quieter and slightly less PRN only. Wounds static and painful episodes of no obvious trigger still occurring.*** **I note regular codeine had been charted from 24 [Month3] and no additional PRN codeine had been administered up until 31 [Month3] which suggests, on the basis of the administration charts, that rapidly increasing pain was not an overriding issue. The fact there was still no firm date scheduled for [Mrs A's] NM assessment is significant and I am mindful of the NM findings a week later (see below) although some of the changes noted may have evolved over the week and were evidently not reported to [Dr F] had they evolved over this period. The [nursing] note does suggest the clinical situation was stable and I believe there are again two scenarios to consider: peripheral pulses had been palpable on 24 [Month3] and the overall clinical situation (including appearance of the foot and pain levels) was stable — probably acceptable management but noting there was still no firm date for NM assessment; peripheral pulses were not palpable on 24 (or 31) [Month3] — moderate criticism that acute vascular surgical referral was not offered as an option noting the likelihood of acute limb ischaemia, there was no certainty regarding the date of intended NM assessment and there was no advantage to further delaying [Mrs A's] vascular assessment.**

11. [Dr F] did not review [Mrs A] subsequently nor was he requested to do so by [care home] staff. The [care home's] spreadsheet and subsequent [wound clinic] notes suggest there was deterioration in [Mrs A's] ulcer and pain levels over the next few days and a referral requesting more urgent assessment of the vascular status of [Mrs A's] foot was faxed to [the wound clinic] by [care home] staff on 3 [Month4]. Assessment took place on 7 [Month4] with [wound clinic] notes including: *Painful foot over past few months but this has increased over past few weeks. RN at rest home reported necrosis*

over past few days. Pain severe, worse when elevated. Not been able to sleep for past three weeks … Right foot cold and cyanosed. Ulceration and necrosis on fourth and third toes. Unable to palpate pedal pulses. Impression: critical limb ischaemia. [Mrs A] was referred directly from [the wound clinic] to the DHB vascular service. At [the public hospital] [Mrs A] was commenced on morphine for pain. Although vital signs were normal, white cell count was elevated and she was commenced on IV antibiotics with her foot the presumed source of infection (later chest X-ray suggested chest as source). Revascularization surgery was being considered when [Mrs A] had a sudden collapse on 10 [Month4] and was confirmed to have suffered a large stroke and bilateral pulmonary emboli. Treatment was changed to palliative and [Mrs A] passed away at [the public hospital] on 12 [Month4].

12. I recommend nursing advice is sought to include comment on the following issues:

- Adequacy of pain recording and management (medication administration charts required)
- Wound monitoring and management
- Escalation of care particularly in [Month4]
- [Wound clinic] referral process
- Communication with GP

13. Addendum 15 March 2023

[Dr F] has included in his response various remedial measures and reflections undertaken since receipt of this complaint. I believe these measures are appropriate and I acknowledge the complexities of managing older patients with multiple comorbidities when invasive treatment might not always be in the patient's best interests or even desired by the patient. Nevertheless, discussion of available options is required in order for the patient to make an adequately informed choice about their management.'

Appendix 1[5]

[5] From: BPAC. The ankle-brachial pressure index: An under-used tool in primary care? Best Practice Journal, 2014. https://bpac.org.nz/bpj/2014/april/ankle-brachial.aspx#tableone Accessed 14 December 2020

Table 1: Clinical interpretation of the ankle-brachial index (ABPI)[1, 4, 5]

Ankle-brachial pressure index (ABPI)	Clinical interpretation
> 1.4	Inconclusive due to non-compressible blood vessels
1.0 – 1.4	Normal; peripheral artery disease can be excluded in most patients
0.9	Borderline; discussion with a vascular surgeon may be appropriate depending on the patients symptoms and risk factors
< 0.9	Abnormal and diagnostic of peripheral artery disease
< 0.4	Critical limb ischaemia

Appendix 2: PRN administration of codeine to [Mrs A] [Months 2–4]

Date	Codeine mg	Date	Codeine mg	Date	Codeine mg	Date	Codeine mg
3 [Month2]	60	2 [Month3]	15	14 [Month3]	30	22 [Month3]	15
14 [Month2]	15	3 [Month3]	30	15 [Month3]	15	24 [Month3]	15
15 [Month2]	15	4 [Month3]	30	15 [Month3]	15	31 [Month3]	15
18 [Month2]	15	6 [Month3]	15	16 [Month3]	15	2 [Month4]	15
20 [Month2]	15	7 [Month3]	15	17 [Month3]	15	3 [Month4]	15
22 [Month2]	15	11 [Month3]	15	18 [Month3]	15	4 [Month4]	15
27 [Month2]	15	12 [Month3]	15	19 [Month3]	15	5 [Month4]	15
29 [Month2]	15	13 [Month3]	15	20 [Month3]	15	6 [Month4]	15

Appendix B: Independent nursing advice to Commissioner

The following independent advice was obtained from RN Professor Karole Hogarth:

'HDC REPORT

REFERENCE: C20HDC00726

COMPLAINT: [THE CARE HOME]

1. Thank you for the request to provide clinical advice regarding the complaint from the family of [Mrs A] between [Month1] and [Month4].

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

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

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

With particular comment on:

1. The adequacy of pain recording and management;
2. The adequacy of wound monitoring and management;

3. Whether [Mrs A's] care was escalated appropriately;
4. Whether referrals were made in a timely manner;
5. The adequacy of communication with the GP;
6. The adequacy of [the care home's] referral process;
7. The adequacy of [the care home's] pain management and wound care policies;
8. Any other matters in this case that warrant comment.

For each question I am asked to advise:

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

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

1. Letter of complaint dated 23rd April 2020.
2. [The care home's] response dated 20th July 2020.
3. Clinical records from [the care home] covering the period from [Month1] to [Month4].
4. Pain management policy
5. Wound care policy

5. Background

[Mrs A] was receiving rest home level care at [the care home]. Her medical history included hypertension, heart failure, ischaemic heart disease, cerebrovascular disease, severe peripheral vascular disease, gout and previous toe amputation. In [Month1], an inflamed area was noted on [Mrs A's] right foot. The condition of her foot worsened until a referral was made to the [wound clinic] on the 27th [Month3]. [Mrs A] was seen at [the wound clinic] on the 7th [Month4] and was referred to hospital. Sadly, [Mrs A] died on the 12th [Month4] with the death certificate stating cause of death as sepsis and right lower limb ischaemia.

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

6. The adequacy of the pain recording and management.

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

The accepted standard of care related to pain management includes assessment of pain, regular pain medication as prescribed, minimal breakthrough pain, and that the resident would state that they have minimal or no pain and that pain does not impact on their ability to undertake normal activities as defined by the resident. Adequate pain relief is a right for all persons in care. The assessment of this in conjunction with carers and family is essential to ensuring the appropriate medication, at the appropriate level is administered regularly as needed.

Documentation should be thorough and pain charts used to determine the resident's stated levels of pain. This should be recorded along with the drug given and the resident's response following administration.

[Mrs A's] pain was regularly assessed and pain relief was administered as required. Pain scores were documented, and treatment appears appropriate from the level of pain reported by the resident. In the progress notes pain is not always mentioned in the summary and some of the daily notes are brief. It is noted that [Mrs A] often scored her pain at low levels with acute episodes of pain which were managed by staff with pain relief or other support. [Mrs A] received regular pain relief — paracetamol, on a daily basis. She did describe breakthrough pain as shooting and lasting seconds from [Month1] into early [Month2]. There was a change to the pain pattern with shin pain added to [Mrs A's] discomfort.

There is some complexity around pain, anxiety and determining the status of the resident at a given time.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information given I would consider that there was no departure from accepted practice and care of [Mrs A] in the initial assessment of her pain and pain management. The wound was dressed and reviewed appropriately at the time of initial assessment.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree that the assessment of [Mrs A's] pain was undertaken at the accepted standard of care and that the ongoing reassessment and documentation has some areas where practice could be strengthened.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.
It would be useful for staff to have a reminder that with residents with chronic pain issues that documentation of this needs to be consistent. The progress notes need to be concise but have enough detail of the resident's status over a shift including dressings and pain.

7. The adequacy of wound monitoring and management

a. What is the standard of care/accepted practice?
The accepted standard of care involves the continued assessment and management of all wounds from any cause beginning with a comprehensive wound care plan based on the policy of the facility.

The wound assessment and ongoing care should include the aspects below:

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

Other aspects to consider are the need for referral to wound care specialists, medication review, allied health assessment e.g. dietician, podiatrist.

[Mrs A] had a complex medical history including peripheral vascular disease, aorto-femoral bypass, and a previous amputation of her L) great toe. This was a flag in her assessment which does not appear to have been fully considered in the management of the ongoing wounds and pain in her feet. This however is not isolated to the nursing staff as gout appears to be the main diagnosis of the ongoing foot pain [Mrs A] was experiencing. There were indications that there were changes in mid-[Month2] when the foot pain ascended into [Mrs A's] shin. This was an opportunity to review which was undertaken by the GP, it is not clear if the changes to the pain pattern were communicated by the care staff to the GP.

The notes are confusing to the reader as to the wounds and feet involved. For example 27 [Month2], 1 [Month3], 6 [Month3] and 9 [Month3] states that infected 1st and 2nd toe on L) foot assessed today. According to the medical record [Mrs A] had no L) 1st toe due to a previous amputation. There is a note by [RN C] on the 20 [Month3] which states large historic ulcer on R) lower leg, half a toe missing on R) foot. The medical notes indicate she had wounds on her R) foot and the ischaemia was diagnosed in her R) leg.

It appears she had issues with both feet and legs though the treatment of both is difficult to follow from the notes as there are no photographs in the file or wound care management or dressing chart and it was not always noted which foot was being written about in the progress notes.

Deviations from policy

- The Wound Care policy requires photographs of wounds weekly
- There is no wound/dressing chart or measurements of the wounds

The wounds appear to have been dressed regularly as documented in the daily notes though it is unclear as to the dressing type. [Mrs A] was regularly reminded to uncross her legs and elevate when sitting. Antibiotics were administered as prescribed.

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

patient. [Mrs A] was seen regularly by a GP and was also seen by a podiatrist in late [Month2]. It was not until late [Month3] that referral was indicated for further assessment, pedal pulses present had been noted prior to the assessment on the 24th [Month3] by the GP.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information given I would consider that there was a moderate departure from accepted practice and care of [Mrs A] in the assessment and ongoing treatment of [Mrs A's] wounds. There are deviations from policy and documentation of the wounds, and her leg pain and ongoing management are confusing.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree that the ongoing management of the wounds on [Mrs A's] feet and legs do not meet the accepted standard of care and that the ongoing reassessment has some areas where practice could be strengthened.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.
[The care home has] indicated corrective actions around the management of chronic wounds and [has] undertaken a review of the wound care policy in relation to [the DHB] and direct referral to the wound care clinic which is positive.

[Educational institution] wound management education which would be useful for staff to remain up to date with current practice. Regular in-service for ENs and HCAs on the assessment of wounds, monitoring, how to measure accurately, dressings including the timeframe of normal wound healing and what the consequences of non-healing wounds may indicate would be a useful addition to improve outcomes.

Improvement of the documentation in regard to chronic wounds is recommended. This should include photographs (as per the Wound Care policy) that are of a good quality and that are regularly updated in the patient's file to show the progression of wound healing or not as in this case. Staff should be encouraged to add detail to this plan to ensure consistency of dressings.

8. Whether [Mrs A's] care was escalated appropriately

a. What is the standard of care/accepted practice?
It would be expected that the care of residents is escalated to external resources when there is indication of change in condition, at request of the family or if there are other circumstances that require consultation. This could include a GP, nurse practitioner, specialists, wound or pain clinics, hospice, district nursing. The purpose of this is to gain expert advice and experience in the ongoing care of residents.

[Mrs A] was reviewed on nine occasions during the time in question [Month1]–[Month4] by a physician including afterhours doctors and cardiologist. She was also

seen by a podiatrist on the 22nd [Month2] who consulted with GP [Dr F]. Family were present as indicated in the progress notes for these consultations on a number of occasions. This is positive as it would have allowed the family to ask questions and to hear the information from the GP firsthand.

This level of GP review shows that nursing staff were proactive in requesting review when indicated by [Mrs A's] condition or in response to the family's request.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information given I would consider that there is no departure from accepted practice and care of [Mrs A] in regard to the escalation of care by the nursing staff.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree that the documented actions meet the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.
Ensure that documentation in the nursing notes also reflects the discussions at the physician visit and if family were present.

9. Whether referrals were made in a timely manner

a. What is the standard of care/accepted practice?
Referral to experts in particular areas of healthcare are normal practice when further care, opinion or advice are required. There are a number of avenues for this depending on the services and relationships in the area.

[Mrs A] was seen by physicians as discussed above. As far as the wound care is concerned current protocols indicate that with monthly reassessment there should be noted a 25% reduction in wound size and that failing to heal within 12 weeks recommends referral to a specialist.

There is an indication in the parts of the progress notes that there was no improvement in the direction of wound healing and that there was continued progression of the wounds including signs of infection at times. From the notes and GP review [Mrs A] did not show the classic signs of ongoing limb perfusion issues. She still had palpable pedal pulses and colour and warmth did not indicate vascular impairment up until late [Month3].

There was no indication that the Complex Wound Care ARC Pathway flow chart was used in the decision making. It is inferred that the wounds were relatively small but the lack of healing and further progression would have indicated that referral to District Nursing should have been initiated and this may have triggered the move to specialist wound management services may have occurred sooner if indicated.

Referral to [the wound clinic] was made after the GP visit on the 24th [Month3] in response to a further change in pain levels and at this time limb ischaemia was

mentioned. [Mrs A] was seen on the 7th [Month4]. This may have occurred more quickly if it were not for the [public holiday]. Due to the timing the staff needed to have increased vigilance of limb circulation and escalate care to hospital services if indicated.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information provided I would consider that there is a mild departure from the accepted standard of care. The main reason for this is that once it was established that there was no improvement of the wounds on [Mrs A's] foot and they were not making any positive progression, a referral to the District Nursing service or [the wound clinic] would ideally have occurred as there was no progression towards healing as indicated in the progress notes. It is difficult for nursing staff as [Mrs A] was reviewed several times by a GP so it is in part about the confidence of the staff and the relationship they have with the GP and external services as to whether nursing staff make contact.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the time of referral does not meet the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.
The facility has indicated that they have begun some relationship building with services such as [the wound clinic] which is a positive move. This may also provide opportunities for further training of staff around the management of complex wounds.

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

10. The adequacy of communication with the GP

a. What is the standard of care/accepted practice?
In residential facilities there should be the capacity for open conversations with medical practice providers to ensure continuity of care for residents.

The multiple visits by the GP between [Month1] and [Month3] show that nursing staff felt able to ring the practice and request a review of [Mrs A]. The documentation of these visits in the medical notes is clear however this could have been better covered in the nursing notes, it is difficult to make an assessment as to what information was conveyed to the physician during these visits or if the family were involved.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information provided I would consider that there is no departure from the accepted standard of care in the communication with the GP. There is a mild departure from the accepted standard of care around the potential to improve the documentation

of the visits from a nursing perspective to show what was discussed and to ensure that issues raised i.e. the point of the visit, were addressed.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the communication with the GP was adequate from what has been documented and that there could be an improvement in the documentation in order to meet the accepted standard.

d. Recommendations for improvement to prevent a similar occurrence in the future.
When a GP visit is requested it would be recommended that the reason for the visit is clearly identified and that there is a summary of the discussion with the GP and that the actions are documented.

11. The adequacy of [the care home's] referral process

a. What is the standard of care/accepted practice?
As discussed above in 9, a resident should be referred to external services when indicated by a resident's condition or on the request of family as appropriate. There was no specific information or policy provided in the information I have reviewed related to [the care home's] process.

The Complex Wound Care ARC Pathway flow chart was included and this is an appropriate tool to use in regards to the referral for wound management advice.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information provided I would consider that there is no departure from the accepted standard of care from the information provided.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree with my assessment that the overall facility referral process meets the accepted standard of care.

d. Recommendations for improvement to prevent a similar occurrence in the future.
Guidelines for staff in regard to [the care home's] process for referral, what resources are available in the community and who the contact people are would be a positive step towards some consistency in the referral process.

12. The adequacy of [the care home's] pain management and wound care policies

a. What is the standard of care/accepted practice?
All facilities should have robust wound care and pain management policies to ensure that there is a framework for staff to follow. A good policy should guide in achieving the objectives for the scenario (wound care, pain management) and it should provide a broad outline of the facility requirements and leave scope for some decision making by staff, flow charts work well. Guidelines can be included and it should be clear who has responsibility for the care, treatment and follow-up, including documentation.

Procedures can also be included as appendices to be used on a day-to-day basis in patient care.

The structure of the policies means that they are quite wordy as they include the procedural aspects of wound care and pain management. This may mean that staff are less likely to engage with the policies. The procedures are the part that staff need to hand on a daily basis, the overarching policy needs to guide and make clear the facility's stance, this is adequate in most aspects. The procedural parts do have clear areas of assessment, examples of tools to use and evaluation of resident responses.

Pain Policy — There are a couple of points to note. It is not clear how decisions are made as to the level of pain relief required and how this would be managed in a consistent manner. There is no inclusion of when and how to escalate to external services such as Hospice or Pain Clinic. The weekly assessment of pain is interesting. Pain can be so transient I am not sure of the benefit of asking a resident at one point in the week to describe their pain especially if they are not in pain at the time.

Wound Care Policy — It has clear information about the management of a range of wound types, the images are useful as the policy is quite wordy. The Complex Wound Care ARC Pathway flow chart could be included as part of the Wound Care policy in regard to external referral as this is an established document.

b. If there has been a departure from the standard of care or accepted practice, how significant a departure is this considered to be?
From the information provided I would consider that there is no departure from the accepted standard of care though have provided some recommendations below.

c. How would it be viewed by my peers?
I believe that my peers in practice and education would agree that the policies would benefit from some streamlining to make them less wordy and to ensure that they are more readable by staff and thereby increasing engagement with the policy. They meet the accepted standard as they do have adequate detail.

d. Recommendations for improvement to prevent a similar occurrence in the future.
In the pain policy I would recommend changing the structure of the policy. The procedures need to be separate as appendices. Adding a flow chart into the policy part would assist greatly as staff negotiate the complexities of ensuring adequate pain relief especially as a resident's condition changes over time.

In the wound care policy suggest changing the structure of the policy in a way that has the requirements of the facility with the wound care guidelines as a separate section. Also need to include the management of vascular wounds which can be long-term and difficult to resolve they also require a trained eye regularly assessing them and surrounding areas such as the full limb. A flow chart would be very useful especially around time timelines of resolution and the national guidelines re this.

Other considerations

Weight loss 4kg over 2 months — it states that this triggered a response though it is not noted if this was followed up.

Progress notes are quite brief in many entries. It would be recommended that there is more detail of the care of residents on a daily basis as it is difficult to get a picture of what has happened for a resident on any given day. An example in the notes of a good level of detail; 3 [Month2] by Bureau Staff HCA; 19 [Month3] by [RN C] CNM; 2 [Month4] by [an] HCA.

Review completed by:

Associate Professor Karole Hogarth JP, RN, BSc, PhD

18th March 2021

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HDC REPORT — ADDENDUM

6 April 2023

REFERENCE: C20HDC00726 [Mrs A]

I have been asked to provide further comment on the above case following further information from [the care home] on whether or not any of the explanations or further information provided in the response causes change to previous advice.

Further information provided by [the care home]

- Short term care plans
- Wound assessment reports
- Response letter dated 19 January 2023

- GP responses

Review

I have reviewed the further information supplied and the reply from [the care home]. [Mrs A's] case was very complex and overall, the management up until the end of [Month3] was mostly as would be expected.

There were two questions from the original advice where a departure was noted:

1. **The adequacy of wound monitoring and management**
2. **Whether referrals were made in a timely manner**

1. The adequacy of wound monitoring and management

It was noted that wound assessment and ongoing care should include the aspects below:

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

The further information provided has addressed most of these points. The short-term care plans describe the issues with both [Mrs A's] L) and R) foot along with assessments and pain scores. Confusion remains in parts around which foot was being discussed. The wound care plans show each date and time the wounds were assessed on [Mrs A's] L) foot with wound descriptions, pain scores and dressings used. Compression is mentioned in the notes and stated, "not to use", this may have been rationalised elsewhere in the notes (not provided). There is some inconsistency (previously identified) about how the wounds were described for example on 30 [Month3] the wounds on the L) foot are described as "yellow/slough; black/necrotic" and on the 1 [Month4] they are described as "pink; epithelising" and back to "yellow/slough; black/necrotic" on 3 [Month4]. Only one photograph appears to have been taken dated 17 [Month2] and the question re photographs in the wound care plans is "not answered" 27 [Month2]–3 [Month4].

It is clear from the progress notes that staff were supportive of [Mrs A] and understood the issues with her feet and legs. She was regularly reminded to uncross her legs and to elevate them as able along with regular pain relief. Leg assessment by an RN occurred and the ischaemic processes underlying her foot condition were not easily identifiable

until mid-[Month3] given that pedal pulses (weak) were present and colour, warmth, movement were satisfactory though pain remained an issue.

Following this review and with the further information provided I amend my previous advice to a **Mild** departure from accepted practice and care. The mild departure is due to the points raised above around inconsistency, no ongoing photographs and confusion around the foot being referred to in notes.

2. Whether referrals were made in a timely manner

As previously noted, [Mrs A] was reviewed and reassessed regularly by RNs and her GP from mid-[Month2] until her hospitalisation in early [Month4]. There had been no progression towards healing in this time. It has been noted that [Mrs A] was referred for further assessment of the chronic ulcers and ongoing pain. The responses note that with hindsight a different decision may have been made with a number of factors identified in this decision making such as [Mrs A's] desire to go home for [a family event], her comorbidities, the availability of services over the [public holiday] and the likelihood that there would be a surgical option for her foot and ischaemia issues.

Doppler vascular assessment was requested by the GP on the 19 [Month2] though this was marked urgent it was not triaged as such. This could have been followed up sooner as this would have allowed time prior to the service reduction at [the public holiday]. A quicker referral may have provided an opportunity for a further set of eyes over [Mrs A's] condition with the possibility of earlier intervention which may or may not have altered the care or trajectory of deterioration and outcome. Changes have been made to the referral process to expedite appropriate external care.

Following this review, I reiterate my previous advice that there is a **Mild** departure from accepted practice in relation to the timeliness of referral and the follow up of the referral given that this was noted as urgent.

Summary

It is clear that there have been a number of changes implemented by [the care home] as identified in their response and following a SWOT analysis. This includes wound care policy review, additional staff education, streamlining the referral process, adding a wound photo repository and monthly reviews of chronic wounds by the RN team along with strengthening the use of ISBAR to ensure clear clinical communication. It is also good to see collaboration and sharing of processes and resources with [Care Home 2].

Professor KJ Hogarth

6th April 2023'