**(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON**

**(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL**

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**IN THE HUMAN RIGHTS REVIEW TRIBUNAL** **[2022] NZHRRT 1**

**I TE TARAIPIUNARA MANA TANGATA**

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| | **Reference No. HRRT 072/2021** |
| **UNDER** | **THE HEALTH AND DISABILITY COMMISSIONER ACT 1994** |
| **BETWEEN** | **DIRECTOR OF PROCEEDINGS** |
| | **PLAINTIFF** |
| **AND** | **SUMMERSET GROUP HOLDINGS LIMITED** |
| | **DEFENDANT** |

**AT WELLINGTON**

**BEFORE:**
**Ms GJ Goodwin, Deputy Chairperson**
**Dr SJ Hickey MNZM, Member**
**Ms BL Klippel, Member**

**REPRESENTATION:**
**Ms C McCulloch for the Director of Proceedings**
**Mr P White for defendant**

**DATE OF HEARING:** **Heard on the papers**

**DATE OF DECISION:** **25 January 2022**

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## (REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Summerset Group Holdings Ltd* [2022] NZHRRT 1. Note publication restrictions.]

**[1]** These proceedings under the Health and Disability Commissioner Act 1994 were filed on 17 December 2021.

**[2]** Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

**[2.1]** A Consent Memorandum dated 8 October 2021;

**[2.2]** An Agreed Summary of Facts, a copy of which is annexed and marked 'A'; and

**[2.3]** A joint Memorandum in Support of Permanent Order Prohibiting Publication of Name and Identifying Details of Aggrieved Person dated 17 December 2021.

**[3]** In the Consent Memorandum dated 8 October 2021 the parties request that the Tribunal exercises its jurisdiction and issues:

> 2(a) A declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill; and
>
> 2(b) A final order prohibiting publication of the name and identifying details of the aggrieved person in this matter (Miss E (deceased)).

**[4]** Having considered the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2(a) of the Consent Memorandum.

**[5]** The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person, for the following reasons.

**[6]** The Tribunal may order final name suppression under s 107(3) of the Human Rights Act 1993 if it is "satisfied it is desirable to do so". In this context, "desirable" is considered from the point of view of the proper administration of justice; a phrase that must be construed broadly to accommodate the particular circumstances of individual cases as well as broader public interests. Any name suppression order should do no more than is necessary to achieve the proper administration of justice. For an order there must be some material before the Tribunal to show specific adverse consequences that are sufficient to justify an exception to the fundamental rule of open justice; see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 and *Director of Proceedings v Brooks (Application for Final Non-Publication Orders)* [2019] NZHRRT 33.

**[7]** This claim arose following the death of Miss E, who was a consumer of the services provided by Summerset Group Holdings Limited ("Summerset").

**[8]** Summerset has acknowledged its failure to provide services to Miss E with reasonable care and skill. There is public interest in the details of Summerset's failures being published, as set out in the detailed Agreed Summary of Facts. This, however, involves Miss E's very sensitive and private health information. There is little or no public

interest in the publication of Miss E's name, nor in her being identified in connection with this case.

**[9]** Publication of Miss E's name alongside the very detailed Agreed Summary of Facts (involving her sensitive and private health information) would cause Miss E's next-of-kin significant distress. In these circumstances the Tribunal is satisfied that there are specific adverse consequences sufficient to justify an exception to the fundamental rule of open justice.

**[10]** In addition, publication of the Tribunal's decision that includes the very detailed Agreed Summary of Facts, with Miss E's name and identifying details redacted, impacts on open justice only to a limited degree. Miss E was not a party to this case, she is deceased, and protecting her very sensitive and personal information by the redaction of her name does achieve the proper administration of justice.

**[11]** Accordingly, the Tribunal is satisfied the order sought by the parties in paragraph 2(b) of the Consent Memorandum should be made.

## DECISION

**[12]** The decision of the Tribunal is that:

**[12.1]** A declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.

**[12.2]** A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person, Miss E.

**[12.3]** There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

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| **Ms GJ Goodwin** | **Dr SJ Hickey MNZM** | **Ms BL Klippel** |
| **Deputy Chairperson** | **Member** | **Member** |

**"A"**

**This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 25 January 2022**

**BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL**
**I TE TARAIPIUNARA MANA TANGATA**

**HRRT /21**

**UNDER** Section 50 of the Health and Disability Commissioner Act 1994

**BETWEEN** **DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994

**Plaintiff**

**AND** **SUMMERSET GROUP HOLDINGS LIMITED** a duly registered company having its registered office at Level 27, Majestic Centre, 100 Willis Street, Wellington

**Defendant**

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## REDACTED AGREED SUMMARY OF FACTS

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Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

**Level 11, 86 Victoria Street, Wellington 6011**
**PO Box 11934, Wellington 6142**
**Phone: 04 494 7900 Fax: 04 494 7901**

**Greg Robins – Acting Director of Proceedings**

# REDACTED AGREED SUMMARY OF FACTS

## INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by s 15 of the Health and Disability Commissioner Act 1994.

2. The "aggrieved person" is Miss E (deceased).

3. At all material times the defendant was a duly registered company which owned and operated Summerset down the Lane ("Summerset") in Hamilton, where the aggrieved person was a resident.

4. At all material times, the defendant was a healthcare provider and/or disability services provider within the meaning of ss 2 and 3 of the Act, and was providing health services and/or disability services to the aggrieved person.

5. On 4 August 2017 the aggrieved person's enduring power of attorney and executor of her estate ("the complainant"), complained to the Health and Disability Commissioner about services provided to the aggrieved person by the defendant.

6. On 11 June 2020, the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised her opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

## BACKGROUND

### *The Aggrieved Person*

7. The aggrieved person, aged 88 years old at the time of these events, had been a resident in an independent villa at Summerset since 2013. On 2 December 2016, following an admission to hospital, the aggrieved person was admitted into rest home-level care at Summerset.

8. On 5 January 2017, due to a decline in the aggrieved person's general condition, the aggrieved person was assessed as requiring hospital-level care at Summerset.

9. On 27 January 2017, the aggrieved person was admitted to Waikato Hospital and diagnosed with sepsis from infected pressure ulcers. The aggrieved person was provided with palliative care and passed away on 29 January 2017.

### *The Defendant*

10. The defendant company owns and operates Summerset, a facility which provides rest home- and hospital-level care to residents for up to 69 residents.

11. Summerset was led by the Village Manager, which was a non-clinical role. The Care Centre Manager, a registered nurse ("RN"), reported to the Village Manager. The Clinical Nurse Leader, also an RN, reported to and assisted the Care Centre Manager. The Clinical Nurse Leader also monitored individual resident care plans, and worked as part of the nursing team.

12. General practitioner ("GP") and Nurse practitioner ("NP") care at Summerset is provided by independent contractors.

**PARTICULARS RELATING TO THE AGGRIEVED PERSON**

***Wound care***

13. At the time of her admission to Summerset on 2 December 2016, the aggrieved person's Waterlow score[1] was assessed as 29 (very high risk). Despite this score, specific pressure prevention strategies tailored to the aggrieved person's risk were not recorded or put in place on admission. The Waterlow assessment was never repeated.

14. Prior to, and during the time the aggrieved person resided at Summerset she developed a number of pressure injuries, including:

    - an arterial ulcer on her lower left leg, present on her admission to Summerset;
    - a pressure injury on her right heel, also noted on the day of her admission;
    - a skin tear on her lower left calf, first noted on 6 December 2016;
    - a urine scald on her buttocks, first identified on 15 December 2016 and recorded in the progress notes as "bleeding on [the aggrieved person's] buttocks" (this later became a sacral wound); and
    - a pressure injury to her left heel, first noted on 10 January 2017.

15. Throughout the aggrieved person's residence at Summerset, there were delays in identifying, managing, treating and escalating the aggrieved person's wounds:

[1] An assessment which gives an estimated risk for the development of pressure sores for a particular patient.

- a short-term care plan and a wound assessment and treatment plan for the aggrieved person's right heel pressure injury was commenced on 5 December 2016, three days after the wound was identified;

- scratch wounds were identified on the aggrieved person's arms and legs on 2 December 2016. No action in relation to those wounds was taken at that time;

- a short-term care plan and a wound assessment plan and treatment plan for the aggrieved person's sacral urine scald was commenced on 18 December 2016, three days after the bleeding on the aggrieved person's buttocks was identified and brought to the attention of the nursing staff. A dressing was also applied on this day, for the first time;

- a GP review of the aggrieved person was sought on 28 December 2017, in relation to general itchiness, one week after it was first complained of;

- on 2 January 2017, the Clinical Nurse Leader assessed the aggrieved person as requiring an alternating pressure mattress. However, the aggrieved person was not provided with an alternating pressure mattress as one was not available or able to be reassigned from another resident;

- despite several wounds being identified throughout December 2016, a turning chart was not commenced until 7 January 2017. From that date onwards, there were significant gaps in the recording of turns;

- assistance from a wound specialist NP was not sought in relation to the aggrieved person's sacral wound until 10 January 2017;

- on 10 January 2017, the NP noted the aggrieved person might require an indwelling catheter if her sacral wound did not respond to the treatment prescribed. Despite the wound not improving, catheterisation was not commenced;

- assistance from a wound specialist NP was not sought in relation to the aggrieved person's lower left leg until 20 January 2017; and

- on or around 26 January, an NP requested the aggrieved person be placed on a pressure relieving mattress. No pressure relieving mattress was provided to the aggrieved person as one was not immediately available, and the aggrieved person was admitted to hospital on 27 January.

16. On multiple occasions when external nursing and medical assistance was being provided, the NPs and GP were not provided with the information necessary to fully assess and/or treat the aggrieved person:

    - on 10 January 2017, an NP attended the aggrieved person and reviewed her sacral scald. Staff at Summerset did not raise any issues in relation to the aggrieved person's other pressure wounds. As a result the NP did not undertake any other assessment or view the aggrieved person's pressure areas;

    - on 20 January 2017, an NP attended the aggrieved person following a request to chart antibiotics for her lower left leg wound. The aggrieved person's dressing was not taken down, and as a result the NP did not view the ulcer. Instead the NP was shown an undated photograph of the aggrieved person's ulcer, which she used as the basis for prescribing a topical antibiotic cream; and

- On 26 January 2017, an NP reviewed the aggrieved person's lower leg and heel wounds. The NP was not advised that the aggrieved person had a sacral pressure wound.

17. On several occasions, the aggrieved person's wounds were inaccurately recorded or not recorded when it would have been appropriate to do so. The wound care documentation recorded the injuries as less severe than they were, or as 'static' or 'improving' when they were not. For example:

- on admission to Summerset on 2 December 2016, the arterial ulcer on the aggrieved person's lower left leg was recorded as 2cm by 2cm. On 2 January 2017, the ulcer was described as static or improving, despite the wound being described as purulent (containing pus) on 29 December 2016. It was consistently described as static until 25 January 2017. On 26 January 2017 it was recorded as 10cm by 15cm;

- the urine scald on her sacrum was first documented on 18 December 2016 as 0.5cm by 0.5cm. By 9 January 2017 the scald covered both buttocks. Between 9 and 27 January 2017, the aggrieved person's urine scald on her buttocks was consistently described as improving. However, following admission to hospital on 27 January 2017, her sacral wounds and pressure areas were described as "large". In the opinion of the expert advisor to the HDC, photographs of the wound on 28 January 2017 showed full thickness skin loss and black necrotic tissue at the sacral crease.

*Pain management*

18. The aggrieved person's medications on her admission to Summerset included gabapentin[2] (300mg daily) for neuropathic pain,[3] and paracetamol (500mg, two tablets up to four times daily as needed for pain).

19. On 6 December 2016, during a wound dressing change to her lower calf, the aggrieved person's pain was recorded to be 5/10[4] and paracetamol was given. This was the only record of paracetamol being given during a dressing change.

20. On 23 December 2016, a resident centred care plan was completed, which stated:

> "[The aggrieved person] has not reported any pain experience or discomfort on admission. But due to her having ulcers and [peripheral vascular disease] she is bound to be [in] pain and there are [sic] pain relief in place if required … encourage [the aggrieved person] to verbalize [sic] feelings of any discomfort or pain. Monitor for symptoms of pain … Observe for objective cues of pain like facial grimace, irritability and guarding behaviour. RN to administer analgesia as charted PRN. Rn to refer to GP as necessary for further pain management when pain gets worse and unrelieved with PRN pain relief. Report to RN any complaints or signs of pain".

21. On 8 January 2017, the Clinical Nurse Leader completed a Single Point of Entry Referral Form which stated the aggrieved person was "unable to voice pain / discomfort".

22. On several occasions during January 2017, staff recorded that the aggrieved person was in pain. On each of these occasions, staff failed to provide

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[2] A pain relief medication used particularly in cases of nerve pain (neuropathy).
[3] Pain caused by damage or disease affecting the nervous system.
[4] A self-reported pain score, where 0 means no pain, 1-3 means mild pain, 4-7 is moderate pain and 8+ is severe pain.

appropriate pain relief to the aggrieved person as set out in her pain assessment and residential centred care plan:

- on 7 January 2017, care progress notes recorded the aggrieved person "complained of pain on bottom";
- on 20 January 2017, care progress notes recorded the aggrieved person "ate and drank little … was in pain from legs and bottom";
- on 21 January 2017, care progress notes recorded the aggrieved person did not eat or drink anything and was "in so much pain";
- at 2.30pm on 22 January 2017, care progress notes recorded that the aggrieved person was "groaning during cares maybe due to her pain";
- at 8.36pm on 22 January 2017, care progress notes recorded that the aggrieved person was "very sore on her bottom and legs"; and
- also on 22 January 2017, the aggrieved person's pain was recorded as 5/10 during a dressing change of her left shin and calf, and 9/10 during a dressing change of her left heel.

23. Staff failed to follow short term care plans, and to report the aggrieved person's pain to the appropriate staff members:

- contrary to the short term care plans created on 2 and 18 December 2016, in relation to the aggrieved person's lower left leg wounds, staff did not report the aggrieved person's pain to the RN on duty when it was identified;
- contrary to the short term care plan created on 18 December 2016, in relation to the aggrieved person's urine scald (which later become the

sacral wound), qualified staff did not administer analgesia as needed, or commence a pain assessment chart; and

- contrary to the short term care plan created on 10 January 2017, in relation to the aggrieved person's sacral wound, staff did not report the aggrieved person's pain to the RN on duty when it was identified.

***Nutrition and fluid management***

24. The aggrieved person was commenced on a hydration chart on 4 December 2016. This was discontinued on 8 December 2016, owing to adequate fluid intake.

25. From 16 January 2017, the aggrieved person's nutritional intake began to reduce. Despite this, the defendant did not consider the need for nutritional support.

26. On 24 January 2017, a hydration chart was recommenced. The chart recorded that between 24 and 27 January 2017, the aggrieved person drank between 300 and 900 ml of fluid each day.

***Clinical management***

27. During the time the aggrieved person was a resident at Summerset, there were changes to the clinical management of Summerset, due to staff turnover and holidays.

28. Ms A was the Village Manager until 19 December 2016. However, the new Village Manager, Ms B, did not begin work until 16 January 2017, owing to an overseas trip. Summerset assigned its Relief Village Manager to the Hamilton village to cover the transition between the departing and incoming manager.

29. The Care Centre Manager took leave between 17 December 2016 and 4 January 2017. During this time, the Clinical Nurse Leader acted as both Care Centre Manager and Clinical Nurse Leader. The Clinical Nurse Leader reported that he needed to work long hours in order to cover both roles.

30. The Clinical Nurse Leader took leave between 10 January and 15 February 2017. During this time the Care Centre Manager acted as both Care Centre Manager and Clinical Nurse Leader. The Care Centre Manager reported that she had to juggle significant demands during the time was covering both roles.

***Communication with next of kin***

31. During the time the aggrieved person resided at Summerset, the complainant (as next of kin) was not kept informed of the increasing severity of the aggrieved person's wounds.

**SUBSEQUENT EVENTS**

32. On 27 January 2017, the aggrieved person was taken to the Emergency Department of Waikato Hospital by ambulance.

33. On admission, the aggrieved person was found to have a fever, high heart rate, and low blood pressure, and was drowsy and confused. The source of infection causing the aggrieved person's illness was believed to be her left heel ulcer. Contrary to the defendant's hydration chart for 27 January 2017, the hospital's medical admission note recorded the aggrieved person had no oral intake[5] in the last 24 hours.

[5] Had ingested no food or fluid.

34. The aggrieved person's clinical notes record that on admission she was found to have a bilateral Grade III[6] or IV heel ulcers measuring 7 cm, a nearly circumferential left heel ulcer, and a sacral pressure area measuring 8 cm.

35. The aggrieved person passed away on 29 January 2017.

**EXPERT ADVICE**

36. RN Jan Grant provided expert advice to the HDC. RN Grant found that the defendant had departed from accepted standards in the care it provided to the aggrieved person, and stated that:

- with a complex medical history, wound history and limited mobility (such as the aggrieved person had), it would have been expected that a pressure mattress be provided to the aggrieved person from the time of her admission;

- expert advice from medical staff and a wound care specialist nurse should have been requested much earlier than it was;

- some of the documentation relating to wound assessments was lacking in accuracy;

[6] Pressure injuries are classified into six categories: Grade/Stage I – intact skin with non-blanchable redness of a localised area; Grade/Stage II – Partial-thickness loss of skin with exposed dermis. The wound bed is visible, pink or red, moist, and may also present as an intact or ruptured serum-filled blister; Grade/Stage III – Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible; Grade/Stage IV - Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible; Unstageable: Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Grade/Stage III or IV pressure injury would be revealed.

- the aggrieved person's pain management was inconsistent, irregular and not proactively managed;
- there was little evidence that the aggrieved person's resident centred care plan, which clearly documented how pain was to be managed, was followed;
- given the wounds that the aggrieved person had on admission, and the wounds that developed and rapidly deteriorated during her stay, it would be highly unlikely that the aggrieved person had little or no pain;
- there was no indication a doctor was asked to review the aggrieved person's pain management;
- on six occasions the aggrieved person's pain was recorded as 5/10 during dressing changes on the aggrieved person's left chin and calf. No paracetamol was given at any dressing changes;
- drug charts show that no paracetamol was given on occasions that staff recorded high levels of pain following dressing changes;
- pain assessments recorded on wound charts did not always coincide with the comments made in care progress notes. For example, on 21 January 2017, the progress notes recorded the aggrieved person "did not drink anything in so much pain" while the wound care notes show a pain score of 0/10; and
- there were inconsistencies in the leadership at senior nursing staff level, particularly over the Christmas holiday period when a number of nursing staff were away. This contributed to a lack of both clinical leadership and monitoring of cares / supervision for caregiving staff.

**DEFENDANT'S RESPONSE TO THE COMPLAINT**

37. The defendant has accepted that there were deficiencies in the care that its staff provided to the aggrieved person and that it has ultimate responsibility for the care that was provided.

38. Following the events set out in this agreed summary of facts, the defendant undertook an internal investigation and corrective action plan which was completed in September 2017. As a result, the defendant has implemented the following actions:

- the Clinical Nurse Leader role has changed to Clinical Manager with a focus on clinical oversight, and is a contact and co-ordination point for external care team members. The Clinical Manager ensures effective communication with family/whānau/advocates, and ensures compliance with Summerset's clinical policies and systems;
- training sessions in relation to wound care, and palliative care and pain management have been delivered every year since 2018;
- continence training has been provided;
- a registered nurse on the team is the wound care portfolio holder and oversees wound care systems for the care centre and supports individual staff;
- wound care training has also been supported by the product supplier Smith and Nephew;
- pressure mattresses have been purchased and a consistent supply is available for use in the care centre. Staff can apply for additional or replacement equipment needed for residents with equipment

delivered within a few days. Equipment that is needed for clinical care and support is not charged to the resident;

- a clinical whiteboard has been implemented to improve communications with care staff for monitoring requirements;
- the handover process has been improved, and is regularly monitored. The improved process involves:
    - using Handover Books to document important information on a daily basis;
    - providing handover sheets to caregivers to ensure they are aware of residents' needs and interventions such as turning charts and intake charts; and
    - the care centre manager and clinical manager attend handovers to provide leadership for the staff;
- a team leader role has been introduced for the caregiver team each AM shift and PM shift to monitor that care is being provided as directed and to support new staff with orientation;
- monitoring charts are placed in residents' rooms instead of on their files and in 2019 Summerset moved to electronic recording in its VCare system which raises alerts when dressings are due for assessment;
- a comprehensive skin assessment is in place led by the care centre manager as a Continuous Improvement Project. RNs on admission complete an assessment for all new residents to assess skin condition as a baseline; and

- nutrition and hydration "tool box" discussions have occurred at handovers and training at staff meetings for caregivers and RNs.

39. Summerset's wound care and pain policies have also been updated to reflect the need to assess non-verbal signs of pain.

40. Summerset has implemented the STOP and WATCH tool for identifying residents changing health condition and has implemented the SBAR (Situation, Background, Assessment and Recommendation) form which provides a structured approach to referring residents to other health professionals for review.

41. The Ministry of Health undertook a provisional audit of Summerset in August 2018, and a surveillance audit in February 2019. Both audits focused on wound care management and no adverse findings were made in relation to the wound care provided.

42. Summerset currently holds a 4-year certification from the Ministry of Health.

43. The defendant has provided a written apology to the complainant.

**BREACH OF THE CODE**

44. Right 4(1) of the Code states: "Every consumer has the right to have services provide with reasonable care and skill".

45. The defendant has a responsibility to operate Summerset in a manner that provides its residents with services of an appropriate standard. The New Zealand Health and Disability Sector Standards also require that rest homes ensure the operation of their service is managed: "in an efficient and

effective manner which ensures the provision of timely, appropriate, and safe services to consumers".[7]

46. The defendant had the ultimate responsibility to ensure the aggrieved person received care that was of an appropriate standard and complied with the Code.

47. The defendant accepts that it failed in that responsibility and breached Right 4(1) of the Code. In particular:

- not all of the aggrieved person's wounds were brought to the attention of the NP and GP when medical assistance was sought;
- specialist wound care was not sought in a timely manner for the aggrieved person, despite her history of peripheral vascular disease and very high risk of developing pressure areas;
- despite being identified as at very high risk of developing pressure areas, the aggrieved person was not put on a pressure-relieving mattress during her admission;
- a turning chart was not commenced as early as it should have been and when commenced, was not completed adequately;
- the aggrieved person's wound care documentation contained gaps and inconsistencies;
- there were delays between the aggrieved person's wounds being identified and appropriate documentation being commenced;

[7] New Zealand Health and Disability Sector (Core) Standards (NZS8134.1.12:2008, Standard 2.2).

- the condition of the aggrieved person's wounds was not recorded accurately (as demonstrated by photographs taken of the wounds);
- the aggrieved person's resident centred care plan as not taken into account by multiple staff members involved in the aggrieved person's dressing changes, particularly in relation to pain management;
- the aggrieved person was not administered paracetamol on multiple occasions where pain was noted in the wound care documentation and progress notes;
- staff failed to adequately assess wither the aggrieved person was giving objective cues of pain; and
- staff failed to consider if nutritional supplements ought to have been given to the aggrieved person, in light of her declining nutritional intake.

_____

Greg Robins
**Acting Director of Proceedings**

Date

I, , agree that the facts set out in this Agreed Summary of Facts are true and correct.

_____

For or on behalf of
**Summerset Group Holdings Limited**

Date