Registered Nurse, RN D

Registered Nurse, RN C

Oceania Care Company Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC01267)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman in a rest home owned and operated by Oceania Care Company Ltd. Following her admission, the woman did not receive her regular medications, including insulin, and she died less than 24 hours after her arrival at the facility.

2. The significance of what transpired in this case, and the dire consequences for the consumer and her family, cannot be over-stated. Registered nurses across many practice settings are key providers of clinical care for people who have diabetes. People in an aged residential care setting are no exception. They frequently present with multiple comorbidities and complex health conditions, including type two diabetes, and often are not in a position to advocate for themselves or alert others to issues of concern. They are reliant on the responsible health professional for their immediate safety and wellbeing. As such, it was reasonable to assume that all those health professionals involved in this consumer's brief episode of care should have been competent to recognise and manage her conditions.

3. This case highlights the importance of accurate forward planning for new admissions, and of vigilance when dealing with consumers who require their medications in a timely manner. The report emphasises the importance of critical thinking and the use of initiative by registered nurses when responding to different scenarios, and the vital role of communication with both colleagues and consumers and their whānau.

Findings

4. Overall, the care provided to the woman fell short of acceptable standards in a number of areas in a time frame of less than 24 hours. At least three of the four nurses involved in her care failed to fulfil their clinical responsibilities and adhere to policies and procedures. Policies are of little use if they are not followed by staff.

5. The Deputy Commissioner found Oceania in breach of Right 4(1) of the Code for failing to provide services with reasonable care and skill. The Deputy Commissioner also found two registered nurses in breach of Right 4(1) of the Code, and made adverse comment about the care provided by two further registered nurses.

Recommendations

6. The Deputy Commissioner recommended that the rest home review its insulin administration policy to include guidance for staff when blood sugar levels are outside the usual parameters; review the process of escalating GP contact attempts in situations where urgent medical review is requested; introduce a GP follow-up deadline; consider adding a reference section to the online note system for charting by GPs at admission or for pharmacy use in the event that a GP cannot be contacted; and review its process for asking the local medical centre to chart residents' medications.

7. The Deputy Commissioner recommended that Oceania and four nurses each write an apology to the consumer's family, and familiarise themselves with the Ministry of Health publication "Medicines care guides for residential aged care" (2011). The Deputy

Commissioner also recommended that the Nursing Council of New Zealand consider whether a review of two of the nurses' competence is warranted.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided by Oceania Care Company Ltd to her mother, Mrs A, at a rest home. The following issues were identified for investigation:

- *Whether Oceania Care Company Limited provided Mrs A with an appropriate standard of care in 2018.*
- *Whether Registered Nurse (RN) D provided Mrs A with an appropriate standard of care in 2018.*
- *Whether RN C provided Mrs A with an appropriate standard of care in 2018.*

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

10. The parties directly involved in the investigation were:

Mrs B	Complainant (daughter of consumer)
Oceania Care Company Limited	Group provider
RN D	Clinical Manager
RN C	Registered nurse

11. Further information was received from:

RN E	Registered nurse
District Health Board	Provider
Dr F	General practitioner (GP)
Medical centre	
Nursing Council of New Zealand	

12. Also mentioned in this report:

Mr B	Mrs A's son-in-law
RN G	Registered nurse
Dr I	Oceania General Manager

13. Independent clinical advice was obtained from RN Julia Russell (Appendix A).

14. I would like to acknowledge the tragic circumstances of Mrs A's death, and express my sincere condolences to Mrs B and Mrs A's other family members and friends.

Information gathered during investigation

Introduction

15. This complaint relates to the care provided to Mrs A at a rest home. Mrs A (aged in her seventies) was admitted to the rest home, and, unfortunately, died the following day.

16. Mrs B and her husband, Mr B, cared for Mrs A (Mrs B's mother) at their home. Mr B held an enduring power of attorney (EPA) for Mrs A's personal care and welfare, and this had been activated by Mrs A's regular GP, Dr F.[1] Mrs A suffered from dementia and type 2 diabetes, and a recent assessment had indicated that she required hospital-level care, which was to be provided at the rest home (owned and operated by Oceania Care Company Limited).

17. Mrs A had a variety of health issues and was reliant on a number of medications, including insulin[2] and warfarin,[3] which are highly time-/dosage-sensitive medications. This report focuses on deficiencies in the care that was provided to Mrs A in the brief period that she was at the rest home, as they relate to the consequences of her not receiving insulin to control her diabetes and manage her blood-sugar levels. I also note, however, that the potentially serious consequences of Mrs A not receiving her required dosage of warfarin should not be underestimated.

Admission

18. On Day 1,[4] Mrs B took Mrs A to the rest home, where she was admitted at 1.00pm by RN E.[5] This was a planned admission, and the progress notes show that a telephone call had been made to Mrs B by the rest home two days before the admission, and that the rest home was aware at that time that Mrs A's GP was Dr F. However, Dr F was not aware of Mrs A's admission to the rest home until after Mrs A's death.

19. On admission, Mrs B handed over Mrs A's medications, including her insulin and warfarin. RN E stated that at that time, the only source of medical history was from Mrs B.

20. RN E said that she explained to Mrs B that the medications would need a prescription, and would need to be added to Mrs A's medication chart by the doctor before the rest home could administer them, "as [the rest home] needed dose and times as well as reason for need to be able to give them". Mrs B maintains that this was not explained to her, as she would have stayed the night to administer medication to her mother had she known that the rest home would not do so.

[1] Dr F had been Mrs A's GP since 2017.
[2] Insulin is a hormone (made in the pancreas) that controls glucose (sugar) levels in the bloodstream. People with diabetes (such as Mrs A) do not produce enough insulin, or their body does not use insulin properly, so insulin is injected to help control blood glucose levels.
[3] Warfarin is a medication used to maintain stable blood clotting and reduce the likelihood of blood clots.
[4] Relevant dates are referred to as Days 1–2 to protect privacy.
[5] RN E's shift on Day 1 was from 6.45am until 2.45pm.

21. Mrs A had an interRAI[6] assessment completed prior to admission. Notwithstanding RN E telling HDC that the only source of medical history was from Mrs B, the interRAI assessment was available to the rest home on admission, and included information about Mrs A's medical conditions and diagnoses. Under the heading "List of medications" on the interRAI, it is noted that Mrs A was taking insulin and warfarin. An entry by RN E in Mrs A's progress notes at 2.24pm also records that Mrs A was on insulin and warfarin.

22. Mrs A was taking Protaphane insulin 15 units daily, with Actrapid short-acting insulin up to three times daily determined by her blood-sugar level.

23. Similarly, Mrs A's warfarin doses were adjusted based on her INR test results.[7] In the lead-up to her admission, Mrs A's GP, Dr F, had been advising Mrs A's family every 1–2 days on whether or not to give warfarin.[8]

24. Diet is very important in the management of diabetes, and also needs to be considered when a person is taking warfarin.[9] However, HDC was not provided with evidence that any dietary management, such as meal plans or monitoring, was considered for Mrs A by the rest home.

Rest home

25. The facility provides rest-home services, hospital-level care, respite care, palliative care, and dementia care. HealthCERT told HDC that the rest home is currently certified for a period of four years.

GP contact and follow-up

26. On admission, RN E created a profile for Mrs A on the Medi-Map database. RN E then sent a fax to the rest home's doctor and Mrs A's usual GP, Dr F at the medical centre, stating that Mrs A had been admitted, and requesting that Dr F supply a list of Mrs A's medical conditions and add her medication to her Medi-Map profile. The box on the fax form stating "urgent" was not checked. The fax was sent to the medical centre at 2.09pm, as confirmed by the transmission report (a copy of which was supplied by Oceania). This date was within regular working days and hours of the medical centre. However, staff at the medical centre told HDC that they did not receive any information by fax or otherwise regarding Mrs A on Day 1. Therefore, the information was not passed on to Dr F in line with usual process. As

[6] An interRAI is an assessment tool used by clinicians to assess care needs, both in the community and in aged residential care. Mrs B was present during Mrs A's interRAI assessment.

[7] INR (international normalised ratio) is a blood test that measures how long it takes blood to clot. It is important because having too little warfarin puts the person at risk of blood clotting, and having too much warfarin puts the person at risk of bleeding.

[8] On Day 1, the medical centre (Mrs A's usual doctors) informed Mrs A's family of the updated INR value of 2.7. The medical centre instructed Mrs A's family to continue with the same warfarin amount as Mrs A was taking at the time, and to re-test her INR in one week's time. It appears from clinical notes that Mrs A was taking 4mg at the time. It is not clear from the notes whether this was communicated to Mr B (Mrs A's son-in-law), or Mrs A's son, who also lived with her.

[9] Some foods that are rich in Vitamin K can affect the way warfarin works, so it is important to consider the amount of Vitamin K being eaten in situations when diet may change, for example during illness or hospitalisation.

mentioned above, Mrs A was a planned admission. As such, there was opportunity for forward planning of Mrs A's care, mitigating the need for urgent action by Dr F.

27. Dr F told HDC that there is no record that the fax was received by the medical centre, and to the best of her recollection, she did not receive the fax. Dr F said that usually when faxes come to the practice, they are given to the doctor directly and by hand by either a nurse or a receptionist. If the doctor is unavailable to receive the fax, it is put on an urgent clipboard, which is fixed to the wall outside the doctor's office. Dr F told HDC that she checks this clipboard routinely multiple times a day, and always before leaving the clinic for the day. Dr F affirmed that she always acts promptly on rest-home faxes, so there is no chance that she would have seen it and decided to act on it later. She stated that usually she would make an entry in the patient's clinical notes when a fax is received about a patient, and once the fax is actioned it is put in a tray for the administrative team to scan into the patient's clinical notes. Dr F confirmed that there is nothing from her or the administrative team in Mrs A's notes regarding a fax.

28. At 2.42pm, it was recorded in Mrs A's care progress notes:

> "[There is] no available medical history except is on warfarin and insulin … [Mrs A] has [a pressure injury] on sacrum not seen on admission and cellulitis[10] on [left] leg, warm to touch and weeping, and fungal infection on right foot for GP to sort."

29. No further notes were made regarding cellulitis, and other than recording that Mrs A was on insulin, RN E did not document any further details as required by the Insulin Administration Policy and Protocol (Appendix B).

30. The warfarin administration policy requires that on admission, the admitting nurse must ensure that relevant information is obtained, including a prescription for the warfarin, the last administration, the current dose, the last INR level, and when the next INR test is due. The resident's GP (in this case Dr F) is to be faxed the prescription, as is the pharmacy, and a follow-up phone call is to be made to check that the fax has been received in full. The GP will then record the dose on a form, and warfarin can be administered on the day of admission (following INR results until further notified by the GP).

31. By the end of her shift, RN E found that there had been no reply from Dr F. RN E notified the nurse on the evening shift, RN C,[11] and the Clinical Manager, RN D,[12] that they would need to follow up on this. However, no attempt to follow up was made. Oceania does not have any specific policy that gives information on when to escalate issues to a GP or nurse practitioner; however, the warfarin policy does state that faxes are to be followed up by phone calls.

[10] Cellulitis is a bacterial skin infection. It is treated with antibiotics, and without treatment can be life-threatening.
[11] RN C's shift on Day 1 was from 3.00pm until 11.15pm.
[12] RN D's shift on Day 1 was from 8.00am until 4.00pm.

32. RN D told HDC that because of the length of time that has passed, she cannot recall any conversations with RN E or follow-up phone calls with the GP or pharmacy. However, she said that it would be normal practice to follow up with the GP urgently. RN C also told HDC that she has difficulty remembering because of the time that has elapsed, but she cannot recall having a handover conversation with RN E about needing to follow up with the GP.

Evening medication

33. Mrs B stayed at the rest home with Mrs A until approximately 4pm, and returned at 7.30pm. Mrs A's progress notes from the evening recorded that she "did not eat much" at dinner.

34. On her return that evening, Mrs B found her mother walking around asking other residents where her daughter was, as she needed her insulin. Mrs B took Mrs A's blood-sugar level, which was high, indicating that urgent attention was needed. Mrs B said that she asked the nurse on duty to administer the appropriate medication, and the nurse replied, "I can't give it to [Mrs A]." Mrs B did not understand at the time that this was because the doctor had yet to prescribe the medication. However, the nurse gave Mrs B the bag of medications so that Mrs B could administer the insulin herself. Mrs B administered short-acting insulin to Mrs A at 9.00pm. RN C was the nurse on duty at this time, and she recorded in Mrs A's progress notes that Mrs B had administered medication.

35. Mrs B told HDC that the personal blood sugar monitor that she took into the rest home was not an accurate tool, and simply reads "HI" if the blood-sugar levels are considered dangerous.[13] Therefore, she did not know whether the insulin administered would be enough to bring her mother's blood-sugar levels back to normal.

36. Mrs B said that she left a note for the nurse to make sure that Mrs A would also be provided with long-acting insulin. Mrs B told HDC that she assumed that observations and a further blood sugar check would be completed by the nurse who saw the note.

37. RN C told HDC that she does not remember Mrs B leaving a note, nor does she recall discussing with RN E the need to follow up contact with the GP. However, at 10.54pm, RN C wrote in Mrs A's care notes: "[N]o contact from GP. Medication not added to Medimap and no list supplied. Medication administered by [Mrs A's] daughter including insulin." There is no record of which specific medication or dose was given. Mrs B later told hospital staff that she had given Mrs A Paracodeine for her arthritis pain at the same time, which was not recorded or known to staff. No blood sugar readings were taken by staff on Day 1.

Decline in health

38. It is recorded in the progress notes that Mrs A did "not eat much during dinner" on Day 1.The notes later record that she slept until approximately 2.00am, when she left her room and walked to the hospital lounge asking to help out the nurse. Mrs A refused a hot drink when offered, and the nurse on duty, RN G,[14] was not able to convince Mrs A to return to bed until 3.50am, when she agreed. Mrs A was checked again at 6.05am during the nurses'

[13] Mrs B told HDC that the monitor's manual says the "HI" reading appears when blood glucose levels are over 33.3mmol/L, meaning the person is hyperglycaemic.
[14] RN G's shift on Day 1 began at 11.00pm and ended at 7.00am on Day 2.

medication round. RN G recorded in the progress notes that Mrs A was "lying straight on her bed in supine position and snoring".

39. At 6.34am, RN G found Mrs A lying across her bed unresponsive. An ambulance was called for urgent transfer to the public hospital, and Mrs B was informed. Observations were documented in Mrs A's progress notes, including a blood-sugar level of "high". The public hospital's records state that staff were "unsure of medication or medical history". Sadly, Mrs A died at the hospital at 7.55am. The Coronial Autopsy Report listed the cause of death as follows:

"Part 1 — a. Hyperosmolar hyperglycaemic nonketotic syndrome[15]

b. Diabetes mellitus.

Part 2 — Alzheimer's disease"

Further information

Mrs B

40. Mrs B told HDC that on Day 2, she checked the reading on the blood sugar monitor machine in Mrs A's room, and the reading from the previous night had not changed. This machine was provided by Mrs B. Mrs B stated that therefore she believes that no additional reading had been taken since she administered the short-acting insulin at 9.00pm the previous night. Mrs A's blood-sugar level was recorded in her progress notes as "high", but it is unclear whether this was on the machine provided by Mrs B (which was left in Mrs A's room) or if testing had occurred on a machine belonging to the rest home.

41. Mrs B wrote a letter to HDC describing the reluctance she had placing her mother in residential care, because she and her husband had been unable to care for her to the level she needed. Mrs B described Mrs A as being "consciously and carelessly neglected" at the rest home, despite being under "hospital level care". Mrs B also questioned why an internal investigation was not carried out following her mother's death. Mrs B told HDC that she has to live with the "terrible outcome" of her decision to place her mother in care, while she feels that the staff at the rest home have "moved on and largely forgotten" about the incident. She said that she feels a "deep sense of regret, self-reproach, loss, and hopelessness", and feels as though she failed "one of the people [she] loved most in this world".

Medical centre

42. Dr F told HDC that it was not unusual for the rest home to call if there were any urgent issues or clarifications needed, but in this case there was no call from the rest home as far as she is aware. Dr F said that rest-home staff have her mobile number, and additionally she lives

[15] Hyperosmolar hyperglycaemic nonketotic syndrome is a condition that can develop either as a result of infection or illness in people with type 2 diabetes, or when diabetes medications are not taken as directed. The condition occurs when there is enough insulin to prevent ketosis (when the body produces high levels of blood acids called "ketones"), but not enough to reduce blood sugar levels and avoid hyperosmolarity (a loss of water caused by high concentrations of sugar in the blood). The condition is also sometimes referred to as a "diabetic coma".

near the rest home (of which staff were aware), so she could have been contacted after hours if need be. She stated that the rest home had called her after 5pm previously, and she had never declined to respond.

43. However, in response to the provisional opinion, RN E told HDC that Dr F could be hard to get hold of. She said that while the Clinical Manager had Dr F's cellphone number, the nurses did not. RN E also noted that nurses had been "pulled up" previously for going to Dr F's house in urgent cases, and so this was not seen as a particularly viable option.

Oceania

44. Oceania told HDC that there is no record of any blood-sugar levels being taken by rest-home staff from the time of admission until just prior to Mrs A's transfer to hospital.

45. Oceania stated that a machine for reading blood-sugar levels is provided for all residents at the rest home, and this was the case at the time of Mrs A's admission in 2018. Oceania noted, however, that if a resident brings their own machine, then that machine will be used rather than the facility machine. I note, however, that this information is disputed by RN E, who told HDC in response to the provisional opinion that this was not the case when she was working at the rest home, and that the rest home relied on clients bringing their own machines from home.

46. Oceania General Manager of Nursing and Clinical Strategy, Dr I, wrote a letter to HDC identifying that there were deficits in the care of Mrs A, and apologising to Mrs B for the inadequate quality of care provided to her mother while she was at the rest home. Dr I also identified a lack of policy by Oceania to give information about when to escalate care issues to a GP or nurse practitioner. This letter was shared with Mrs B, who commended Oceania for taking responsibility, but expressed that without answers and assurances that the same events will not happen to another family, she is unable to accept Oceania's "second-hand" apology.

RN C

47. RN C told HDC that when she received notification of the complaint from HDC, she approached the rest home for Mrs A's file to help her to recollect the events, but was told that the file could not be located.

Responses to provisional report

Mrs B

48. Mrs B was given the opportunity to comment on the "information gathered" section of the provisional report. She advised that she had no further comments to add.

Oceania

49. Oceania was given the opportunity to comment on the provisional report. Dr I stated that Oceania deeply regrets the inadequate quality of care provided to Mrs A, and sincerely apologises for the impact that this had on her family. Oceania confirmed its commitment to take action in response to the recommendations made in the provisional report, as set out below.

50. In response to the recommendations relating to the insulin policy, Oceania told HDC that it will review the insulin administration policy to include guidance for staff when blood sugar readings are found to be outside usual parameters. The policy will also be updated to include medications reconciliation at the time of admission. Oceania told HDC that a nurse practitioner at Oceania provided an education session on blood sugar monitoring.

51. Oceania also advised that it is developing and introducing a policy for escalating care to a GP or a nurse practitioner when urgent medical review is requested, as suggested by HDC. The policy will also introduce a follow-up process for guidance if there has been no response to contact by a registered nurse. Oceania also said that it will develop a notation system in Medi-Map for when a GP or nurse practitioner is unavailable or unable to be contacted.

52. The Clinical Manager will conduct education on the use of the STOPANDWATCH early warning tool,[16] which was launched in 2022. Oceania also has monthly Clinical Safety Forums and Professional Development days for registered nurses, which also include education on the STOPANDWATCH tool.

53. Oceania advised that the Medication Management Policy was reviewed in September 2021 and now includes a section on medication reconciliation. The policy states that a prescription for insulin must be obtained as part of the admission process, and that a medication reconciliation must be completed. Oceania told HDC that it will review its process for charting medication and incorporate it into the Medication Management Policy.

54. In line with the recommendation in the provisional report, Oceania confirmed that all medication-competent staff have read the Ministry of Health publication "Medicines care guides for residential aged care" (2011), and that the guide is available on site at the rest home for staff reference. Oceania also told HDC that teaching on the requirements of the guide will occur periodically and formally during Professional Development days for registered nurses.

RN D

55. RN D was given the opportunity to comment on the relevant sections of the provisional report, and had no comments on the findings.

RN E

56. RN E was given the opportunity to comment on the relevant sections of the provisional report. Where appropriate, changes have been incorporated into the report.

57. RN E told HDC that she accepts that the cellulitis, fungal infection, and pressure area needed attention upon admission, but she documented this for follow-up when the GP attended to complete the in-person admission. RN E also agreed that vital signs and blood sugar levels

[16] STOPANDWATCH is an early warning tool that stands for: Seems different than usual; Talks or communicates less; Overall needs help; Pain — new or worsening/Participating in fewer activities; Ate less; No bowel movement in 3 days or diarrhoea; Drank less; Weight change; Agitated or more nervous than usual; Tired, weak, confused, drowsy; Change in skin colour or condition; Help with walking, transferring, toileting more than usual.

should have been taken at admission. She noted that it was common practice to ask healthcare assistants to do this or to hand over to the next shift to complete. She acknowledged that in hindsight there was more that she could have done.

58. RN E agreed that Mrs A's interRAI assessment was completed prior to her admission, but noted that its transfer to allow staff to view it may have been yet to occur.

59. RN E told HDC that this incident has made her reflect deeply on her practice as a nurse, and the way in which she conducts herself. She said that she has used this reflection to improve her practice to ensure that such an event does not happen again. She also told HDC that on reflection of her time at the rest home, there were many shortfalls that allowed for slips in care, and she is happy to see that changes have been made and education provided so that similar events do not occur again.

RN C

60. RN C was given the opportunity to comment on the relevant sections of the provisional report. She advised that she did not have further comments to add to the report, but she commented generally about the workload and lack of support for staff in rest homes.

RN G

61. RN G was given the opportunity to comment on the relevant sections of the provisional report. She advised that she recalls Mrs A being up in the night, but she appeared to be unsettled because it was her first night in the rest home, and she did not seem restless or distressed. RN G recalls that Mrs A's medication had not been charted in the Medi-Map system, and that it had been handed over to her that all Mrs A's medications had been administered by Mrs B. RN G recalls visually checking on Mrs A in the morning, and finding her sleeping and snoring. RN G said that she decided not to wake up Mrs A, and to check on her again once she had finished her rounds in the dementia unit, which is when she found her unconscious.

Opinion: RN E — adverse comment

62. RN E admitted Mrs A to the rest home. RN E created a Medi-Map profile for Mrs A, and took her medications for storage, as required under the rest home's medication management policy. RN E faxed a request to Dr F to chart Mrs A's medications. RN E recorded in Mrs A's progress notes that Mrs A's medication charting had been faxed to the GP, and that while her medical history was unknown,[17] Mrs A was taking warfarin and insulin.

63. My independent expert advisor, RN Julia Russell (a registered nurse who specialises in aged care) considers that RN E's initial assessment was adequate and met the expected standard

[17] Mrs A had an interRAI assessment completed prior to admission. Notwithstanding RN E stating that the only source of medical history was from Mrs B, the interRAI assessment was available to the rest home on admission, and included information about Mrs A's medical conditions and diagnoses.

of care, and I accept this advice. However, RN Russell also considers that it would have been appropriate for RN E to have taken Mrs A's blood-sugar level and temperature, as Mrs A's diabetes and cellulitis had been identified on admission. I accept this advice, as both conditions can be subject to rapid change.

64. Furthermore, Oceania's Insulin Protocol requires specific details to be recorded, such as the patient's last blood-sugar reading and dose of insulin taken. Even though Mrs A's medical history from Dr F was unavailable at the time of admission, Mrs B had been Mrs A's primary caregiver, and had been present at Mrs A's interRAI assessment. Mrs B was a useful source of knowledge on Mrs A's condition, and this was not utilised well during Mrs A's admission. Mrs B could have provided Mrs A's usual dose of insulin and her last blood-sugar level, and explained the option to administer long-acting or short-acting insulin depending on the different blood-sugar levels. However, none of this information was requested of her.

65. I am also concerned that the fax for medication charting that was sent to Dr F was not noted as urgent, when RN E knew that Mrs A's conditions required essential medications. Mrs A was reliant on life-saving medication that required timely administration, including warfarin and insulin. The urgent nature of the administration of these drugs is well known, especially by nurses, and it is therefore expected that the request would be treated as urgent.

66. RN E stated that she had two separate handover conversations with RN D and RN C, where she made it clear to both of them that follow-up with the GP regarding medication charting still needed to occur. Neither RN D nor RN C can recall such a conversation, owing to the time that has elapsed. Regardless of whether or not a verbal conversation occurred, by leaving the medication information in the progress notes, RN E made the information available to all other nurses who cared for Mrs A subsequently. RN E specifically noted the medications used and the time at which she requested the charting from the GP. RN E's shift finished at 2.45pm. I consider that by the time she left, insufficient time had elapsed to warrant criticism for not following up again with Dr F.

67. Overall, RN Russell considers that the admission procedure met the requirements of an aged-care facility, and I accept this advice. While I have some concern that RN E did not follow the Insulin Protocol, I am satisfied that she did alert her co-workers about Mrs A's condition and the need to follow up, and she took steps to seek charting of the medication from Dr F. I accept that in the short time RN E was involved in Mrs A's care, she could not have foreseen that there would be a delay in charting the medication.

Opinion: RN C — breach

Start of shift

68. RN E admitted Mrs A to the rest home and sent a fax to the GP seeking prescription details for Mrs A's medications. RN E stated that when she finished her shift at 2.45pm on Day 1, she handed over to RN D and RN C. RN C was the nurse on duty on the afternoon shift,

beginning at 3.00pm. RN C told HDC that she cannot remember a conversation with RN E. However, RN C recorded in the progress notes at 10.54pm that there had still been "no contact from GP".

Medication administration

69. Mrs B told HDC that around 9pm on Day 1, Mrs A told her for the second time that she had not yet been given any insulin. Mrs B said that she asked the nurse on duty to administer Mrs A's insulin, but the nurse declined and provided the medication for Mrs B to administer herself. RN C told HDC that because of the time that has elapsed, she does not recall this conversation. However, as RN C was the nurse on duty at this time, I consider it more likely than not that she is the nurse referred to by Mrs B. Mrs B told HDC that after she administered the short-acting insulin and also Paracodeine, she left a note for the nurse to make sure that her mother was given long-acting insulin. RN C told HDC that she cannot recall seeing any such note.

70. RN C recorded in Mrs A's progress notes at 10.54pm that Mrs B had administered Mrs A's "medication including insulin". There is no record of Mrs B having administered Paracodeine. RN C should have confirmed with Mrs B whether any other medication was given, such as Paracodeine or warfarin. Under Oceania's Medication Management Policy and Insulin Protocol, RN C was required to record the type and amount of insulin administered, the time at which it was administered, and Mrs A's last blood-sugar reading.

71. RN Russell advised that the dose of the medications given by Mrs B should have been recorded, and commented that not following up with Mrs B about the details of the insulin administration was a serious departure from accepted practice.

72. I accept RN Russell's advice and am critical that none of this information was recorded in accordance with policy. RN C had the clinical knowledge to understand the urgency of Mrs A's medications, and the means of monitoring her health in the meantime. I am also concerned that RN C did not confirm with Mrs B whether any other medication was given at the same time as the short-acting insulin.

Future doses

73. Under the Medication Management Policy, all nurses are required to question or seek clarification where medications are not available. There is no evidence that RN C took steps to question or seek clarification with any colleague, the GP, or Mrs B, regarding Mrs A's medication requirements.

74. RN Russell stated that further clarification of Mrs B's actions, or clarification of what medications were given, would have alerted RN C to the fact that a further insulin dose was needed. RN Russell advised that failure to follow this up for a type two diabetic is a serious departure from the standard required in aged care, and I accept this advice. At that time, Mrs B, as Mrs A's previous primary caregiver, was the best source of information about the medication doses Mrs A might require overnight. Alternatively, Dr F indicated that it was normal for the rest home to contact her after hours, and she could have provided this information. RN C's failure to follow the Medication Management Policy and Insulin

Protocols meant that no further detail was obtained that could assist in future doses. Furthermore, after RN C recorded that Mrs B had administered insulin, RN C should have ensured that there was a plan in place for Mrs A to receive her next dose, which did not occur. RN Russell identified that RN C recorded that medication charting had not occurred, but made no attempt to take action or address this.

75. Dr F confirmed that she could have been contacted after hours, and the Medication Management Policy outlines the process for obtaining a verbal order in urgent circumstances. As Mrs A was a new admission and required ongoing medications that had been administered previously, either course of action would have been appropriate for RN C to take. A registered nurse has the clinical knowledge to understand that insulin is a life-saving medication, and that someone reliant on it would need to be monitored regularly. RN Russell advised that even if Mrs A did not need any more insulin that evening following the dose given by Mrs B, Mrs A would still have needed further insulin before a GP could complete the charting in the morning. I accept this advice and am critical that RN C did not follow up with Dr F or request a verbal order to ensure that Mrs A received essential medications in a timely manner.

Conclusion

76. In the evening of the day of admission, of the staff at the rest home, RN C was in the best position to recognise the seriousness of delays in charting insulin and warfarin and following this up. I am critical that RN C did not follow up the lack of medication charting for Mrs A, despite her knowledge that Mrs A was reliant on life-saving medications. RN C did not act in accordance with Oceania policies, in particular the Insulin Protocol and Medication Management Policy. She had the knowledge that further medication was needed, and did not action this by either seeking a verbal order or following up with Dr F. This was a significant omission. I consider that RN C did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[18]

Opinion: RN G — adverse comment

77. RN G was on the night shift from 11pm on Day 1 until 7am on Day 2. She recorded in Mrs A's progress notes that when she was doing the medication rounds at 6.05am, she sighted Mrs A "lying straight on her bed in supine position and snoring".

78. Mrs A had been out of bed throughout the night. At 3.50am, RN G managed to convince Mrs A to return to bed, after she had got out of bed and walked down to the hospital lounge.

79. RN G wrote her first note about Mrs A being out of bed below the note left by RN C saying that there had been no contact from the GP, and that medication had not yet been added

[18] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

to Medi-Map and no medication list had been supplied. The note did mention that Mrs A's daughter had given her insulin.

80. In response to the provisional opinion, RN G told HDC that she was aware that Mrs A had not had her medications charted. However, RN G said that she understood that all medications had been given by Mrs A's daughter, and she thought that Mrs A was unsettled because it was her first night in the facility.

81. In my provisional opinion, I stated that when Mrs A was sighted lying on her back and snoring, it is possible that she was losing consciousness and entering a diabetic coma. When observing Mrs A in this position, in my view, RN G should have recognised the possible medical issues at hand and completed a more thorough check on Mrs A. No further observations were recorded. I maintain my view that this may have been a missed opportunity to arrange earlier medical intervention for Mrs A.

Opinion: RN D — breach

82. RN D was the Clinical Manager on duty on Days 1 and 2. Her shifts on both of these days were from 8.00am until 4.00pm, and she was on duty at the time of Mrs A's admission. RN D was one of two registered nurses on duty on Day 1, working with RN E until 2.45pm and RN C from 3.00pm until the end of her shift at 4.00pm.

83. RN E stated that upon finishing her shift on Day 1, she had a handover conversation with RN D and RN C, and told them that follow-up needed to occur with the GP for the prescribing of Mrs A's medications. While neither RN D nor RN C can recall this handover, I note that RN C recorded in the progress notes later that evening that no contact from the GP had been made. In my view, this shows that it is likely that some form of handover as described by RN E did occur.

84. Regardless of the content of the handover, as the Clinical Manager, RN D had responsibilities that were not upheld on Day 1. The Medication Management Policy states that a Clinical Manager is responsible for monitoring policy compliance and assisting with provision of safe medicine systems. The job description of Clinical Manager provided to HDC outlines obligations to provide oversight and monitoring of the nurses working on their shift.

85. Mrs A was a planned admission, but a plan for how she would receive her essential medications after her admission was lacking. Further, no plan was made to monitor Mrs A despite her being identified as having multiple health conditions including cellulitis and type two diabetes on admission, and despite her requiring warfarin and insulin. She was a frail elderly woman who required hospital-level care and was at risk of rapid deterioration unless her medications were administered as required. Her condition warranted close monitoring. Furthermore, as a new admission with a history of dementia, staff should have recognised that because they were unfamiliar with her, she required closer observation, not least to help her to adjust to her new environment and feel safe.

86. RN Russell advised that recording of a blood-sugar level and temperature would have been reasonable for a resident with Mrs A's medical profile. I accept this advice, and note that the recording of a patient's last blood-sugar level on admission was also a requirement of the Insulin Protocol and Medication Management Policy. While RN D herself did not complete Mrs A's admission, in her role as Clinical Manager she should have overseen that it was completed in full and compliant with policy.

87. Oceania told HDC that as the Clinical Manager on duty at the time of Mrs A's admission, RN D should have followed up with the medical practice to ensure that it had received the urgent medication prescription information, before she finished her shift. RN Russell also advised that as RN D was on duty as Clinical Manager at the time of these events, she should have followed up with the medical practice to ensure that any issues had been addressed and any urgent information had been received, especially in regard to medication prescriptions, before leaving the facility for the day. There is no evidence to suggest that RN D did this.

88. I accept RN Russell's advice, and consider that before RN D finished her shift, she should have checked the planning that had been made for Mrs A in terms of GP follow-up, monitoring of blood-sugar levels throughout the night, and medicine administration in the absence of GP prescribing. RN D had the knowledge and position either to follow up with Dr F, or in the event that Dr F could not be contacted, to seek a verbal order as outlined in the Medication Management Policy.

Conclusion

89. RN D's inaction with regard to a vulnerable patient dependent on life-saving medication fell short of her responsibilities as Clinical Manager. Mrs A was a planned admission. Her interRAI assessment had been completed and included information about her medical conditions and diagnoses, and it was available to the rest home when Mrs A presented for admission. As such, there was opportunity for forward planning and for RN D to ensure that certain fundamental requirements were in progress. I am concerned that RN D did not put in place plans to ensure that Mrs A received essential medications and monitoring overnight. I consider that these shortfalls meant that RN D did not provide services to Mrs A with reasonable care and skill, and amount to a breach of Right 4(1) of the Code.[19]

Opinion: Oceania Healthcare — breach

Introduction

90. In accordance with the Code, Oceania Healthcare had a duty to provide Mrs A with services of an appropriate standard. The Health and Disability Service Standards require organisations (including rest homes that provide hospital-level care) to ensure that they

[19] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

provide services to consumers in a safe and timely manner.[20] The Standards also require organisations to ensure that consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.[21]

91. Oceania had policies in place to manage medication for new admissions (see Appendix B). These included specific policies for insulin and warfarin, to enable continuity of life-saving medications for new admissions. It was noted on Mrs A's admission assessment that she was taking warfarin and insulin, and Oceania Healthcare was therefore on notice that Mrs A required potentially life-saving medication and regular monitoring.

92. Despite that notice, and having policies and procedures to manage this exact situation, Mrs A did not receive a prescription or verbal order for life-saving medications and, tragically, did not receive medications that could have managed her blood-sugar levels and ultimately prevented her death. While there is individual accountability for this, I also consider that Oceania must take responsibility for failures at an organisational level for the reasons outlined below.

Inadequate planning on admission

93. Oceania's Insulin Protocol requires various steps to be completed on admission, including ensuring that a prescription for insulin is available, noting information about when it was last administered, and planning for the next dose and for blood-sugar monitoring. The Medication Management Policy's guidance for warfarin administration has similar requirements for warfarin, and requires a plan for testing of INR levels. This protocol also notes that diet can affect anticoagulant medications, and requires certain planning around the resident's dietary profile.

94. As RN Russell notes, the medicines Mrs A required needed to be charted urgently. However, no staff involved in Mrs A's care complied with relevant protocols and policies, and none of the required steps were taken. RN Russell advised that the failure by rest home staff to follow their own policies and requirements for a new admission was a serious departure from accepted practice, and I accept this advice. It would not have been difficult for them to have done so — relevant information could easily have been obtained by asking Mrs B, as Mrs A's primary caregiver, or referring to Mrs A's GP records. I am concerned at what is evidently a lax attitude by multiple staff in this case to plan for Mrs A's ongoing care adequately. There was a clear absence of critical thinking on the part of the registered health professionals involved.

Inadequate monitoring of blood-sugar levels

95. An essential health need for a person with diabetes is monitoring of their blood-sugar levels. RN Russell advised that regardless of whether medications were charted, Mrs A should have had her blood-sugar levels taken before meals. However, there is no evidence that any Oceania staff member did any testing of Mrs A's blood-sugar levels on Day 1 or Day 2. As RN Russell notes, the failure to take blood-sugar levels was a shortfall by all the registered

[20] NZS 8134.1.2:2008 at 2.2.
[21] NZS 8134.1.2:2008 at 3.12.

nurses involved in Mrs A's care across all shifts. This demonstrates a concerning level of negligence and lack of attention to Mrs A's health needs.

96. Oceania told HDC that in the event a patient brings their own machine, this will be used instead of the facility machine. However, Mrs B told HDC that Mrs A's machine was not particularly accurate, as it showed only "high" when blood-sugar levels were too high. It would have been appropriate for Oceania to use its own machines, so that clear numerical blood-sugar levels could be read and recorded. Regardless, if Mrs A's own machine was used by Oceania staff, this was never documented in her progress notes.

97. I note that in response to the provisional opinion, RN E indicated to HDC that the rest home did not have blood sugar monitors for each patient, and they relied on patients bringing their own from home. I would be very concerned if this was the case, but given the conflicting accounts I am unable to verify this. I expect rest homes providing hospital-level care to have blood-sugar level monitors for their patients.

Failure to follow up with GP or pharmacy

98. All progress notes made by the nurses involved in Mrs A's care failed to mention that follow-up was needed with Dr F for Mrs A's medication prescriptions. There was a general awareness amongst staff that medication was needed and charting had been requested, but none of the nursing staff, or any other staff at the rest home, proactively followed up with Dr F, the medical centre, or the pharmacy.

99. In particular, there was no follow-up with the medical centre when the fax was not replied to. Whether or not the fax was received by the medical centre, it is clear that the rest home did not receive a response to it in a timely manner. In such circumstances, I note that there are other more reliable means of communication than fax that could have been utilised.

100. Similarly, despite the urgent need for administration of these medications, immediate contact with Mrs A's GP through telephone was not undertaken on admission. Follow-up by phone call should have been attempted during the day, or at the very least as the medical centre neared closing time. In my view, it was the responsibility of the nurses on duty in the afternoon/evening, who were aware of Mrs A's medication requirements, to follow up on the prescription.

101. RN Russell advised that the failure to escalate attempts to contact the GP was a serious departure from accepted standards. She identified that no recognition was made of the need to contact the GP or the pharmacist, who could have provided a verbal order or the original prescriptions. I accept RN Russell's advice, and I am concerned that this did not occur when the fax was not responded to in a timely manner.

102. RN Russell also identified that no specific Oceania policy provides information on when care issues should be escalated to a GP or nurse practitioner, and this indicates an area where Oceania has fallen short in planning. I accept this advice, and consider that in this case such a policy would have been helpful to guide nursing staff on when to follow up with Dr F.

Communication

103. The above failures point to a culture of poor communication at the rest home. In addition to the poor communication with Mrs A's GP, as outlined above, there was poor communication between nurses at the rest home. RN E stated that she had a handover conversation with RN C and RN D, but neither nurse can recall the conversation owing to the time elapsed. No documentation of the conversation exists, and no plans were formulated for managing follow-up or caring for Mrs A. RN Russell, referencing the letter from Dr I, states that there was a lack of clear nursing handover and follow-up contingency plans between the morning and afternoon shifts.

104. There was also poor communication with Mrs B. As noted above, on Mrs A's admission, Mrs B was not approached for information about her mother's medications. Mrs B was not given sufficient information to allow her to understand the medication prescribing requirements, both prior to and following admission, and was not given clear instructions as to what options were available while GP charting was being sought. As the admission was planned, Mrs B also could have been warned that prescription documentation was needed for her mother's medication to be administered. Furthermore, Mrs B's communication with nurses went undocumented.

105. RN Russell advised that there were shortcomings in the quality of communications both amongst staff and from staff to Mrs B, and that overall, this resulted in Oceania failing to care for Mrs A to an adequate level. I agree. Within a short period of time at the rest home, a number of communication deficiencies occurred involving a number of staff, which paints a concerning picture of the coordination of care and effective communication between staff and with Mrs A's family at the time of the events.

Internal investigation

106. Under the Medication Management Policy, if a dose of medication is missed (which is defined as a delay of over two hours in administration) it is considered a "medication incident" that must be reported on an incident form. I am concerned that there was no reporting of Mrs A's missed doses of medication. While the absence of a prescription may mean that Mrs A's missed doses do not fall under this aspect of the Medication Management Policy, in my view, absence of active attempts to obtain a prescription either from a GP or through a verbal order, and therefore failure to abide by the Medication Management Policy, would be grounds for an internal investigation, particularly given the circumstances under which Mrs A died.

107. I am very concerned that Oceania has not investigated these events. Internal investigations are an important tool to identify deficiencies in Oceania's processes and to facilitate changes to mitigate the likelihood of adverse events recurring.

Conclusion

108. I cannot overemphasise the significance of what transpired here, and the dire consequences for Mrs A. I respectfully acknowledge the lasting impact it has had on Mrs B and Mrs A's other family members. Registered nurses across many practice settings are key providers of diabetes clinical care. Older people receiving hospital-level care in an aged residential care

setting are no exception, often presenting with multiple comorbidities and complex health conditions, including type two diabetes. As such, it is reasonable to assume that all those involved in Mrs A's care were both familiar with her medical history and competent to recognise and manage her conditions.

109. Overall, the care provided to Mrs A fell short of acceptable standards in a number of areas in a time frame of less than 24 hours. At least three of the four nurses involved in Mrs A's care failed to adhere to policies and procedures. There is very little use in having policies if they are not adhered to by staff. Oceania's nursing staff, as registered health professionals, should have been aware of the need to plan for and monitor the blood-sugar levels of a type two diabetic resident, and should have recognised the need to take action in the event that critical medications were not charted. There was a complete lack of critical thinking on the part of the nursing staff involved. Sufficient consideration was not given to the importance of having these medications charted in a timely manner. A combination of poor communication and lack of initiative to take responsibility for Mrs A's care, particularly her medication and following up on her prescription, resulted in Mrs A not receiving her medication in a timely manner. In my view, this case indicates at best a need for additional training, and at worst a pattern of poor care and low adherence to policy at the rest home. In my opinion, the responsibility for the failure to provide Mrs A with life-saving medication, and the widespread failure to comply with policies, lies with Oceania at an organisational level.

110. Accordingly, I find that Oceania Care Company Ltd breached Right 4(1) of the Code for failing to provide Mrs A services with reasonable care and skill.

Changes made

111. Oceania told HDC that it has implemented the following changes at the rest home:

- Senior management has changed, and now the rest home is also supported by a Regional Clinical Manager.
- A new resident management system has been implemented, which "ensures better visibility by the Clinical Manager into the current care requirements, admission assessment, care planning and follow up".
- An agreement has been made with the district health board for nurses at the rest home to contact the Emergency Department at the public hospital for advice and support of a deteriorating resident.
- Four nurse practitioners have been recruited to work between Oceania facilities in the area.
- Discussion was held at a staff meeting on 23 February 2021 about the complaint and what to do if a resident requires life-saving medications but they have not been charted by a GP and there is no prescription. It was agreed that the options were:

  - To follow up with the GP;
  - To call a family member to administer;
  - To administer from the label and document in the progress notes;
  - To send the resident to an Emergency Department if none of the above options are possible.
- Training was provided to staff on 3 February 2021 about admissions and medications, including:
  - Registered nurse admission process — scenario discussed based on Mrs A's situation;
  - Discussion held about options and both the medication administration policy and the admission process.
- The insulin administration policy is to be reviewed, as currently there is no process to guide staff when blood sugars are outside usual parameters.

Recommendations

112. HDC's independent advisor, RN Russell, noted the changes made at the rest home, and commented that they show a concerted effort to improve the services to allow the facility to better provide for its residents and their families/whānau.

113. I acknowledge Oceania's commitment to compliance with the recommendations made in my provisional report. I recommend that within three months of the date of this report, the rest home (in consultation with Oceania management):

a) Review the insulin administration policy to include guidance for staff when blood sugars are outside usual parameters, and report to HDC on the changes made.

b) Review the process of escalating GP contact attempts in situations where urgent medical review is requested, including but not limited to patients who require life-saving medication, and report to HDC on the changes made as a result of the review.

c) Introduce a GP follow-up deadline, such as making a follow-up phone call (or requesting a verbal order if needed) if GP contact has not been responded to by the end of the working day, and report to HDC on the changes made.

d) Consider the addition of a reference section to Medi-Map for charting by GPs at admission, or the use of a pharmacy if the GP cannot be contacted or is unavailable. If it is not possible to add this to the Medi-Map software, another kind of notation system is recommended. A report back to HDC on consideration of this and any changes made should be provided.

e) Review its process for requesting charting of residents' medications from the medical centre, in particular whether there is a better alternative to using facsimile, and report back to HDC on the review.

114. In the provisional opinion, I recommended that Oceania and RN D provide written apologies to Mrs and Mr B. These apologies have now been received and provided to the family.

115. I recommend that within three weeks of the date of this report, RN C, RN G, and RN E individually:

a) Write a letter of apology to Mr and Mrs B and provide this to HDC for forwarding.

b) Familiarise themselves with the Ministry of Health publication "Medicines care guides for residential aged care" (2011).

116. I recommend that the Nursing Council of New Zealand consider whether a review of RN D's competence is warranted.

117. I recommend that the Nursing Council of New Zealand consider whether a review of RN C's competence is warranted.

Follow-up actions

118. A copy of this report with details identifying the parties removed, except Oceania Care Company Ltd and the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN C's and RN D's names in covering correspondence.

119. A copy of this report with details identifying the parties removed, except Oceania Care Company Ltd and the expert who advised on this case, will be sent to the district health board and HealthCERT.

120. A copy of this report with details identifying the parties removed, except Oceania Care Company Ltd and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

121. A copy of this report will be sent to the Coroner.

Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from RN Julia Russell:

"The purpose of this report is to review the care provided to [Mrs A] at [the rest home] following her admission on [Day 1]. [Mrs B] has complained as she is concerned about the care of her mother by [the rest home], which is part of the Oceania Group. Responses to the questions 1–5 are completed following a review of the documents which included:

1. Complaint from [Mrs B] raising concerns about her mother [Mrs A]
2. Letter from Oceania dated 28 August 2019:
    a. Communication with family form
    b. Admission Documents
    c. General Consents
    d. Initial Assessments
    e. Initial Person-Centred Care plan
    f. Care Progress notes
    g. Medication chart
    h. Community interRAI Assessment
    i. Signed Admission Agreement
    j. EPOA documentation
    k. File Review by [the] (Regional Clinical and Quality Manager)
    l. Call bell records
    m. Relevant policies
    n. Statement from [RN E]

Background

[Mrs A] had been living at home with her daughter and son in law supporting her. [Mrs A] had complex health requirements including dementia, asthma, a heart arrhythmia and type two diabetes. To manage her diabetes, long-acting and short-acting insulin were prescribed. The dose of these to be administered was determined by blood sugar levels (BSL). The decision was made for [Mrs A] to move into a facility that could provide her hospital level care. [Mrs A] was admitted to [the rest home] on [Day 1] at 1.00pm with her son in law, [Mr B], as her enduring power of attorney (EPOA).

The admission process was worked through by [RN E] with [Mrs A] and [Mrs B]. As part of the admission [RN E] created a Medimap profile for [Mrs A] and sent a fax at 2.09pm requesting the general practitioner (GP) to provide [Mrs A's] medical history and to chart her medications into Medimap. This is required so the residents have their medication correctly charted so it can be administered correctly. The fax stated [Mrs A] was being admitted on the day the fax was sent. There is no documentation regarding any follow up by the GP practice or that the RN on the next shift followed up with the GP practice.

Having called in to see her mother, [Mrs B] was told by [Mrs A] that she had not had her insulin. After taking a BSL (which was high) [Mrs B] administered short-acting insulin at around 8.45pm. [Mrs B] left a note for the RN on duty to make sure that her mother was administered with her long-acting insulin. This was not administered as medications were not charted by the GP, so no evening dose of long-acting insulin was administered. The next morning [Mrs A] required urgent transfer to hospital where she died that morning.

1. Based on the referral received and her presenting condition, comment on the appropriateness of admitting [Mrs A] into care on [Day 1] without a medical history and prescriptions received from her GP.

   i. [Mrs A] was admitted to [the rest home] on [Day 1] and arrived at 1pm. The GP summary was not available however this was a planned admission and the interRAI assessment was available. The interRAI is a comprehensive assessment providing information about all aspects of [Mrs A's] life and health and has details regarding her medical conditions and diagnoses (as below).

K. Oral and Nutritional Status

2 NUTRITIONAL ISSUES

Reports having a poor appetite and often only has a few bites before leaving her meal. I thinks has lost weight, he is not sure how much in the last 3 months. He has had to reduce all insulin doses as her appetite has reduced significantly.

I. Disease Diagnoses

1 DISEASE DIAGNOSES

Demonstrates short term memory loss - has hallucinations related to Alzheimer's Dementia diagnosis, has been occurring for over a year.

M. Medications

3 ADHERENT WITH MEDICATIONS PRESCRIBED BY PHYSICIAN/GP

Medication oversight and administration by sorts meds into weekly dispenser, both take Blood glucose levels and adjust insulin doses as required.

1 LIST OF ALL MEDICATIONS

Warfarin and Insulin are adjusted dependent on test results.

   ii. At the time of admission, [Mrs B] provided information and the insulin and medicine with them for the admission. It is not clear if the medicines were taken and stored away, as [Mrs B] was able to give [Mrs A] her insulin. According to policy and procedure the medicines should have been removed.

   iii. Admitting a resident with the summary coming from the GP and the Medimap charting not yet done is not uncommon and is acceptable. However, the medicines [Mrs A] required needed to be charted urgently and as per the policy

this is a requirement and there is a process for staff to follow. As well as this [Mrs B] was available to assist with the insulin as she did.

iv. It is not clear if the medicines were removed, but if they were not how would [Mrs B] have given the insulin to [Mrs A]. [Mrs A] was not able or competent to administer her own insulin. Failure to do this is a serious breach of the expectations of the care provided.

2. Comment on the adequacy and timeliness of the care provided to [Mrs A] once admitted to [the rest home] until the end of her life.

a. Initial [rest home] assessment of [Mrs A]

This was done thoroughly and followed the process/form. The expectations of the care provided to [Mrs A] was adequate and meets the expectations of care provided.

b. Charting [Mrs A's] medications

[RN E] admitted [Mrs A]. The normal process of requesting the charting to be done by faxing the GP was done and then [RN E] finished shift (as below). It was recorded on the progress notes that [Mrs A] was on insulin and that her other medicines were not charted. RN C notes on the afternoon shift that the Medimap had not been updated by the GP.

By shift end there had no response and I handed over to the RN on the PM shift that follow up would be needed, also informed Clinical manager about this as well. I then left shift.

c. Clinical handover and documentation

There is no documentation provided about handover to the following shifts regarding [Mrs A's] care. In the afternoon clinical notes there is a reference to the need for the charting of the medicines and that [Mrs A's] daughter gave her the insulin.

d. Coordinating care with her (i) General practitioner (GP) and (ii) EPOA.

There is no evidence of follow up regarding getting the medicines charted. The afternoon [RN C] records this has not occurred but makes no mention of any actions taken to address this.

e. Blood sugar level monitoring and baseline observation; and there is no recorded information about the frequency of blood sugars required.

[Mrs A] would have required a BSL to be done before meals to determine the amount of insulin to be given. Even though the medicines were not charted, blood sugars should have been taken.

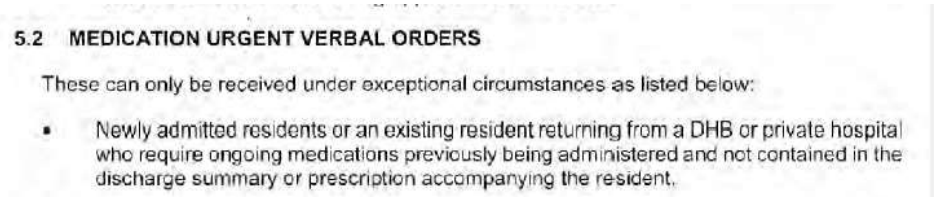
f. Actions taken as [Mrs A's] condition deteriorated.

[Mrs A] was up and about in the early hours of the morning and there are no reports of her appearing unwell. When she was found unwell and lying on the

bed, a blood sugar was done and the ambulance was called — these actions were correct.

3. [Mrs A's] conditions were not flagged as 'high risk' in any of the clinical documentation from [the rest home].

   [Mrs A] was a type two diabetic requiring before meal blood sugar readings and two types of insulin. As well as this, she also took warfarin which is a medicine that requires regular monitoring. [RN E] faxed the GP and wrote in the notes regarding the medications. There is no information that there was a plan in place if the GP did not complete the charting. The medications policy provides the option of requesting a verbal order to ensure [Mrs A] received her regular medicines.



5.2 MEDICATION URGENT VERBAL ORDERS

These can only be received under exceptional circumstances as listed below:

- Newly admitted residents or an existing resident returning from a DHB or private hospital who require ongoing medications previously being administered and not contained in the discharge summary or prescription accompanying the resident.

   The expectation would have been that there would be a plan in place for [Mrs A] — this would include pre meal blood sugar levels. Failure to plan this for a type two diabetic is a serious departure from the standards required in aged care.

4. What actions would be clinically indicated once it was known that [Mrs B] had administered her mother's insulin on the evening of [Day 1].

   [Mrs B] left a note for the RN stating insulin had been given. A phone call should have been made to clarify what the note meant. Once this conversation had been had it should have alerted the RN that a further dose of insulin was required. Failure to follow this up for a type two diabetic is a serious departure from the standards required in aged care.

5. Are the policies, procedures, protocols, and guidelines (PPPG), adequate in providing care for [Mrs A] at [the rest home], in particular:

   a. Admissions policy

      This is a standard policy and meets the requirements. An area of improvement would be to refer to medicine reconciliation.

   b. The service level agreement with the GP to assess in potentially urgent scenarios, such as obtaining medications for diabetic patients.

      There is no out of hours requirement in the GP service agreement to address this scenario. This is not uncommon for aged care providers.

   c. Escalation of GP contact attempts

      There was no escalation of the need to contact out of hours service to either the GP or the Pharmacy who could have provided a verbal order, the original prescriptions which the staff could have used to ensure [Mrs A] had her insulin. This is seen as a serious breach of expectations of the care provided.

d. Would any additional policies, procedures, processes or guidelines be warranted for patients with [Mrs A's] presenting conditions.

The insulin procedure is adequate and meets the requirements for staff administering insulin. An area of improvement would be adding a reference to Medimap for charting by GPs at admission or the use of the Pharmacy in the event the GP is not available/cannot be contacted. This may not be in the policy as not all of the group's facilities had fully electronic systems at the time of this incident.

The Medication Policy provides a process for obtaining a verbal order for newly admitted residents (as [Mrs A] was). This process was not followed. The medication policy has no information in it regarding medicine reconciliation and would benefit from this.

5.2 MEDICATION URGENT VERBAL ORDERS

These can only be received under exceptional circumstances as listed below:

- Newly admitted residents or an existing resident returning from a DHB or private hospital who require ongoing medications previously being administered and not contained in the discharge summary or prescription accompanying the resident.

Section 6 of the Medication policy states that the RNs and other staff groups are accountable for their actions.

ACCOUNTABILITY

All Doctors, Registered Nurses, Enrolled Nurses and Healthcare Assistants are accountable for:

- Their actions
- Their omissions
- Failing to take appropriate actions in the safe administration of medications
- Failing to adequately supervise the administration of medications by others for whom they are responsible
- Failing to question or seek clarification where a medication chart is not clear or appropriate with Oceania Healthcare policy
- Failure to question or seek clarification where medications are not available
- Ensuring that their practice is based on the best available clinical evidence

e. Admission procedure

A GP summary is a requirement at [the rest home] and as it was not provided a key piece of information was missing. Despite this the interRAI was provided and this has an overview of diagnoses and medications, however this did not record there were two types of insulin. There is no mention in the admission procedure or check list of medicine reconciliation which would ensure a closer inspection of the medicines [Mrs B] bought with them to the admission.

The admission procedure completed meets the requirements of an aged care facility.

In conclusion [Mrs A's] admission was planned and the interRAI information and [Mrs B] provided information including medicine information. The staff undertook a thorough admission assessment and told [Mrs B] they could not give the insulin until it was charted. [RN E] undertook to get this done by sending a fax saying [Mrs A] was being admitted on that day. The clinical notes had information regarding follow up to get the insulin charted. There is no information that this was identified as an important matter to follow up by either the Clinical Manager or the afternoon RN. [Mrs B] visited with her mother for the afternoon — and returned in the early evening to hear her mother say that she had not had her insulin. [Mrs B] gave her mother insulin and left a note for the [RN C] that [Mrs A] had her short acting insulin, and this was recorded in the afternoon shift notes. Even if [Mrs A] did not require further insulin in the evening, she would need insulin well before a GP could be contacted the following morning to complete the charting. There was the medications policy stating a verbal order could be obtained or [Mrs B] could have returned to administer the second dose or keep her mother at home for one more night.

There are a number of serious departures from the standards of care required for [Mrs A], these include points:

1. It is not clear if the medicines were removed, how [Mrs B] gave the insulin to [Mrs A]. [Mrs A] was not able or competent to administer her own insulin. Failure to remove these medicines is a serious breach of the expectations of the care provided.
2. [Rest home] staff did not follow their own policy and requirements for a new admission has meant serious breach of the expectations of the care provided.
3. Not identifying [Mrs A's] need to have her medication charted and establishing a plan for this is a serious breach of the expectations of the care provided.
4. Not following up with [Mrs B] about the insulin administration was a serious breach of the expectations of the care provided.
5. Failure of escalating attempts to contact the GP was a serious breach of the expectations of the care provided.

Given that the information was documented that charting was still necessary and there was other staff available to do this it is difficult to determine exactly who was responsible for this failure.

End of report

Julia Russell, RN, Masters Phil (Nursing)"

The following further expert advice was obtained from RN Russell:

"This report is a review of further material following a report sent to [HDC] on the 21 October 2020. The report was regarding the care provided to [Mrs A] at [the rest home] following her admission on [Day 1]. [Mrs A's] daughter, [Mrs B], complained as she had

concerns about the care of her mother by [the rest home], which is part of the Oceania Group.

The purpose of this report is to provide comment on any change to the initial report and provide comment on the actions taken since [Mrs A's] admission and discharge from [the rest home]. Documents reviewed as part of this review include a 20 March 2021 letter to the Health and Disability Commissioner from [Dr I], General Manager Nursing and Clinical Strategy of Oceania. There are also responses from two of the Registered Nurses (RNs) involved in [Mrs A's] care, [RN C] and [RN D]. The two RNs have no recollection of the shift/time and situation, both have left their employment at [the rest home].

[Dr I's] letter identifies deficits in care of [Mrs A] and apologises to [Mrs B] for the inadequate quality of care provided to [Mrs A] in the short time she was at [the rest home]. The deficits identified include shortfalls in the nursing care and follow up with the General Practitioner around medication requirements that would have enabled them to manage her medication appropriately. Further to this there were shortcomings in the quality of the communication between both the nursing staff (handover), between the staff and [Mrs B].

[Dr I] identifies a number of issues which include:

a. There is no specific Oceania Policy that provides information on when to escalate care issues to a GP/Nurse Practitioner (NP). Some Oceania policies have reference to this, e.g. the Falls Management Policy refers to GP/NP escalation following a fall. Oceania's RN study days make reference to STOP AND WATCH and the use of the ISBAR form with clinical reasoning guide reference from the Frailty Care Guides (Health & Quality Commission 2019) which also contributes information on escalating issues.

b. There is no evidence that the RNs attempted to gain a verbal order for the required medication. This should not have been required given that a GP had access to the Medimap system and [Mrs A] had already been added into the system. The safer option would be that the GP add the prescription straight onto Medimap.

c. [RN D] was the Clinical Manager employed during this period and was on duty at the time of the admission. On this occasion she should have followed up with the medical practice to ensure that any issues had been addressed and any urgent information received, especially in regard to medication prescriptions before she left the facility for the day. There is no evidence to suggest that on this occasion the Clinical Manager did this.

d. There were no initial observations taken at the time of admission, although these were only required within the first 24 hours of admission. It would have been appropriate on this occasion, to take a blood sugar level, as well as a temperature recording, given that the RN suspected the development of cellulitis on [Mrs A's] left leg and a possible infection to an area on her right foot; these were described in the

admission progress note entry. Both observations of possible infection would have had the potential to raise blood sugar levels and temperature should have guided short-term care planning.

e. Progress note entries did not suggest any follow up plans with regards to further observations to be made by the nurses or what plan might be put in place to ensure that [Mrs A] was able to receive her medication. This is a serious shortfall by both the morning and afternoon RNs and the Clinical Manager. There is no evidence to suggest any escalation of the problems to the Business and Care Manager and no evidence of further options being discussed with [Mrs B].

f. Lack of follow up by the afternoon nurse, [RN C], with regards to the note left by [Mrs B]. [RN C] has indicated in her afternoon shift progress note entry that she understood that all the medications, including the insulin, had been given by the daughter, however this was not clarified. The list of medications and doses given, were not recorded within the progress note entry. The insulin dose given by [Mrs B] should have been recorded.

g. Expectation of the RNs would take regular blood sugar levels (BSL), at least pre-meal. There was a shortfall by the RNs across all shifts, especially as the evening blood sugar recording taken by [Mrs B] indicated a reading that needed some immediate nursing/medical intervention. Blood sugar levels were taken just prior to [Mrs A's] admission to hospital on the morning of [Day 2].

h. Communication was lacking in many areas:

    i. Communication between RNs and [Mrs B] regarding possible options for further medication administration (as the GP failed to provide a prescription).

    ii. A lack of clear RN handover and follow up contingency plans between morning and afternoon shifts.

    iii. Lack of urgent follow up with the medical practice and GP during [Mrs A's] short admission to ensure that important information was received by them.

i. [RN C's] afternoon shift progress note entry suggested that [Mrs B] had administered all medications including insulin to her mother during her visit. However, there is no indication that this was clarified with [Mrs B] and no indication of the amount of short acting insulin that had been given by [Mrs B] in response to her mother's high blood sugar level, as indicated on her BSL check taken at the time. This lack of information would have played a part in the communication held with the GP or other medical practitioner regarding further insulin requirements for the rest of the evening.

The deficits that [Dr I] identifies in her letter confirm the issues in the original report regarding this matter. In the matter of whether the medications were taken away from [Mrs B] and [Mrs A], [Dr I] points out the medication was given back indicating it had

been removed and then returned. This would need to be corrected in the initial advice given, paragraph 1(i).

Further to these deficits [Dr I] identifies areas of improvement that have occurred. These include improvement to policies and study days.

- The insulin administration policy has been reviewed with guidance into medication reconciliation at the time of the admission. As yet there is no process to guide staff when blood sugars are outside of usual parameters. This policy will be reviewed to include guidance on this.
- A review of the insulin administration policy includes guidance into medication reconciliation at the time of the admission. As yet there is no process to guide staff when blood sugars are outside of usual parameters. This policy will be reviewed to include guidance on this.
- Since this event there has been a change in Senior Management at [the rest home] and the site is supported by a Regional Clinical Manager.
- Oceania has launched a new resident management system (eCase) which ensures better visibility by the Clinical Manager into the current care requirements, admission assessment, care planning and follow up.
- Due to the ongoing out of hours/on-call provision to the facility by GP services there is an agreement with the DHB that the RN can contact the Emergency Department at the public hospital for advice and support of a deteriorating resident.
- As an ongoing solution to GP service provision Oceania has recruited four Nurse Practitioners. These Nurse Practitioners are based at, and work between, facilities in the area. Oceania has also contracted with a Nurse Practitioner service to provide on call and out of hours care. This has commenced in the Auckland region and is expected to be rolled out to provide the service to other regions.
- Since this event, the facility has provided further training and education to the nurses regarding the admission process and insulin admission protocols. Education records and meeting minutes were attached.

The deficits in care identified in the original advice given are consistent with [Dr I's] points a-1. Furthermore, the areas of improvement demonstrate a concerted effort to ensure improvement in the services the facilities are able to provide to residents and their families/whānau.

End of report.

Julia Russell RN, M Phil (Nursing)"

Appendix B: Policies

Insulin policy

[The rest home] has a specific policy regarding the administration of insulin, the Insulin Administration Policy and Protocol (July 2012) (the Insulin Protocol). This states that the following must be established on admission:

- A prescription for insulin is available
- When the insulin was last administered
- The type of insulin that was administered and any special requirements for mixing of insulin doses
- Dose and time(s) to be administered
- Last blood sugar level
- Required frequency of blood sugar level testing
- Charting blood sugar parameters

Medication management policy

[The rest home] also has a policy to ensure that medication is managed and administered safely and properly, the Medication Management Policy (January 2012).

This states that Clinical Managers are responsible for "assisting with the provision of safe medication systems within the facility" and "monitoring staff practice and compliance with policy". The Clinical Manager during these events was [RN D].

The policy also states that medication may be withheld from a resident only if an RN clinically assesses them and finds that administration of the medication may compromise their health status. Withholding medication must be documented on Medi-Map along with reasoning for withholding.

The policy provided for urgent verbal orders for medication to be taken in exceptional circumstances, including "newly admitted residents … who require ongoing medications previously being administered and not contained in the … prescription accompanying the resident".

The policy states that registered nurses are accountable for: failing to take appropriate actions in the safe administration of medications, failing to question or seek clarification where a medication chart is not clear or appropriate with Oceania Policy, and failing to question or seek clarification where medications are not available.

The policy also includes a section on the administration of warfarin (the Warfarin Protocol). This states:

> "This Policy/Protocol is achieved when the following happens:
>
> Registered nurses receive education on safe medication administration and understand:
>
> a. The medical history of the resident and rationale for anticoagulant therapy; and
> b. The pharmacology of anticoagulant therapy."

It states that the admitting nurse checks to ensure the discharge summary and prescription from the referring organisation includes: the prescription for warfarin, when it was last administered, the dose to be administered, the last INR level, and when the next INR test is due. The policy states that if a blood INR report does not accompany the resident, the nurse refers back to the discharging ward on the day of admission. This protocol also notes that diet can affect anticoagulant medications. Therefore, the resident's dietary profile should be altered and the kitchen management notified.