Summerset Group Holdings Limited
t/a Summerset by the Park

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC00680)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Table of contents

Executive summary 1

Complaint and investigation 2

Information gathered during investigation 3

Opinion: Summerset Group Holdings Limited t/a Summerset by the Park — breach 6

Recommendations 8

Follow-up actions 8

Appendix A: Independent advice to the Commissioner 9

Executive summary

1. Mrs A, was admitted to Summerset by the Park (Summerset) for respite care. She had an existing injury to her right shin, and the injury was treated by a visiting registered nurse (RN) from a home healthcare company. The wound healed and, on 14 Month1[1], Mrs A was discharged from the home healthcare company's nursing care, although she remained at Summerset.

2. On 17 Month1, Mrs A injured her right calf. The wound was assessed and dressed by a nurse at Summerset. An Incident and Accidents form and a Wound Initial Assessment form were completed. An Ongoing Wound and Assessment and Treatment form recorded that the dressing was to be changed after three days. There were no other entries to this form and no evidence that the dressing was changed after three days.

3. A Short Term Care Plan (STCP) was not created for the care of the wound, and no photos were taken of the wound.

4. Mrs A's progress notes for 18 and 19 Month1 record that the dressing was intact, and an entry dated 20 Month1 notes the existence of the dressing. There was no documentation regarding whether the dressing was changed.

5. On 20 Month1, Mrs A was transferred to a long-term residential apartment at Summerset.

6. On 6 Month2, the dressing was changed. Summerset told HDC that there was confusion amongst the staff about who was treating the wound.

7. Mrs A's progress notes for 7 and 9 Month2 record that the dressing was intact, and an entry dated 10 Month2 notes the existence of a dressing.

8. On 10 Month2, Mrs A asked for the dressing to be checked, but there is no documentation regarding whether this was done. The next day, Mrs A's family took her to her GP because they were concerned about the pain she was experiencing. The GP recorded that there was a yellow discharge from the wound, that it was smelly, that the dressing was wet, and that there was cellulitis[2] surrounding the wound.

9. On 11 Month2, Mrs A returned to her GP. The dressing was changed and she was referred to the home healthcare company for ongoing care of the wound. Mrs A's progress notes for 11 and 12 Month2 do not document either the wound or the dressing.

10. Mrs A's family discharged her from Summerset on 13 Month2.

Findings

11. Summerset breached Right 4(1)[3] of the Code of Health and Disability Services Consumers' Rights (the Code) by failing to develop an STCP for the care of the wound, failing to provide adequate wound care, and failing to monitor the wound adequately.

[1] Relevant months are referred to as Months 1-2 to protect privacy.
[2] Cellulitis is a bacterial infection of the skin and the tissues beneath the skin.
[3] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Recommendations

12. In the provisional report, the Deputy Commissioner recommended that Summerset provide a formal written apology to Mrs A. In response, Summerset provided an apology letter.

13. The Deputy Commissioner recommended that Summerset provide HDC with the training material and the training records associated with the wound management policy implemented in May 2018.

14. It was also recommended that Summerset provide HDC with a random audit of the wound care documentation, to assess compliance with the wound management policy implemented in May 2018.

Complaint and investigation

15. The Commissioner received a complaint about the services provided to Mrs A by Summerset Group Holdings Limited t/a Summerset by the Park. The following issue was identified for investigation:

- *Whether Summerset Group Holdings Limited t/a Summerset by the Park provided Mrs A with an appropriate level of care between 17 Month1 and 13 Month2.*

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

17. The parties directly involved in the investigation were:

Mrs A	Consumer
Complainant/consumer's daughter-in-law	
Complainant/consumer's son	
Summerset Group Holdings Ltd	Provider

18. Information was reviewed from:

Dr B	General practitioner
RN C	Provider/Registered nurse
Home healthcare company	Provider
The Ministry of Health	
DHB	

Also mentioned in this report.

Dr D	General practitioner

19. Independent expert advice was obtained from a nurse practitioner, Margaret O'Connor (**Appendix A**).

Information gathered during investigation

20. Mrs A was admitted to Summerset for respite care. Mrs A had an existing injury to her right shin, which was treated by a visiting registered nurse, RN C. The wound healed, and on 14 Month1 Mrs A was discharged from the home healthcare company's nursing care, although she remained at Summerset.

21. On 17 Month1, Mrs A injured her right calf. The wound was assessed and dressed by a nurse at Summerset, and a range of forms were completed or partially completed. The Incident and Accidents form records that Mrs A had a 2cm tear to her right calf. A Wound Initial Assessment form records a 2cm skin laceration to Mrs A's lower back leg, and that the wound was dressed.

22. The Ongoing Wound and Assessment and Treatment form was partially completed. The form states that the dressing was to be changed after three days. There are no other entries on the form after this date, and there is no evidence that the dressing was changed after three days.

23. An STCP was not created for the care of the wound, and no photos were taken of the wound. According to the wound management policy in place at the time an STCP is used to identify a wound and the ongoing care that is required for the treatment of the wound.

24. Summerset told HDC:

> "The critical step that should have occurred, and would have ensured quality ongoing care despite the change in residence, was the completion of a short term care plan. Summerset expected this to occur, but for some unknown reason it was not completed."

25. Mrs A's progress notes for 18 Month1 record that the dressing was intact.

26. A healthcare assistant recorded in Mrs A's progress notes for 19 Month1 that Mrs A was "afraid of getting her dressing wet. Informed [nurse manager]." The progress notes record that the dressing was intact.

27. On 20 Month1, Mrs A transferred from respite care to a long-term residential apartment at Summerset. A registered nurse recorded in Mrs A's progress notes for 26 Month1 the existence of the dressing, but there is no documentation regarding whether the dressing was changed.

28. An enrolled nurse recorded in Mrs A's progress notes that on 6 Month2 the dressing was changed. The enrolled nurse recorded that she used a dressing that Mrs A had been given by a district nurse, and that no pain or discomfort was noted. The dressing change was not recorded on the Ongoing Wound Assessment and Treatment form.

29. Summerset told HDC that there was confusion amongst the staff about who was treating the wound. Summerset stated: "They appear to have been under the impression that the District Nurse [RN C] was continuing to provide the care for this wound." However, Summerset acknowledged that "it had an obligation to be keeping abreast of this wound and ensure it was properly cared for".

30. Mrs A's progress notes record that on 7 Month2 the dressing was intact and appeared clean and dry. Another healthcare assistant recorded in the progress notes on 9 Month2 that the dressing was intact and that on 10 Month2 Mrs A refused to have a shower because she did not want to get the dressing wet.

31. Later on 10 Month2, Mrs A asked for the dressing on her leg to be checked. The caregiver recorded this request in the progress notes and stated that the request was conveyed to a registered nurse. There is no documentation regarding whether the dressing was checked.

32. Mrs A's husband was concerned about the amount of pain that Mrs A was experiencing, and asked his daughter to take Mrs A to her GP, Dr B, immediately.

33. Mrs A was seen by Dr D at Dr B's surgery on 11 Month2. Dr D recorded a yellow ooze/discharge from the wound, and that the wound was smelly, the dressing was wet, and there was surrounding cellulitis. A swab was taken and a heavy growth of *Staphylococcus aureus*[4] identified.

34. Dr D also noted:

> "[Mrs A was] unsure/unable to recall exact date of injury, background of dementia. Has been receiving regular dressing changes with ACC nurse — [RN C] … Daughter and mum also states that [RN C] has been coming to change dressings out of her own time."

35. RN C told HDC: "I, [RN C] did not review, or make any requests for ongoing wound care from Summerset by the Park for client [Mrs A] during 17 [Month1]–11 [Month2]."

36. Mrs A returned to Dr B's surgery on 12 Month2 for the dressing to be changed, and a referral to the home healthcare company was arranged for ongoing care of the wound.

37. Mrs A's progress notes for 11 Month2 and 12 Month2 record that on both days Mrs A went out with her family. The progress notes do not mention that Mrs A was going to her GP, and they do not document either the wound or the dressing.

38. On 13 Month2, Mrs A's family discharged her from Summerset.

39. Summerset told HDC:

> "Summerset accepts that the care provided by its staff to [Mrs A] in relation to her wounds was not up to [Mrs A's], nor Summerset's, expectations … The reasons why [Mrs A's] care was not up to expectations was due to several factors at Summerset by the Park at the time. These factors are nursing staff not adhering to policies in place at the time, and improvements made to the wound management policy in [Month1] not having been fully implemented at the time of this incident."

[4] *Staphylococcus aureus* is a type of bacteria that can cause a range of illnesses and diseases.

40. In response to HDC's notification to Summerset of the commencement of an investigation on 22 September 2017, Summerset stated: "As none of [the staff caring for Mrs A's wound] are still employed by Summerset, statements cannot be obtained from them."

Wound Management Policy

41. The Wound Management Policy in place at the time of these events had been reviewed by the clinical team and implemented at Summerset in Month1. Summerset told HDC that "[it] always takes some time for a policy to be embedded in a site's culture, and that would not have occurred by 17 [Month1] when caring for [Mrs A]".

42. The Wound Management Policy stated that its purpose was as follows: "[W]here a resident has a wound, a comprehensive plan of care will be put into place aimed at promoting healing and minimising discomfort for the resident."

43. The policy required staff to undertake the following actions:

- Complete an Incident and Accidents form.
- Complete a Wound Initial Assessment form.
- Take digital photos of the wound once informed consent was obtained.
- Complete an Ongoing Wound Assessment and Treatment form, and document ongoing assessment and review.
- Complete an STCP.

44. Summerset told HDC that this policy and the earlier wound management policy were substantively the same, and that the actions described in the preceding paragraph were also included in the old policy. The key differences between the old policy[5] and the new policy were as follows:

> "Responsibilities
>
> - The Nurse Manager/Clinical team leader is responsible for clinical leadership and over sight of all wounds
> - Each care centre will have a designated wound care registered nurse who will be responsible for ensuring best practice wound management techniques are in place
> - Staff involved in wound management will undertake wound care training and a competency annually."

45. Summerset told HDC that "having a designated wound care registered nurse … only became an expectation in [Month1]", and that at that time, Summerset did not employ a wound care specialist nurse. Summerset advised that, at that time, it sought the services of a wound care specialist nurse from the district health board when specialist wound care services were required.

[5] The old policy was implemented in June 2013.

Responses to provisional opinion

Mrs A's daughter-in-law

46. Mrs A's daughter-in-law was given an opportunity to comment on the "information gathered" section of the provisional opinion. She advised HDC that she did not wish to make any further comment.

Summerset

47. In response to the provisional opinion, Summerset advised that it accepts the findings and "that the care provided by its staff to [Mrs A] in relation to her wounds was not up to [Mrs A's] nor Summerset's expectations".

48. Summerset provided a written apology letter for forwarding to Mrs A.

49. Summerset stated that a new wound management policy was implemented in May 2018.

Opinion: Summerset Group Holdings Limited t/a Summerset by the Park — breach

50. On 17 Month1, Mrs A injured her right calf while she was receiving respite care at Summerset. Her injury was treated and dressed immediately by a nurse at Summerset, and an Incident and Accidents form was completed.

51. My expert advisor, Nurse Practitioner (NP) Margaret O'Connor, advised that the initial care provided to Mrs A in respect of this wound was appropriate.

52. The Wound Management Policy at Summerset provided that staff were required to complete several forms regarding wound care. The Wound Initial Assessment form recorded the 2cm skin tear and that the wound was dressed. Staff at Summerset were required to take photos of the wound and to complete an STCP. No photos were taken of the wound, and an STCP was not completed. Summerset acknowledges that the completion of an STCP was a critical step that should have occurred. NP O'Connor advised that the "documentation of care is … substandard in that there was no [STCP]".

53. The lack of an STCP meant that a plan for the care of the wound was not developed. I am critical that Summerset's staff failed to follow its own policy and develop a comprehensive plan to promote healing and minimise discomfort.

54. The Ongoing Wound Assessment and Treatment form was started on 17 Month1, but was not updated after that date. It stated that the dressing should be changed after three days. However, there is no evidence that the dressing was changed after three days. The first recorded dressing change was on 6 Month2, approximately 19 days after the wound was first assessed. NP O'Connor advised that this length of time between documented dressings is not acceptable.

55. I accept NP O'Connor's advice, and I am deeply concerned that it appears that Mrs A's dressing was not changed for this length of time. I also note that the Ongoing Wound Assessment and Treatment form was not updated and, as a result, the condition of the wound was not recorded.

56. On 10 Month2, Mrs A asked for the dressing to be checked. The progress notes record that this request was conveyed to a registered nurse by the caregiver. However, there is no evidence that the dressing was checked. Again, the Ongoing Wound Assessment and Treatment form was not updated, and another opportunity to review the wound was missed. The lack of ongoing documentation meant that Summerset was not able to monitor the progress or lack of progress of the healing of the wound and escalate its treatment accordingly.

57. I note the discrepancy between RN C's statement, that she did not provide wound care to Mrs A between 17 Month1 and 11 Month2, and Dr D's notes, which record that either Mrs A or her daughter said that RN C was changing Mrs A's dressings in her own time. I also note the entry in the progress notes on 6 Month2, which states that the dressing was changed using a dressing supplied by the district nurse.

58. I am unable to make a finding as to whether RN C did attend Mrs A between 17 Month1 and 11 Month2. However, by this time it should have been clear to Summerset that the wound required attention. Mrs A was sufficiently concerned about her wound to request a review. In addition, Mrs A's family was concerned about the pain she was experiencing, and made arrangements for Mrs A to attend her GP.

59. It is clear that by the time Mrs A was seen by her GP, the dressing was wet and the wound had deteriorated to such a degree that it was infected and smelly with yellow discharge, and there was surrounding cellulitis. At the commencement of this investigation, the staff involved were no longer employed by Summerset. I have therefore relied on the records and Mrs A's GP's account of the wound when it was reviewed by her and, having considered these, I find that the wound care provided to Mrs A by Summerset was inadequate.

60. NP O'Connor advised: "I have concluded from the information supplied to me, that Summerset [by] the Park have not provided an appropriate standard of wound care to [Mrs A] with a significant departure from expected standards."

61. The NZS Health and Disability Services (Core) Standards[6] requires an organisation to ensure that the day-to-day operation of the service is managed in an efficient and effective manner that ensures the provision of timely, appropriate, and safe services to the customer. By failing to complete the appropriate documentation, Summerset was not able to monitor Mrs A's condition and, as a result, the provision of services to Mrs A was not managed in an effective manner. The services that Summerset provided to Mrs A were not timely, appropriate, or safe.

62. Summerset has noted that its staff may have been under the impression that a district nurse was providing wound care for Mrs A. However, Mrs A had been discharged from the care

[6] The *NZS Health and Disability Services (Core) Standards* (Standards New Zealand, 2008) include NZS 8134.1.2:2008 — Standard 2.2.

of the district nurse on 14 Month1 after her previous wound had healed. From 17 Month1 to 14 Month2, Summerset was responsible for providing wound care, and Summerset failed to do so.

63. Summerset Group Holdings Limited t/a Summerset by the Park had a responsibility to ensure that Mrs A received care that was of an appropriate standard. In my view, by failing to develop an STCP for the care of the wound, failing to provide adequate wound care, and failing to monitor the wound adequately, Summerset Group Holdings Limited t/a Summerset by the Park failed in that responsibility, and breached Right 4(1) of the Code.

Recommendations

64. In the provisional report I recommended that Summerset Group Holdings Limited provide a formal written apology to Mrs A. In response, Summerset provided an apology letter, and this will be forwarded to Mrs A.

65. I recommend that within three months of the date of this report, Summerset Group Holdings Limited provide HDC with the training material and the training records associated with the wound management policy implemented in May 2018.

66. I recommend that within six months of the date of this report, Summerset Group Holdings Limited provide HDC with a random audit of its wound care documentation, to assess compliance with the wound management policy implemented in May 2018.

Follow-up actions

67. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Summerset Group Holdings Limited t/a Summerset by the Park, will be sent to the DHB, HealthCERT, and HQSC, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from a nurse practitioner, Margaret O'Connor:

"I have been asked to provide an opinion of whether Summerset by the Park Rest Home (SP) provided an appropriate standard of wound care to [Mrs A] for the period of 17 [Month1] until discharge on 20 [Month2]. I have read the Commissioner's guidelines for independent advisors and agree to follow them to the best of my ability.

Professional profile

Since registering as a Comprehensive Nurse in 1988 I have completed a Bachelor of Nursing (2001), Graduate Certificate in Hospice Palliative Care (2002) and a Masters of Nursing with a clinical pathway (2009). My initial nursing experience was as a Public Health Nurse after which I worked in hospital based orthopaedic nursing then acute/general medical in a rural hospital. On an overseas trip I worked as an agency nurse in various hospital wards, a district nurse in London and in a Nursing Home for older people. Back in New Zealand I experienced 5 years in Assessment, Treatment and Rehabilitation then from 1997 to 2011 I worked for a non-profit charitable organization managing various aged care facilities. Most recently I managed a retirement village of 60 beds; residential, hospital and dementia levels, and 21 cottages. Currently I am a Nurse Practitioner for Older Persons Health in a joint initiative between a District Health Board and a non-profit charitable organization. I am a member of the New Zealand College of Nurses and NZ Nurses Organisation and enjoy providing education and insight into care of the older person for various groups in my region.

Background

The documentation I have reviewed includes

Letter of complaint

Summerset by the Park's responses

Clinical records from [the home healthcare company], Summerset by the Park and [Dr B]

Wound photographs

NASC 1004 Notification and Summerset's F08 Wound management policy

[Mrs A] was admitted to Summerset by the Park for respite care on [date] at rest home level care which was initially provided in care room […]. She occasionally spent time in her husband's apartment. On admission, she had healing wounds on her anterior right lower leg (shin) that were being treated by [the home healthcare company]. This care continued until the wounds were healed and on 14 [Month1] [Mrs A] was discharged from [the home healthcare company] Community Nursing care.

On 17 [Month1] [Mrs A] sustained another wound on her posterior right lower leg (calf). This was initially dressed, on the day, by a registered nurse at Summerset by the Park. On 20 [Month1], she was transferred permanently to [rest home level of care].

On 11 [Month2], she was seen by [Dr D] at [Dr B]'s practice, her GP, regarding an undressed wound on her right leg lateral calf area. A referral was sent to [the home healthcare company]. A swab was taken and she was commenced on antibiotics. She returned to her GP's practice on 12 [Month2] for a further review.

On 13 [Month2], she was discharged from Summerset by the Park (SP) with her husband by her sons.

Documentation review regarding wound care

Evidence found in Care Progress notes:

17 [Month1] — 1300 hours Notes by Registered Nurse (RN) regarding wound and dressing.

18 [Month1] — 2230 hours RN reports [Mrs A] back from an outing. Dressing on right lower leg dry and intact.

19 [Month1] — 1045 hours Refused shower as afraid of getting dressing wet. Dressing was noted to be intact on leg. Health Care Assistant (HCA)

20 [Month1] — Shifted to husband's apartment. HCA

26 [Month1] — 1330 hours 'Dressing in her lower legs'. No designation

Notes reviewed by R N 19 [Month1], 26 [Month1]

6 [Month2] — Leg dressing changed. Own dressing from DN used. Nil pain or discomfort noted. Enrolled Nurse (EN)

7 [Month2] — Dressing intact on leg and appears clean and dry. EN

Each shift comments on skin integrity and pain.

9 [Month2] — dressing intact on leg — HCA

10 [Month2] — 1110 hours Refused shower as doesn't want dressing to get wet. HCA

2100hrs asked for 'dressing on left leg checked'. States she reported it to [an RN]. By [caregiver**]**

13 [Month2] — [Mrs A] and husband moved out by sons. RN

Wound forms
'Wound Initial Assessment' form shows [Mrs A] reported at 1230 hours on 17 [Month1] with a skin tear to posterior right lower leg. The form showed appropriate treatment for a '2 cm skin laceration' and is signed by a Registered Nurse. The signature was not legible and not dated. Not all appropriate sections on the form were completed such as date of commencement.

The 'Ongoing Wound assessment and treatment' form was commenced on 17 [Month1] with no other entries made. It is noted that the wound was to be reviewed after 3 days on 20 [Month1]. No evidence is recorded that this was done.

Clinical Handover Report shows:

17 [Month1] — 'Skin tear back of right lower leg dressing done'

20 [Month1] — 'gone to apartment [number] with meds'.

27 [Month1] — still in apartment [number] onwards till discharged 13 [Month2].

Letter from [SP] to HDC 14 June 2016

Letter states [Mrs A] 'elected to have the District Nurse continue with her wound care'.

Conclusions

Documentation shows that appropriate care was given by RN at initial presentation of wound. Initially there is appropriate documentation in care progress notes, an incident and accident form and the two wound forms required to be filled out as per wound management policy on the new wound. Notes were also made on the clinical handover form. However, no short-term care plan was evidenced regarding the wound nor wound photos as required by SP's Wound Management policy. [Mrs A]'s notes were recorded as reviewed by an RN on 19 and 26 [Month1] but no changes appear to have been made to wound care nor documentation at these times.

The wound on the right calf was to have been reviewed on 20 [Month1] but no record is made of it being done. There is also no further record of it being reviewed once [Mrs A] became a permanent rest home level resident except by HCAs noting the state of the dressing and a dressing completed by EN on 6 [Month2]. No other plan is evidenced for its care even though SP states in a letter that they thought the District Nurse was caring for the wound. [Mrs A] did elect to have DN continue to provide her wound care on admission to SP as a respite resident. However, this wound healed and she was discharged from [the home healthcare company] on 14 [Month1]. There is no evidence of this being communicated to staff at SP likewise there is no evidence from either SP staff or [the home healthcare] staff regarding communication around care of this new wound. However, [Mrs A] became a permanent resident on 20 [Month1], the day the wound was due its first review therefore the care of her wound remained SP's responsibility. This is stated in the Age Related Residential Care Services Agreement for the provision of Residential Care (2016), which also reflects the required Health and Disability Services Standards (8134.1.3.5, 2008). In relation to wound care Providers are required to:

> Develop and document policies, procedures, protocols, and guidelines … Such policies shall include, but are not restricted to, policies relating to: wound care (D5.4)
>
> Each Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status (D16.3)

> Care Plans are available to all Care Staff and that they use these Care Plans to guide the care delivery provided according to the relevant staff member's level of responsibility (D16.3, l)
>
> You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated or by a change in the Subsidised Resident's condition (D16.4, a)

On 6 [Month2], the wound dressing was changed by an EN according to the care progress notes. Her intervention was not recorded on the 'Ongoing Wound assessment and treatment' form. On 10 [Month2], it is recorded that [Mrs A] asked for her dressing to be checked. The HCA states she reported it to [an RN] but there is no record of this RN reviewing the wound.

Summary

I have found that the ongoing management of [Mrs A]'s wound, which she sustained on 17 [Month1], is less than what is acceptable and required under the Agreement for provision of services. Initial care provided was appropriate but follow-up care was only provided once by an Enrolled Nurse on 6 [Month2] despite there being a documented review due on 20 [Month1]. This is approximately 19 days between documented dressings which is not acceptable. [Mrs A] went to her GP on 11 [Month2] another 5 days later where she presented with an obviously infected wound. No mention of this GP visit is made in SP's documentation therefore I can only assume that it was family initiated.

There is documented a request by [Mrs A] to have her wound reviewed on 10 [Month2] at 2100hrs asked for 'dressing on left leg checked'. The [caregiver] states she reported it to [the RN]. However there is no documented evidence that the RN received this report and that it was followed up. Documentation of care is also substandard in that there was no short-term care plan formulated around [Mrs A]'s wound care as required by the Agreement. I do wonder if the provision of care was complicated somewhat by [Mrs A] moving to a care apartment on 20 [Month1] and poor communication to staff of her required wound care. However she was deemed as rest home level and SP has a requirement to provide her wound care regardless of whether she was in a care room or apartment.

In summary, I have concluded from the information supplied to me, that Summerset on the Park have not provided an appropriate standard of wound care to [Mrs A] with a significant departure from expected standards.

Margaret O'Connor, NP, MN

2 July 2017"