Radius Residential Care Limited
Registered Nurse, Mr B
Registered Nurse, Ms C

A Report by the
Deputy Health and Disability Commissioner

(Case 12HDC01091)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2012, Mr A, aged 86 years, was discharged from a public hospital and admitted to a private rest home/hospital (the rest home) after being assessed as requiring 24 hour hospital level care.

2. Registered Nurse (RN) B completed Mr A's admission assessments and initial care plan at the rest home, and noted that Mr A was diabetic and required mildly thickened fluids to prevent aspiration pneumonia.

3. Following Mr A's evening meal on Day 6 of his admission[1], Healthcare Assistant Ms E noted that Mr A was finding it hard to communicate and breathe. Ms E reported Mr A's condition to RN B, who immediately assessed Mr A. RN B noted that Mr A's breathing was "chesty and gurgly". RN B considered that Mr A was experiencing his "usual respiratory distress" and commenced Mr A on oxygen at a rate of three litres per minute. RN B advised that Mr A's condition improved on oxygen, but he did not record that in the clinical records.

4. RN B handed over Mr A's care to RN C at approximately 11pm that evening. RN C assessed Mr A as not warranting hospital admission or medical intervention. At 2.30am on Day 7, Mr A complained of not being able to breathe, and RN C increased his oxygen to four litres per minute without checking whether oxygen therapy had been prescribed. RN C did not record Mr A's response to the oxygen.

5. At 7:45am on Day 7 RN C recorded that Mr A remained "dyspnoeic and gurgly", and Mr A was transferred to the public hospital.

6. While RN B's initial assessments and care plan for Mr A were appropriate, he failed to respond appropriately to Mr A's signs and symptoms on the evening of Day 6, and to escalate his concerns to Mr A's general practitioner or refer Mr A to hospital. Accordingly, RN B breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights 1996 (the Code).[2]

7. RN C also failed to respond appropriately to Mr A's signs and symptoms on the night of Day 6 to Day 7, by failing to escalate her concerns to Mr A's GP for advice, or refer Mr A to hospital. Accordingly, RN C breached Right 4(1) of the Code.

8. Radius Residential Care Limited (Radius), which owned and operated the rest home, breached Right 4(1) of the Code for failing to have appropriate senior staffing in place, failing to provide sufficient clarity in its Incident Report Policy on the types of events that should be reported, and for failing to ensure its staff met the required standards for documentation.

9. Adverse comment was also made about Radius' communication with Mr A's wife on Day 6 and Day 7.

[1] Dates of Mr A's admission are referred to as Day 1 – Day 7 to protect privacy.
[2] Right 4(1) of the Code states: "Every consumer has the right to have services provided with reasonable care and skill."

Complaint and investigation

10. The Deputy Commissioner received a complaint from Mrs A about the services provided to her husband, Mr A at a rest home, which, at the time of these events, was owned and operated by Radius Residential Care Limited.[3] The following issues were identified for investigation:

- *Whether Radius Residential Care Limited provided an appropriate standard of care to Mr A in 2012.*
- *Whether RN B provided an appropriate standard of care to Mr A in 2012.*
- *Whether RN C provided an appropriate standard of care to Mr A in 2012.*

11. An investigation was commenced on 4 September 2013. This report is the opinion of Ms Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner. The parties directly involved in the investigation were:

Mrs A	Complainant
Radius Residential Care Limited	Provider
RN B	Registered nurse
RN C	Registered nurse
RN D	Facility manager, registered nurse
Ms E	Healthcare assistant

Also mentioned in this report:

RN F	Registered nurse
Dr G	General practitioner

12. Information from all these parties was reviewed during the investigation.

13. Information from the District Health Board (on behalf of the public hospital) was also reviewed during the investigation.

14. Independent expert advice was obtained from in-house clinical advisor RN Dawn Carey, and is attached as **Appendix A**.

Information gathered during investigation

Mr A — overview

15. Mr A had a history of ischaemic heart disease (IHD), previous myocardial infarction, type 2 diabetes mellitus, deep vein thrombosis, and had had a left knee joint replacement and a left hip joint replacement.

[3] Radius Residential Care Limited sold the rest home on 31 August 2013.

16. Mr A, who was 86 years old and living at home, suffered a fall following which he developed confusion, drowsiness, and weakness in the limbs on his left side. The following day Mr A was admitted to the ED at the public hospital, and he was diagnosed as having a subdural haemorrhage and a secondary subarachnoid haemorrhage.

17. During his hospitalisation Mr A developed acute and chronic renal failure, and was noted to be short of breath. Mr A's public hospital progress notes state:

> "… He becomes short of breath with minimal exertion … He has the tendency to choke when swallowing fluids so has them mildly thickened."

18. Mr A was discharged from hospital and transferred to the rest home, which was owned and operated by Radius Residential Care Limited (Radius), as, following his fall, he required 24-hour hospital level care. Mr A's "[Multi-disciplinary team] Patient Discharge Summary" from the public hospital states, "[Mr A] has been re-trialled on thin fluids throughout his stay, however continues to have difficulty with this consistency and as such is unsafe on thin fluids currently".

19. At that time, RN D was part-time facility manager at the rest home and part-time facility manager at another Radius facility, pending the appointment of a new facility manager at the rest home the following month. There was no clinical manager employed at the rest home at that time, although Radius advised HDC that the clinical manager of another facility was available to be contacted, and visited the rest home a minimum of two to three times a week.

Care provided by RN B

From admission to the rest home to Day 4

20. RN B was employed at the rest home as an RN.[4] RN B undertook Mr A's admission assessments and put in place an initial care plan for him. The care plan stated that Mr A was diabetic and required mildly thickened fluids. The admission notes also state, "slightly thickened fluids to prevent aspiration pneumonia and regular oral cares needed. Medications to be taken by [illegible] with mildly thickened fluids …"

21. RN B advised HDC that during this time Mr A appeared frail and totally dependent for daily living. He said that Mr A was breathless in exertion and in rest, and was using inhalers to relieve his dyspnoea.[5] RN B told HDC that Mr A usually had a poor appetite and would get breathless when he ate. He stated that Mr A was dependent on staff to be fed as he was too frail to feed himself.

[4] Radius' Registered Nurse job description states that the "Main Purpose of the Job" is "…to provide professional nursing care to clients to optimise their health, level of function and wellbeing and provide support for family/Whanau." The RN job description also states "Anticipating deterioration and subtle changes in Resident's health status before explicit signs are obvious and acting accordingly".

[5] Dyspnoea is an uncomfortable awareness of one's breathing effort. It is a normal symptom of heavy exertion but becomes pathological if it occurs in unexpected situations.

22. On Day 2, general practitioner Dr G assessed Mr A and confirmed that Mr A had the capacity to participate in discussions regarding power of attorney, and personal finance and health issues.

23. On Day 3, RN B recorded in the progress notes at 2.30pm "choking when taking medications whole. Crushed and gave it with apple mildly thickened fluids preferred". There is no incident form relating to an event of choking on Day 3.[6]

24. In response to my provisional opinion, RN B told HDC that while he acknowledges that he mentioned "choking" in the notes for Day 3, that this event was "really more of a coughing type episode". RN B stated:

> "When [Mr A] took the medication as whole pills he had a cough in the sense of a basic reflux. I did not see it as an incident or accident and did not consider that an incident form was necessary."

25. On Day 4, RN B recorded that Mr A was "getting breathless when doing his cares and turning him on bed".

Respiratory distress — Day 6

26. Healthcare Assistant Ms E advised HDC that she recalls caring for Mr A on the afternoon and evening of Day 6. She stated that when she commenced her shift Mr A was sitting up in bed and was in a "very unsettled state". She said that Mr A was finding it hard to communicate and was having problems with breathing. Ms E advised that she reported Mr A's condition to RN B who told her he would check on Mr A. Ms E told HDC that she saw RN B check on Mr A "a number of times" during the shift.

27. Ms E also told HDC that she recalls taking Mr A a tray of food at "supper time", which included "thickened … vegetable soup". She stated that she recalls helping him initially to take a few sips of soup, but then he was able to feed himself unsupported "with the sipper cup in his hands". She state that when she checked on him later on he was still sitting upright but had fallen asleep with his cup in his hand and that he had drunk most of the soup. However she went on to describe his condition soon after that:

> "I remember when I checked him approximately 20-25 min later he was awake and in a very anxious state, he asked me to help him sit up more as he was having difficulty breathing. I quickly raised him up to an upright position and tried to calm him by telling him to take deep breaths to control his breathing and to ease his anxiety … I rushed out and got [RN B] … He rushed there straight away and [Mr A] was administered oxygen, from what I observed [Mr A's] breathing had become gurgley (sic) and had gotten worse."

[6] See paragraphs 54 to 58 for information on Radius' incident reporting policy.

28. RN B advised HDC that at 8.30pm Ms E reported to him that Mr A "had respiratory distress…was having difficulties in breathing after supper time …". RN B told HDC that this was the first time that Ms E reported to him regarding Mr A's unsettled state.

29. RN B said that he assessed Mr A in his room, and he noted that Mr A was conscious, interactive and verbally responsive. RN B considered that Mr A was experiencing his "usual respiratory distress" which he had after exertion. RN B advised HDC that Mr A "usually developed respiratory distress (breathless, chesty, dry cough) after he had his meals". RN B recorded the following in Mr A's progress notes:

> "[Mr A] became unsettled after his supper. Breathless ++, inhalers given as prescribed. Elevated[7] his bed head…Responding well to the verbal commands, dry cough (unproductive cough) evident. Chesty and gurgly, especially after the meals and in exertion. Reasonable fluid intake but poor dinner even after a lot of encouragement."

30. RN B checked Mr A's vital signs and his oxygen saturations which, at 84%, were below normal.[8] RN B started Mr A on oxygen therapy, at a rate of three litres per minute. RN B advised that the usual practice at the rest home at that time was to give oxygen to patients in respiratory distress and this would be signed off by the doctor later.

31. Ms E recorded in Mr A's notes: "[Mr A] has not eaten very much on pm shift he had vege soup 250ml of fluid. Very unsettled 8.30pm [RN B] has given oxygen to help him to breath (sic)."

32. RN B and Ms E advised HDC that after the oxygen was started Mr A showed signs of improvement. RN B stated that he subsequently tested Mr A's saturation level which was slightly improved and in the lower range of normal at 90%, however this is not recorded in Mr A's clinical notes. RN B advised that he checked on Mr A "a number of times" before the end of his shift at 11pm. However, there are no other records in the progress notes for this shift, other than Ms E's entry as outlined above.

33. RN B told HDC that he did not consider that Mr A's condition was life threatening, so he did not inform Mr A's family, his GP or the hospital. He stated, "I assessed [Mr A] as having dyspnoea associated with [chronic obstructive pulmonary disease] or asthma and he did not show any obvious signs of choking".

Care provided by RN C

Night shift Day 6–Day 7

34. RN C[9] stated that RN B gave her a verbal handover at the commencement of her night shift on Day 6. She recalls that RN B told her that Mr A had been given "200mls of

[7] In response to the provisional opinion Mrs A disputed that Mr A's bed could be elevated.
[8] Normal oxygen saturations are between 95-98%, however, in an elderly patient it is not unusual to have an oxygen saturation level as low as 90%.
[9] RN C is no longer employed at the rest home.

hot chocolate" for supper by his caregiver,[10] and that RN B also advised her that Mr A's oxygen saturation levels were reduced so he had commenced oxygen therapy.

35. RN C told HDC that at the beginning of her night shift, she assessed Mr A as "not warranting hospital admission for medical intervention".

36. RN C told HDC that during the night she and a caregiver monitored Mr A "half hourly to hourly". Between 1.30 and 2.00am, RN C recalls that she and a caregiver assisted Mr A to reposition himself onto his side. She stated that half an hour later Mr A was no longer comfortable in this position so she repositioned him to be sitting upright. She stated that, at this point, Mr A complained of "not being able to breathe". She stated that at this time she believed Mr A's breathlessness was due to his exertion in repositioning himself.

37. At 2.30am RN C wrote in Mr A's clinical notes:

> "Repositioned [Mr A] on his side, not comfortable after 1/2 hr. Returned to sitting upright. Anxious [complains of] 'not being able to breathe'. O2 via nasal prongs increased to 4 L/min. O2 stat 90% [pulse] 86, [respiratory rate] 24. Requested I suction oral cavity. [Mr A] unable to expectorate.[11] Sips of slightly thickened fluid given. Has bedcradle in situ to alleviate weight of bedlinen."

38. RN C stated, "without checking that oxygen therapy had been prescribed I increased the flow level to 4L/min" and recorded Mr A's vital signs. RN C stated that she did not record any other findings, including Mr A's response to the oxygen flow.

39. RN C stated that Mr A was awake at 3.30am but after that he was sleeping when she or the caregiver checked him.

Morning shift — transfer to hospital

40. RN C recorded at 7.45am on the morning of Day 7, that Mr A:

> "remain[ed] dyspnoeic and gurgly [Dr G] contacted 0720hrs. Informed of [Mr A's] deterioration in condition since [the evening of Day 6]. Advised transfer to [the public hospital]. ?aspiration. Wife aware of transfer."

41. There are no records regarding Mr A's condition between 2.30am and 7.45am.

42. RN C told HDC that she decided that Mr A should be transferred to hospital after RN F arrived for the morning shift. RN C told HDC that RN F was not familiar with the hospital transfer procedure so RN C assisted in filling out the necessary paperwork.

43. RN F advised that she contacted Mr A's wife, Mrs A, to inform her that Mr A was being transferred to hospital. RN F recorded:

[10] This appears to be a reference to the vegetable soup given to Mr A by Ms E at supper time (see paragraph 27). It does not appear that a separate drink of hot chocolate was given.
[11] To eject or expel matter, as phlegm, from the throat or lungs by coughing or hawking and spitting.

> "7.00am. Informed his wife about the transfer. Informed the emergency department about the patient condition. Rang the ambulance … Ambulance reached at 7.45am."

44. In contrast to RN F, Mrs A advised HDC that she was not contacted by the rest home at 7.00am. She told HDC that she contacted the rest home at 7.30am to "see how [her] husband was" and was informed that there had been an "incident" after supper the night before and Mr A was being transferred to hospital but that he was "ok". She stated that she was not informed of the seriousness of her husband's condition. Mrs A contacted the public hospital a short time after being advised that Mr A was being transferred and was told that she needed to come to the hospital urgently. By the time Mrs A arrived at hospital Mr A was unconscious.

45. The "Transfer Form", completed by RN C, states as the reason for transfer to the public hospital:

> "Deterioration in condition since [Monday] evening. ? aspiration following a drink. Became dyspnoeic and gurgly . O2 via nasal prongs overnight at 4 L/min."

46. St John Ambulance records state:

> "History of being given late night snack last night. Staff noticed soon after pt [patient] had "gurgling" breath sounds. Thought pt had aspirated. Left overnight. Phoned ED [emergency department] for advice this am → ambulance called…"

47. Mr A arrived at hospital at 8.30am, and was noted to be in respiratory failure. The public hospital triage notes state:

> "Unwell since last night — given a drink then developed noisy breathing ?Aspirated. Now this AM had low sp02[12] (in 70–80s) & pt [patient] deteriorated O/E [on examination] Pt sitting up, non verbal, very mottled Ø peripheral[13] pulses. Poor respiratory effort."

48. Further the public hospital clinical notes record: "Had 'trouble' with evening liquids/meal last night ↑resp distress overnight…" Mr A died at approximately 11.30am on Day 7.

Further information obtained during HDC's investigation

"Choking incident" Day 6

49. Mrs A told HDC that a doctor at the public hospital told her that he thought Mr A had choked on something that had caused him to aspirate, and had resulted in respiratory failure. Mrs A told HDC that she was very unhappy that she was not informed "that there had been an incident of choking at supper time...".

[12] Saturation, Pulse Oxygen. The abbreviation Sp02 reading indicates the amount of oxygen being carried by red blood cells and indicates how effectively a patient is breathing and how well blood is being transported throughout the body. The average reading for a normal, fit adult is 96%.

[13] A pulse on a person's peripheral like on a wrist or a foot. Absence of a peripheral pulse may be an indication of severely low blood pressure.

50. Radius' "On-call/Emergency Assistance Policy and Procedure" stated: "Family/Whanau are always to be contacted where a client's condition has changed…Ongoing attempts must continue … to contact family/Whanau until contact is made."

51. Ms E told HDC: "I honestly do not recall any choking incident that has been alleged". RN B advised: "I was not present when [Ms E] was feeding [Mr A] his supper" and that Ms E "did not mention choking".

52. Facility Manager RN D advised HDC that when she arrived for her shift on Day 7 RN F advised her that Mr A did not look well so RN F had sent him to hospital. RN D advised that, by the time she arrived, Mr A had already been taken to hospital, and RN F did not seem concerned and did not say that Mr A had choked the night before.

53. In response to my provisional opinion RN B told HDC that while he did check on Mr A a number of times during his shift on the evening of Day 6, he did not record all of these due to time limitations. RN B further told HDC in response to my provisional opinion that:

> "… I checked on [Mr A] a number of times and my assessment was that his respiratory distress episode was relieved by oxygen therapy. Likewise there seems to have been no indication from [RN C] that [Mr A] was struggling to breathe at the start of her shift (23.00hrs). It was only after 2.00 that she noted difficulty in breathing, and that seemed to be on exertion with repositioning.
>
> I accept that I should have documented more on the night of [Day 6]. However … I do not accept that there were indications for second level treatment being required by the end of my shift."

Incident reporting

54. Radius' incident report policy, valid at that time, stated:

> "Reporting
>
> - All Accidents/Incidents/Near Misses MUST be reported on the form available in all facilities.
> - Any serious accident/incident must be reported IMMEDIATELY to the Facility Manager.
> - All accidents/incidents/Near misses MUST be reported to NOK/EPOA/Family/Whanau on that shift or within 24 hours. This needs to be indicated as done on the accident/incident form and details of the event and notification to the family."

55. The policy further stated:

> "The accident form must be completed for every accident that harmed or might have harmed … clients of Radius Residential Care Ltd…The Accident/Incident/Near Miss Form must record every occurrence of … injury …"

56. RN B stated that he did not complete an incident form because he was "not aware of any choking by [Mr A]". RN B stated that he believed that Mr A was experiencing similar breathlessness to what he had on previous occasions.

57. Radius told HDC that the rest home staff failed to complete an incident form following Mr A's "choking incident" on the evening of Day 6. Radius advised HDC that, at that time, the relevant Incident/Accident form did not specify bruising or choking as a reportable event. Radius stated that for this reason staff had not identified the choking incident as a reportable event.

58. As a result, later in the year, Radius Care Operations Management Team reviewed and updated the incident form to include "bruising" and "pressure injury" as well as "other events" to allow events such as choking to be included as an identifiable event to be reported and investigated. Radius provided HDC with a copy of this updated policy.

Internal investigation

59. Radius has undertaken an internal investigation into the care provided to Mr A. It stated that "correct judgements were not made by two registered nurses during the time [Mr A] became unwell prior to his transfer to hospital on [Day 7]".

60. Following the investigation Radius made the changes outlined above, as well as the following:

a. Radius has had two follow-up meetings with Mrs A to discuss the incidents leading to her husband's death, as well as the results of its internal investigation.

b. Compulsory training for all registered staff on documentation, communication and following guidelines for acute illness has been implemented. The following training was completed in 2012:

i. Documentation/Duty of Care and professional boundaries;

ii. Nursing Assessment and Clinical documentation and effective communication;

iii. End of life cares;

iv. Nutritional requirements of Older Adults;

v. Falls prevention and management; and

vi. The Code of rights and advocacy.

c. As well as group training all RNs have received individual training and mentoring on site, and further mentoring and education held off site in 2012.

61. Radius also advised HDC that, prior to this incident, it commenced a review of all Radius policies and procedures to ensure that they reflect evidence based best practice. Radius advised HDC that this review has been completed subsequent to Mr

A's incident, and that all policies are now updated to "current best practice standards".

62. Radius' Regional Manager told HDC that, following these events, she visited the rest home at least fortnightly in order to undertake random checks including file audits, wound audits, medication audits, incident form checks, and to speak with staff and clients to gauge level of satisfaction. She stated that the results of her review were fed back to the Facility Manager at the rest home.

RN B

63. RN B advised HDC that, since these events, he has completed Aged Concern training as well as training provided by his employer. He advised that, over a couple of months, he attended weekly training sessions with the new Facility Manager at the rest home, and that the new Facility Manager assessed him and was satisfied at the improvements he had made.

RN C

64. RN C is not currently practising as an RN and is not currently registered with the Nursing Council of New Zealand (NCNZ).

Opinion: Preliminary matters

"Choking incident"

65. On the evening of Day 6, Healthcare Assistant Ms E asked RN B to check on Mr A because Mr A was struggling to breathe after eating his dinner and having trouble communicating.

66. Mrs A informed HDC that on the morning of Day 7, she was told by rest home staff that there had been an "incident" after Mr A's supper the evening before. In addition, it is recorded in both the rest home's "Transfer Form" and the ambulance records that Mr A appeared to have aspirated the evening before following a drink or late night snack.

67. In contrast, Ms E told HDC that she "[did] not recall any choking incident…" and RN B told HDC that Ms E "did not mention choking". There is no record of a choking incident in Mr A's clinical records, or in any incident reporting form, from the rest home. Further, there is no evidence from those present that Mr A's breathing difficulties followed a choking incident.

68. While I am unable to determine the exact nature of any incident following Mr A's supper on the evening of Day 6, it is evident that Mr A's condition deteriorated. Mr A's symptoms warranted a timely referral to either his GP or to hospital, which the RNs caring for him failed to do.

Opinion: RN B

Initial care plan — No breach

69. RN B was responsible for admitting Mr A to the rest home and putting in place an initial care plan.

70. As noted by my expert advisor, RN Dawn Carey, Mr A's initial assessment and care plan at the rest home "correctly identified his specific nutrition requirements", and also correctly noted his food and fluid texture needs.

71. I accept RN Carey's advice that the initial assessments and plan of care to manage Mr A's risk of aspiration were appropriate, and in accordance with accepted standards. Accordingly, RN B did not breach the Code in respect of his initial assessments and the care plan he developed for Mr A on Mr A's admission to the rest home.

Response to Mr A's deterioration — Breach

72. RN B advised HDC that, at 8.30pm on the evening of Day 6, Ms E reported to him that Mr A was having difficulties breathing. RN B advised that he assessed Mr A in his room, and noted that Mr A was conscious, interactive and verbally responsive. RN B documented in the clinical notes that Mr A was "[c]hesty and gurgly", and Ms E also documented that Mr A's breathing "had become gurgley [sic] and had gotten worse".

73. RN B considered that Mr A was experiencing dyspnoea and respiratory distress after exertion, which was usual for him. RN B checked Mr A's vital signs and his oxygen saturations, which were below normal at 84%. RN B started Mr A on oxygen, at a rate of three litres per minute. RN B also gave Mr A his inhalers, as had been prescribed.

74. RN B advised HDC that Mr A improved on oxygen, and his oxygen saturations rose to 90%. This is not documented in Mr A's progress notes. RN B said that he checked on Mr A a number of times before his shift ended at 11pm, and at no time did he consider that Mr A's condition was life threatening, so he did not contact the hospital, Mr A's GP or Mrs A. RN B did not make any entries in the progress notes after 9.15pm.

75. RN Carey is critical of the nursing care provided to Mr A in response to the signs and symptoms that Mr A presented with on Day 6, regardless of whether a choking incident had occurred. In particular, RN Carey advised that the descriptions of Mr A's breathing as "chesty and gurgly" should not be applied to a person's respiratory system without some concern, particularly in the context of a resident with an impaired swallow. RN Carey stated, "I would expect that a RN attributing descriptors such as 'chesty and gurgly', would be concerned and would escalate those concerns to the resident's GP or to a senior RN for advice".

76. RN Carey noted that Mr A's respiration was compromised on the evening of Day 6, more than his normal level of dyspnoea, and this is evidenced by the fact that Mr A required oxygen, which was a new intervention. By the end of RN B's shift at 11pm, Mr A had received three litres of oxygen therapy for more than two hours, and

continued to require it. While RN B advised HDC that Mr A improved on oxygen therapy, this is not documented.

77. I accept RN Carey's advice that, while RN B "acted appropriately in instigating first level treatment – assessment, oxygen, monitoring", RN B did not instigate appropriate "second level treatments", including escalating his concerns to Mr A's GP, and/or transfer to hospital. I accept RN Carey's advice that RN B's nursing care of Mr A in this respect departed from accepted standards of nursing care to a moderate degree.

78. I acknowledge that RN B did not have the support of a clinical manager and only had the support of a part time facility manager who was not on shift at the relevant time. However, RN B's job description required him to "[anticipate] deterioration and subtle changes in Residents health status before explicit signs are obvious and [act] accordingly", and in any event, the ability to take such action is a basic nursing competency. As such, and as a registered nurse, RN B must take responsibility for the shortcomings in the care he provided to Mr A.

79. In my opinion, for the reasons set out above, RN B failed to provide services to Mr A with reasonable care and skill on the evening of Day 6, and breached Right 4(1) of the Code.

80. Since the incidents involving Mr A, RN B has provided a written apology to Mrs A for the shortcomings in his care of Mr A. RN B has undergone additional training following Radius' internal investigation into the care provided to Mr A.

Opinion: RN C

Response to Mr A's deterioration — Breach

81. RN C provided care to Mr A on the night of Day 6 to Day 7. At the start of her shift, RN C received a verbal handover from RN B. She recalls being told at handover that Mr A's oxygen saturation levels were reduced, and so RN B had started him on oxygen therapy.

82. RN C said that she assessed Mr A at the start of her shift as not requiring hospital admission. She also said that she and a caregiver continued to monitor Mr A "half hourly to hourly" throughout the night, and assisted him to reposition himself on two occasions.

83. At 2.30am on Day 7, RN C recorded in Mr A's clinical notes that he was anxious and complaining of not being able to breathe. RN C also recorded that Mr A's oxygen saturations were at 90%, and she increased Mr A's oxygen to four litres per minute. RN C advised HDC that she did this without checking whether oxygen therapy had been prescribed for Mr A.

84. RN C did not record Mr A's response to the increased oxygen therapy. However, on the morning of Day 7 she observed that Mr A "remain[ed] "dyspnoeic and gurgly" and she decided to transfer Mr A to hospital. RN C and RN F arranged for Mr A's transfer for "? Aspiration". RN C did not record any changes in Mr A's condition between 2.30am and 7.45am, or provide any information regarding why she failed to arrange transfer to hospital earlier than 7.45am.

85. My expert advisor, RN Dawn Carey, is critical of the nursing care RN C provided to Mr A on the night of Day 6 to Day 7. In particular, RN C failed to recognise that Mr A was deteriorating and showing signs of respiratory compromise.

86. As noted above, RN Carey advised that the descriptions of Mr A's breathing as "chesty and gurgly" should not be applied to a person's respiratory system without some concern, particularly in the context of a resident with an impaired swallow. RN Carey advised that she would expect such concerns to be escalated to the resident's GP or to a senior RN.

87. RN Carey further noted that Mr A's respiration was compromised on the night of Day 6 to Day 7, more than his normal level of dyspnoea, and this is evidenced by the fact that Mr A required oxygen, which was a new intervention.

88. RN C failed to act appropriately in response to Mr A's signs and symptoms. She should have contacted Mr A's GP or transferred Mr A to hospital in a timely manner. RN Carey is especially critical of the fact that Mr A's GP was not contacted until approximately ten hours after Mr A first showed signs of respiratory failure. I note that RN C was on shift from at least 11.00pm on Day 6 and Mr A's GP was not contacted until eight hours later.

89. I accept RN Carey's advice that the standard of nursing care RN C provided to Mr A on the night of Day 6 to Day 7 was a moderate to severe departure from accepted standards. Accordingly, I find that RN C failed to provide services to Mr A with reasonable care and skill, and accordingly, breached Right 4(1) of the Code.

90. Since the incidents involving Mr A, RN C has written a short letter of apology to Mrs A for the shortcomings in her care of Mr A. In addition, RN C attended a course in "Professional Issues for Nurses". I note that RN C is no longer registered as a nurse.

Opinion: Radius Residential Care Limited

Introduction

91. Radius had a responsibility to operate the rest home in a manner that provided its clients with services of an appropriate standard. As this Office has noted in a previous opinion:[14]

[14] See Opinion 10HDC01286 (18 November 2013), available at www.hdc.org.nz.

> "That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It also includes responsibility for the actions of its staff."

92. As noted above, the care RNs B and C provided to Mr A on Day 6 and Day 7 fell below the accepted standard, and was a breach of Right 4(1) of the Code. I accept that, on Day 6 and Day 7, RNs B and C made poor clinical judgements in that they failed to appropriately recognise and respond to Mr A's signs and symptoms of respiratory distress. I consider that Radius had a reasonable expectation that its registered nurses would identify clinical concerns regarding a resident's condition, and respond appropriately and in accordance with the knowledge and skills of a registered nurse in New Zealand.

93. Nevertheless, I consider that Radius failed in its organisational duty to ensure that Mr A received services of an appropriate standard while at the rest home, for the reasons set out below.

Clinical care and treatment — Breach

94. At the time of Mr A's admission, Radius failed to ensure appropriate provision of senior staff at the rest home. In particular, at that time, there was no clinical manager and only a part-time facility manager. RN Carey was critical that RN B did not escalate concerns about Mr A's condition to a senior RN or Mr A's GP for advice on the evening of Day 6. In the absence of senior staff such as a clinical manager, and only a part time facility manager, it is not clear to whom, at the rest home, RN B would have escalated such concerns. While this does not excuse RN B's actions in this case, Radius must bear some responsibility for the shortcomings in the care provided to Mr A by failing to provide sufficient oversight and senior support at the rest home over that period.

Documentation — Breach

95. Radius provided the rest home staff with an Incident Report Policy, which required that all accidents, incidents and/or near misses must be reported on an incident form and the appropriate person (i.e. next of kin, enduring power of attorney, and/or family/whanau) be immediately notified. On Day 3 RN B noted that Mr A had choked "when taking medications whole". There is no incident form relating to an event of choking on Day 3. Radius stated that its policy did not specify choking as a reportable event. RN Carey advised me that she would view an incident of choking as one that should be captured on an organisation's error/incident reporting system. I accept RN Carey's advice and consider that the failure to complete an incident form in relation to the Day 3 event is evidence of a process gap by Radius. I also note her comments that "Incident forms have relevance for capturing and analysing themes within errors" and that incident forms "are part of a process that is open, transparent, and committed to learning and quality improvement".

96. I am also concerned about the standard of the documentation of Mr A's care generally, at the rest home. In particular, on the night of Day 6 to Day 7 the RNs reported changes in Mr A's clinical signs and his concerns about his breathing, but did not document any evaluation of the significance of those signs and concerns, or details of any ongoing monitoring of Mr A. RN B said that Mr A responded favourably to the oxygen therapy he commenced, but RN B did not document that response. There is also no evidence that he put in place steps to ensure that the oxygen he commenced Mr A on was signed off by the doctor, even though he acknowledged that this was usual practice at the rest home.

97. RN C did not record her assessment of Mr A at 2.30am on Day 7, she did not document Mr A's response to the increase in oxygen flow to four litres per minute, and did not record any other findings (other than his vital signs). As stated above, RN C did not record any notes between 2.30am and 7.45am, regarding Mr A's condition. Furthermore, the documentation surrounding the conversation between nursing staff and Mrs A about Mr A's transfer to hospital was suboptimal, as there is no documented detail of which RN contacted Mrs A, or what information was conveyed to Mrs A. I agree with RN Carey that "Clinical records must be accurate, concise and include the care that is given and the resident's response to the provided care".

98. In this case, multiple staff failed to adequately document their care and treatment of Mr A, for which Radius must bear some responsibility. As this Office has previously stated, failures by multiple staff to adhere to policies and procedures suggests an environment and culture that do not sufficiently support and assist staff to do what is required of them.[15]

Conclusion

99. In summary, I consider that, by failing to have appropriate senior staffing in place, failing to provide sufficient clarity in its Incident Report Policy on the types of events that should be reported, and failing to ensure its staff met the required standards for documentation, Radius failed to provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Communication with Mrs A — Adverse comment

100. I am concerned about the standard of communication between Radius and Mrs A on Day 6 and Day 7. In particular, Mrs A was not informed about the deterioration in her husband's condition on the evening of Day 6. Furthermore, while I am unable on the evidence to establish whether the RNs called Mrs A on the morning of Day 7 or Mrs A called the rest home herself, it is clear that she was not provided with sufficient information about the nature of her husband's condition and his deterioration.

101. I agree with RN Carey that the quality of communication between Radius and Mrs A on Day 6 and Day 7 was suboptimal. In my view, in these circumstances, Mrs A was entitled to receive timely and accurate information about her husband's deterioration

[15] See Opinion 07HDC16959 (20 May 2008) and Opinion 10HDC00308 (29 June 2012), available at www.hdc.org.nz.

and his transfer to hospital. I recommend that Radius reflect on this matter and its contribution to the distress this caused to Mrs A.

Recommendations

102. I recommend that RN B apologise to Mrs A for his breach of the Code. RN B's apology should be sent to this Office within **four weeks** from the date of this report, for forwarding to Mrs A.

103. I recommend that RN C apologise to Mrs A for her breach of the Code. RN C's apology should be sent to this Office within **four weeks** from the date of this report, for forwarding to Mrs A.

104. I recommend that Radius:

- Apologise to Mrs A for its breach of the Code and its poor communication with her on Day 6 and Day 7. Radius' apology should be sent to this Office within **four weeks** from the date of this report, for forwarding to Mrs A.
- Review its documentation and incident reporting policies and procedures, and report to HDC on the outcome of that review within **four weeks** from the date of this report.
- Ensure that Radius staff receive training regarding appropriate documentation, including the requirement to document any incidents of choking in incident forms and provide evidence to HDC that this has been done within **four weeks** from the date of this report.

Follow-up actions

105.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Radius Residential Care Limited, will be sent to the Nursing Council of New Zealand and the District Health Board, and they will be advised of RN B's and RN C's names.
- A copy of this report with details identifying the parties removed, except the experts who advised on this case and Radius Residential Care Limited will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

The following expert advice was obtained from HDC's in-house nursing advisor, RN Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs A] about the care provided by [the rest home] to her late husband, [Mr A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines to Independent Advisors.

2. I have reviewed the information on file: complaint from [Mrs A]; response from Radius Residential Care Ltd (RRCL); [Mr A's] clinical file from [the rest home]; and clinical file from [the public hospital].

3. **Background and complaint**

[Mr A] was transferred to [the rest home] on [Day 1]. He had spent the previous month at [the public hospital] following a right frontal subdural haemorrhage (SDH). The SDH was treated conservatively. [Mr A's hospital stay] was complicated due to having positive Clostridium difficile Toxin in his stool and acute on chronic renal failure. A needs assessment was completed, which identified [Mr A] as needing hospital level residential care and a room was secured at [the rest home].

Following the SDH [Mr A] required mildly thickened fluids, needed supervision when swallowing medications, had fluctuating clarity of speech, was incontinent of faeces, was a difficult two person assist to stand, and required a super stroller to mobilise up to 4 metres. The [the public hospital] multidisciplinary patient discharge summary (MDPDS) also identified that [Mr A] had very fragile skin, required regular analgesia, could not sit for long periods, had a high falls risk, and required assistance to meet his personal hygiene needs. Other relevant past medical history included: ischaemic heart disease (IHD), previous myocardial infarction, Type 2 diabetic, previous left knee and hip joint replacement, previous deep vein thrombosis.

[Mrs A] reports that on [Day 7] when she telephoned [the rest home] to enquire about her husband, she was told that he was being transferred to [the public hospital] and that there had been an incident the night before during supper. She reports that the staff member stated her husband was "ok". Shortly afterwards she received a phone call from [the public hospital] asking her to come to the hospital urgently. [Mr A] had been intubated due to respiratory failure secondary to aspiration. Due to his significant co-morbidities a decision was made to extubate [Mr A]. [Mr A] died at [the public hospital] on [Day 7] at 11.44 am.

[Mrs A] questions why she was not informed earlier that her husband had an incident or required transfer to [the public hospital], why she was told by a RN at [the rest home] that her husband was "ok", the quality of the assessment of her

husband on [Day 6], and the standards of care to manage her husband's risk of aspiration at [the rest home].

As a RN peer, I have been asked to provide clinical advice on:

(i) The management of [Mr A's] aspiration risk at [the rest home]

(ii) The standard of provided nursing care on [Day 6] and [Day 7]

(iii) Whether [Mr A] should have been transferred to [the public hospital] on [Day 6]

(iv) Communication between [the rest home] and [Mrs A] on [Day 7]

4. Response from Radius Residential Care Ltd (RRCL)

Following receipt of this complaint, RRCL completed an investigation. RRCL acknowledges that the RNs who assessed [Mr A] when he became unwell demonstrated incorrect decision making. RRCL instigated disciplinary processes, which has resulted in one RN having their employment terminated and a report being forwarded to Nursing Council of New Zealand (NCNZ), two RNs receiving formal warnings and one RN being identified as requiring further training to improve the quality of her spoken English.

The RRCL investigation also identified process gaps, which they acknowledge should not have occurred. They are managing these gaps by working with the staff involved to ensure that correct processes are followed in future. RRCL report that a comprehensive training schedule has also been developed and that they are working with the [the rest home] staff team to ensure that the standard of provided care at [the rest home] is raised promptly.

5. Review of [the rest home] clinical records

(i) The management of [Mr A's] aspiration risk at [the rest home]:

A very comprehensive approach to safe transfer of care and notification of [Mr A's] needs was completed by [the public hospital]. The nursing patient transfer (NPT) sheet identified that following his SDH, [Mr A] required a soft diabetic diet. The MDPDS identified that [Mr A] had an intermittent *delay in swallowing, was unsafe with thin fluids, tolerated a diet of normal consistency and mildly thick fluids.* Contact details for the [the public hospital's] Speech and Language Therapy (SLT) department were included plus a request to contact them should it be thought that [Mr A's] swallow had improved so that they could assess him. The need for regular oral cares following each meal to minimise risk of pneumonia was also highlighted.

At [the rest home] [Mr A's] initial assessment/careplan correctly identified his specific nutrition requirements. Food and fluid texture needs are also correctly noted on his completed [rest home] dietary requirement form. The corresponding entry in the multi-disciplinary progress notes (MDPN) reports *…on a chopped soft*

diabetic diet … slightly thick fluids to prevent aspiration pneumonia and regular oral cares needed.

Within the MDPN there are entries that relate to [the rest home] staff recording [Mr A's] oral intake or commenting on swallowing ability:

[Day 3] 2.30pm …reasonable eating and drinking … choking when taking medication as whole. Crushed and given with apple. Mildly thickened fluids preferred.

[Day 3] 10pm Medications easily taken when crushed and mixed in apple puree …

As a RN peer, I consider that the initial assessments and plan of care to manage [Mr A's] risk of aspiration were appropriate and meet expected standards.

(ii) The standard of provided nursing care on [Day 6] and [Day 7]:

The quality of documentation in MDPN from 9.15pm on [Day 6] is suboptimal. Entries by RNs report clinical signs and [Mr A's] concerns but without any evaluation of their significance:

9.15pm Became unsettled after his supper. Breathless ++ … put him on O_2 3l/min … BP76/48, T35.1, p88, S_pO_2 84% with O_2 …Chesty and gurgly especially after the meals and on exertion …

2.30am … Anxious c/o 'not being able to breathe'. O_2 increased to 4l/min. S_pO_2 90%, R24 … sips of slightly thickened fluids given …

7.45am … remains dyspnoeic, gurgly.

I am critical that the RN caring for [Mr A] during his supper did not respond appropriately to the signs and symptoms that he presented. I am critical of a RN noting these signs and symptoms but failing to evaluate them. Registered nurses are accountable for ensuring all health services they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by the appropriate standards. Integral to this is the responsibility to seek guidance should the RN have concerns about a resident and be unsure how to proceed. I am critical that a RN should commence a resident on oxygen therapy, record a poor response to the therapy, and not evaluate this response and what this means for the resident's respiratory system. I am especially critical of the fact that [Mr A's] GP was not contacted until approximately 10 hours after [Mr A] first showed signs of respiratory compromise. I consider that the standard of nursing care provided to [Mr A] on [Day 6–Day 7] does not meet registered nurse competencies 1.1, 1.4, 2.1, 2.2, 2.6, 2.8, 2.9, 3.3, 4.1 and 4.2[1].

[1] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).

Within the submitted [rest home] clinical file I have not received an incident form, which captured the event of [Day 6] and I have therefore presumed that one was not completed at the time. I am happy to apologise and review my advice should this presumption be erroneous. Incident forms have relevance for capturing and analysing themes within errors. They are part of a process that is open, transparent, and committed to learning and quality improvement. I would view this event as one that should be captured on an organisation error/incident recording system[2]. I note that within the response from RRCL, process gaps were noted. I view the failure to complete an incident form, escalate concerns, and appropriately notify as being part of a process gap. In my opinion it would be beneficial for RRCL to inform the Commissioner of their progress in highlighting organisational policies amongst their staff team, and supporting/ensuring compliance thus preventing future process gap incidences.

As a RN peer, I consider that the standard of nursing care provided to [Mr A] on [Day 6–Day 7] constitutes a moderate–severe departure from the standard of expected care. I note that RRCL instituted disciplinary actions against the registered nurses involved, have commenced training sessions across the staff team, and commenced fortnightly random file and medication audits. In my opinion, these actions are appropriate and demonstrate a commitment from the provider to ensure that the expected standard of nursing care is provided to their residents.

(iii) Whether [Mr A] should have been transferred to [the public hospital] on [Day 6]:

Yes, the signs and symptoms that [Mr A] presented as documented in the MDPN are signs of respiratory compromise. The fact that these symptoms persisted, required continuous oxygen therapy — which was a new intervention — and required an increase in oxygen therapy indicate that [Mr A] should have been transferred to [the public hospital]. Whilst I acknowledge that even if [Mr A] had been transferred to [the public hospital] earlier his death may still have occurred, he would not have struggled with feeling unable to breathe for 10 hours, and his family would have had a period of time together whilst he was conscious.

(iv) Communication between [the rest home] and [Mrs A] on [Day 7]:

Within the reviewed clinical file on [Day 7] at 7.45am it is reported that *wife aware of transfer.* This is the first reference of [rest home] staff notifying [Mrs A] of her husband requiring hospital assessment. The subsequent entry — in MDPN — is recorded as 7am and repeats *informed his wife about the transfer.*

Neither entry details what information was conveyed to [Mrs A] or whether both RNs contacted her or are reporting a delegated task. I note that within [Mrs A's] complaint she reports that she was only informed about the imminent transfer when she enquired about her husband via telephone. As a RN peer, I consider that

[2] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

[Mrs A] should have been informed on [Day 6] that her husband was presumed to have aspirated. In my opinion, the quality of communication conveyed to [Mrs A] was at its best inaccurate and very untimely. Registered nurses are challenged that their written and verbal communication is objective, patient centred, honest and empathetic. There is no evidence that such an approach was employed to [Mrs A]. As a RN peer, I consider the RN communication with [Mrs A] on [Day 7] to be suboptimal.

Accurate documentation is a critical element of nursing practice. Clinical records must be accurate, concise and include the care that is given and the resident's response to the provided care. Discussions held with the wider healthcare team, the resident and their family also need to be captured[3]. Both registered and enrolled nurses accept responsibility for ensuring their nursing practice and conduct meet the standards of professional, ethical and relevant legislative requirements such as NCNZ competencies[4,5] and Health and Disability Services Standards[6]. To be part of a resident's clinical records entries should include the date and time, ensuring that retrospective entries and additions are identified as such; phone calls should be identified as incoming or outgoing, name those involved, the time of the call, and the content of the telephone conversation needs to be objectively recorded. The staff member completing the documentation should sign, print their surname and include their designation. These requirements are necessary to ensure compliance with NCNZ competency 1.3 and 2.3[4]. There are incidences within the submitted file where the standard of clinical documentation does not meet the required standards. I note the RRCL response that training on documentation requirements and random file audits has commenced. In my opinion, these are appropriate actions.

6. **Clinical advice**

As a RN peer, I have been asked to provide clinical advice on:

(i) The management of [Mr A's] aspiration risk at [the rest home] — I consider that the initial assessments and plan of care to manage [Mr A's] risk of aspiration were appropriate and in accordance with expected standards.

(ii) The standard of provided nursing care on [Day 6] and [Day 7] — In my opinion this was a moderate–severe departure from the expected standard of nursing care.

(iii) Whether [Mr A] should have been transferred to [the public hospital] on [Day 6] — Yes, in my opinion a RN should have realised that [Mr A] was

[3] New Zealand Nurses Organisation (NZNO), *Documentation* (Wellington: NZNO, 2010).
[4] Nursing Council of New Zealand (NCNZ), *Competencies for registered nurses* (Wellington: NCNZ, 2007).
[5] Nursing Council of New Zealand (NCNZ), *Competencies for the enrolled nurse scope of practice* (Wellington: NCNZ, 2010).
[6] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

showing signs consistent with aspiration and sought a transfer to [the public hospital] or a review by the GP.

(iv) Communication between [the rest home] and [Mrs A] on [Day 7] — In my opinion was suboptimal.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner"

Further advice

RN Carey provided further expert advice on 20 March 2014, as follows:

"1. Thank you for the request that I provide secondary clinical advice in reply to the additional responses and statements from [the rest home]). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. This additional clinical advice is to be read in conjunction with my preliminary advice.

2. I have reviewed the additional Provider responses including statements from [Ms E]; [RN B]; [RN C]; [RN D]. I have also reviewed the submitted [the rest home] and [the DHB's] clinical file for [Mr A] and my preliminary clinical advice.

3. **[Day 6] afternoon shift HCA: [Ms E] reports**

(i) Checking [Mr A] regularly.

(ii) No recollection of any choking incident.

(iii) That [Mr A] was assisted to take some thickened soup via a sipper cup and that he consumed most of the soup unsupported and unsupervised.

(iv) That when [Mr A] was noted to be anxious and reporting difficulty in breathing (post supper) it was reported to [RN B].

(v) Her observation that [Mr A's] breathing had become gurgly and gotten worse.

(vi) That RN B administered oxygen and was constantly monitoring [Mr A].

Comment: It was appropriate that RN assistance was sought when [Mr A] reported difficulty in breathing.

4. **[Day 6] afternoon shift RN: [RN B] reports**

(i) Not being informed of or observing [Mr A] choking.

(ii) Assessing [Mr A] as having dyspnoea, which was usual for him.

(iii) Administering the prescribed inhalers.

(iv) [Mr A's] breathing pattern and oxygen saturations ($Sp0_2$) improved to 90% following the administration of oxygen but this was not documented.

(v) Checking on [Mr A] regularly.

(vi) Not considering that [Mr A's] situation required completion of an incident form, hospitalisation, GP contact or a call to [Mrs A].

(vii) Accepting that he should have documented more in the clinical notes.

Comments: I do not see the evidence to support [RN B's] assessment that [Mr A] was showing his usual level of dyspnoea. From my review [Mr A] requiring oxygen therapy was a new intervention. At the end of [RN B's] shift on [Day 6], [Mr A] had required 3 litres of oxygen therapy for more than two hours and continued to require it. I disagree with [RN B's] assessment that this was usual for [Mr A]. It is also difficult to accept the validity of retrospective documentation and memory that reports a favourable response to therapy — SpO_2 improved to 90% — but was omitted from the contemporaneous clinical documentation — *SpO_2 84% with O_2*. I note that [RN B] reports now being more focussed on the thoroughness of his clinical documentation. I agree that this is appropriate.

In my clinical opinion, there are descriptive words — e.g. gurgly — that should not be applied to a person's respiratory system without some concern. In the context of a resident who has an impaired swallow, I would expect that a RN attributing descriptors such as *chesty and gurgly*, would be concerned and would escalate those concerns to the resident's GP or to a senior RN for advice. I do not think that it was necessary for [RN B] to have been told or to have witnessed [Mr A] to choke, to be able to clinically assess that on this occasion [Mr A] was respiratory compromised and that this was more than his normal level of dyspnoea. Whilst I agree that [RN B] acted appropriately in instigating first level treatment — assessment, oxygen, monitoring — I am critical that he did not instigate second level treatments. I accept that [RN B] did not complete an incident form as he was unaware of [Mr A] having a choking incident.

I remain of the opinion that the nursing care provided by [RN B] departed from the expected standards of nursing care. I consider that this was a moderate departure.

5. **[Day 6] night shift RN: [RN C] reports**

(i) That the verbal handover from [RN B] covered commencing him on oxygen 3l/min to give SpO_2 85%.

(ii) Checking on [Mr A] regularly.

(iii) That [Mr A] complained of not being able to breathe following repositioning and that she assessed this as being due to the exertion involved and increased his oxygen therapy to 4l/min achieving SpO_2 90%.

(iv) That when the morning duty RN arrived she asked that they check [Mr A's] blood pressure (BP) as there had been difficulty in determining it and the accuracy of the sphygmomanometer had recently been queried.

(v) That the decision to transfer [Mr A] to the hospital was made after the morning duty RN confirmed [Mr A's] BP.

(vi) That she was not involved in the telephone communications with [Mr A's] GP or his wife.

(vii) That NCNZ have imposed conditions on her practising certificate.

Comments: I remain critical of the nursing care provided by [RN C] to [Mr A]. In my opinion, there was a failure to recognise him as deteriorating and showing signs of respiratory compromise. This is at odds with the standard of respiratory system knowledge and assessment skills expected of New Zealand registered nurses. In my opinion the standard of nursing care provided by [RN C] was a moderate–severe departure from expected standards.

6. Additional comments

In my opinion, whether it was noted that [Mr A] coughed/choked during his supper does not change the response required from the registered nurses involved in his care. Whilst the initial interventions were appropriately and timely instituted there was then a failure to evaluate [Mr A's] response or to instigate the next level of interventions e.g. contacting GP, transfer to hospital, contacting family. Fundamental to the circumstances that led to this complaint was the lack of recognition of the signs of a deteriorating patient/resident. In my opinion, there was an overwhelming lack of critical thinking employed by the RNs. The Provider reports the completion of a schedule of training for the registered nurses to ensure that unwell/deteriorating residents are recognised and receive the appropriate interventions within the expected timeframes. In my opinion this was appropriate.

There is documentation that I expected to be part of [Mr A's] [rest home] clinical file but have not been received. Whilst it is reported that [Mr A] was on regular monitoring — daily blood pressure (BP) following a GP review on [Day 2] — there is no documentation — separate observation chart or an entry in the MDPN — that shows daily BP monitoring occurring. Also whilst the MDPN and staff statements refer to a food/fluid chart being in progress, and the administration of medications, neither document has been received. Whilst omitting these does not have a significant impact on my clinical advice within this case, I would encourage the Provider to review how they manage all components of a resident's clinical file and the process for collating such documentation when a resident or their representative makes a complaint to the HDC.

[The rest home reports] that the RN who communicated with [Mrs A] on [Day 7] was identified as requiring further training. As expressed in section 5(iv) of my preliminary advice I considered the standard of communication with [Mrs A] to have been suboptimal. I remain of this opinion. I agree that it is appropriate that [the rest home] include 'effective communication' as part of their RN training

schedule and for the identified RN to be supported to improve the standard of her spoken English.

7. Clinical advice

[RN B] provided nursing care on [Day 6] to [Mr A] that was a moderate departure from the expected standards of nursing care.

[RN C] provided nursing care on [Day 6–Day 7] to [Mr A] that was a moderate–severe departure from the expected standards of nursing care.

Communication between [the rest home] and [Mrs A] on [Day 7] was suboptimal.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner"