HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Deficiencies in hospital management of man with dementia and diabetes

1. In January 2022, the Health and Disability Commissioner (HDC) received a complaint from Mrs A about the standard of care provided to her late husband, Mr A, at Waikato Hospital over a two-day period in December 2019. The complaint was made after Mr A was found unconscious after leaving the Coronary Care Unit (CCU) having fallen down a stairwell. Mrs A is concerned about the standard of diabetes care provided to Mr A and the delay in staff recognising his absence from the CCU.

Information gathered

Emergency Department

2. Mr A, aged 79 years at the time, had multiple comorbidities, including an extensive cardiac history, longstanding memory loss, dementia, mild cognitive impairment with a Montreal Cognitive Assessment (MoCA)[1] score of 24/30, and insulin-dependent type 2 diabetes. An adverse event review (AER) completed by Health New Zealand | Te Whatu Ora Waikato (Health NZ) noted that Mr A was independent with his activities of daily living. In contrast, Mrs A stated that he had reduced mobility and required monitoring due to his dementia.

3. At 3.10am on Day1 December 2019, Mr A presented to the Waikato Hospital Emergency Department (ED) with chest pain. He was accompanied by Mrs A. Mr A had a working diagnosis of non-ST-elevated myocardial infarction (a type of heart attack). At the time of triage, a nurse recorded that Mr A's history included type 2 diabetes. However, the clinical notes do not record whether Mr A was on insulin or other medications for his diabetes. Mr A's blood glucose level (BGL) was measured as 15.2mmol/L[2] (high) at 3.10am, but there is no record of further BGL testing in the ED.

4. Mrs A told HDC that they brought Mr A's diabetic kit, diabetic record book, and medications with them to the hospital. Mrs A said that Mr A's BGL was not measured, and ED staff did not give him insulin in the morning. Mrs A stated that she queried this with an ED nurse, but the nurse did not check Mr A's BGL, did not get the insulin charted, and did not document this conversation. Mrs A decided to test Mr A's BGL, and she gave him his insulin injection and noted this in his diabetic record book.

5. The clinical notes contain limited documentation by the ED nurses. The notes include a triage summary, vital sign measurements, and two very brief notes[3] in the ED chart. However, there is no documentation of the care Mr A received, and little evidence of a

[1] A rapid screening tool used to detect cognitive impairment. A score of 26 or above is generally considered normal.
[2] Normal BGL levels are between 5mmol/L and 8mmol/L, although normal levels can vary between people.
[3] An entry at 3.40am recorded Mr A's pain levels and that he had taken glyceryl trinitrate (to dilate blood vessels) at home with no relief. An entry at 7.10am recorded that Mr A was alert and that his care was handed over.

nursing assessment having occurred. There is no mention of any tasks undertaken, such as taking a BGL, or whether cardiac monitoring occurred. However, the blood test results indicate that a sample was taken at 3.30am, and the triage summary indicates that an ECG was taken. Several documentation entries made by the ED staff are illegible.

CCU

6. Mr A was transferred to the CCU (CCU3)[4] at 2.30pm on 29 December 2019. There is minimal documentation around the information that was handed over to CCU staff. The next BGL check occurred at 5.37pm and was noted to be 6.8mmol/L. Thereafter, regular BGLs were recorded pre-meals, and insulin was administered in accordance with Mr A's prescription. Nursing notes record that Mr A had diabetes, that he was to have a diabetic diet, how often his BGLs were to be tested, and that he was on insulin.

7. Despite Mr A having presented as orientated and stable while he was in the ED, clinical records indicate that around 11pm he was unsettled with possible confusion. The AER notes that a Confusion Assessment Method (CAM)[5] is required when there is a change in behaviour. However, this did not occur. At 1.30am on Day2 December 2019, Mr A was noted to be settled and sleeping well.

8. At 5.30pm on Day2 December 2019, Mr A's BGL was 5.3mmol/L, and insulin was administered. Following this, Mr A had his dinner, and at 9.30pm a further BGL was taken, which returned a level of 4.4mmol/L. Mrs A told HDC that Mr A would be unsteady and his cognitive ability would decline at a reading as low as 5mmol/L. Health NZ said that this reading was within the lower range, and its Diabetic Emergencies Hypoglycaemia[6] guideline (dated 2017) requires a carbohydrate snack to be given when the BGL is under 4mmol/L.

9. Mr A expressed concern to the afternoon CCU nurse about having a BGL of 4.4mmol/L. Health NZ said that the nurse told Mr A that she would get him a drink and a sandwich, but as there were no sandwiches in the CCU3 fridge, the nurse went to look in the CCU2 fridge. Health NZ said that when the nurse returned to the room at 9.44pm, Mr A was not there. The AER notes that if food had been available in the CCU3 fridge, this would have enabled the rapid provision of food to Mr A and reduced the risk of him leaving the CCU.

10. As Mr A was not in his room at 9.44pm, the nurse left the food on his bedside cabinet and returned 10 minutes later. At this point, Mr A was still not in his room, and the nurse assumed that he was in the toilet, as this was occupied. Health NZ said that the nurse's assumption reduced the recognition of the necessity to sight Mr A, and the escalation of his missing status was not triggered. Health NZ stated that the nurse understands that the assumption she made was an error in judgement and resulted in a delay in escalating a search. In addition, the Diabetic Emergencies Hypoglycaemia guideline requires that the BGL is retested 10 minutes after the intervention, but this did not occur.

[4] There are three CCUs at Waikato Hospital.
[5] A tool used to identify delirium or a sudden change in mental status in acute settings.
[6] A BGL below normal, which can result in a medical emergency.

11. Clinical notes record that the nurse checked Mr A's room again at 10pm and, because he was still not in his room, she tried to call Mrs A to ask whether Mr A had a mobile phone. The call to Mrs A was not answered. The nurse then tried to find Mr A by looking outside CCU3 and downstairs. After this, she informed the nurse coordinator and rang hospital security to try to locate Mr A. The exact time of informing the nurse coordinator and hospital security is not known. In response to the provisional report, an immediate family member of Mr A said that there was a delay in notifying the nurse coordinator and security.

12. Mrs A told HDC that Mr A's mobility was not good, and he became unsteady when he experienced hypoglycaemia. Waikato Hospital CCTV footage showed Mr A standing in front of a vending machine at 10.27pm. Mrs A said that he would have had to move from one end of the ward, past the nurses' station, past the reception area to the doorway, where he would have had to press the hand-activated button to exit. CCTV footage also shows that 11 people walked past Mr A, seven of whom appeared to be staff. However, staff did not appear to check on Mr A.

13. Health NZ said that it recognises that people with dementia have a higher propensity to delirium when outside their normal environment and routines. The CCU environment was busy on Day2 December 2019, and this may have created some disorientation for Mr A.

14. The AER notes that the CCU is an open unit, and that after 8pm, the electronic doors are locked. Exiting the ward areas requires hand activation of a wall button, which unlocks the door. At the end of CCU1 and CCU3 there are double fire doors that are not alarmed on opening. The AER notes that it is not uncommon for staff to use the CCU3 fire door egress and stairwell to go to the cafeteria. After this event, this door was checked and found not to be locked, allowing entry from the outside into CCU3. The AER notes that patients are free to move around within the unit, and they are asked to notify the nursing team if they wish to leave the unit. The AER found that there was a lack of signage and visual reminders to patients and family regarding notification to staff if they were leaving.

15. At 11.01pm, Mr A was found unconscious on the stairwell past the fire doors. A cardiac arrest call was put out, and cardiopulmonary resuscitation (CPR) was started. Mr A's BGL was noted to be 1.8mmol/L. Sadly, Mr A died at 11.22pm.

16. Mrs A is concerned that Mr A was missing from the ward for 55 minutes before a search was undertaken, and it was not until 76 minutes after he left CCU3 that he was found.

Responses to provisional report

17. Mrs A and an immediate family member of Mr A were provided with the opportunity to comment on the 'information gathered' section of the provisional report. Both members of Mr A's family reiterated that Health NZ failed to keep Mr A safe. The immediate family member said that staff disregarded family input into the treatment plan and the insulin record book, which showed Mr A's previous insulin levels. In addition, the immediate family member said that there were consistent indicators of decreasing blood sugar levels over the course of Mr A's admission, which should have resulted in a medical review. Other comments have been incorporated elsewhere in the report, including Appendix B.

18. Health NZ was provided with the opportunity to comment on the provisional report. Health NZ's comments have been incorporated within this report as relevant.

Clinical advice

19. Independent clinical advice was received from registered nurse (RN) Marion Picken (Appendix A). RN Picken noted that the standard of cardiac management was acceptable. However, she noted the following departures from the accepted standards of care:

- Nursing admission assessment and documentation by ED nurses — **moderate to severe departure**.
- Standard of diabetic management over the course of Mr A's admission — **moderate to severe departure**.
- Appropriateness of overall management of Mr A in light of his age, frailty, cognitive impairment, and consideration of delirium — **severe departure**.

Opinion: Health NZ — breach

20. At the outset, I express my sincere condolences to Mr A's family. Mrs A was closely involved in her husband's care, and his sudden death has been traumatic for her and the family.

21. Having reviewed all the information on file, including Health NZ's AER and the clinical advice, I find that Health NZ failed to provide Mr A with a reasonable standard of care in accordance with Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

22. I am critical of the care provided to Mr A in the ED. As stated by RN Picken, there is minimal documentation of the care Mr A received, and limited evidence of a nursing assessment, particularly with respect to Mr A's diabetes. I am especially critical of the lack of BGL monitoring in the ED given that Mrs A had alerted staff that Mr A was taking insulin. I am concerned that the lack of care led to Mrs A checking Mr A's BGL and administering the insulin herself.

23. Once Mr A had been transferred to CCU3, regular BGLs were recorded. The afternoon nurse recognised when Mr A became hypoglycaemic, and she sourced appropriate food to correct this. However, I am critical that the nurse did not check whether Mr A had eaten the food or recheck his BGL afterwards. I am concerned that she did not check Mr A's whereabouts, and she delayed her escalation to the nurse coordinator. In the context of Mr A's underlying cognitive impairment and hypoglycaemia, this was crucial. The delay in searching for Mr A meant that his BGL dropped further. While there was a lack of critical thinking by the afternoon nurse, I also note that there were failures by Health NZ in ensuring that there was adequate food available within CCU3, as this delayed the afternoon nurse in correcting Mr A's hypoglycaemia and likely contributed to Mr A leaving the unit in search of food. Moreover, I am also critical of the inadequate systems in place to alert staff when patients leave the unit, and that Mr A was able to walk past seven staff while outside the unit, with none of them stopping to assist him.

24. Overall, I consider that the nursing care provided to Mr A was very poor regarding the management of his diabetes.

Changes made since events

25. Health NZ has made the following changes since the events:

a) All doors in and out of the CCU are now more secure, with swipe-card access to get in, and a door-release button on a side wall to get out of the unit. The door can be locked from a central point if required. There is also signage at exits to remind patients and family to let a nurse know when they are leaving and where they are going.

b) The fire door in CCU3 is now alarmed to alert staff if the door has been opened. It is not locked, as it remains a fire exit.

c) Each day, the fridges in all the CCUs are checked to ensure that there is a sufficient stock of snacks for patients with diabetes.

d) An educational session regarding the management of diabetes was undertaken across the Cardiology service. Part of this education was to ensure that there is a clear understanding of the guidelines and policies.

e) Staff now ensure that patients with identified low BGL receive their food and/or treatment in a timely manner and, where this does not occur, an escalation process is initiated.

f) Management of patients with dementia has also been addressed by implementing additional strategies to maximise environmental calming and individual routines into care. This aids in the recognition of specific triggers that can cause agitation for patients with dementia and assists staff in developing personalised strategies to manage these triggers.

g) Staff now ensure that patients at risk are placed more centrally in the CCU, closer to the nursing station.

h) Health NZ is in the process of identifying a patient monitoring system that will work within the acute environment, which can facilitate independence while also providing traceability of the patient.

i) The emergency nursing department received education in March 2025 regarding the expected standards of recording assessments and shift summary reports. Subsequently, there has been weekly auditing of the documentation.

j) A new electronic documentation suite, called Centrix, will replace the clinical progress notes, vital signs, and forms at Health NZ Waikato in 2027.

Recommendations

26. I recommend that Health NZ Waikato complete the following actions:

a) Provide a formal written apology to Mrs A and her family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs A.

b) Provide education sessions on the expectations for nursing documentation within the ED, including the use of the ABCDE[7] tool and recording of clinical history, allergies, and medications every time a nurse receives a new patient. Evidence of completion of this education by way of staff attendance records is to be sent to HDC within three months of the date of this report.

c) Provide HDC with evidence of the last three months of the weekly documentation audits undertaken in the ED, including analysis of the findings of the audit and any corrective actions taken, within 12 months of the date of this report.

d) Consider implementing an electronic documentation system in the ED. An update on this consideration is to be sent to HDC within 12 months of the date of this report.

e) Undertake a random audit of 15 patients with diabetes who presented to CCU3 over the last 12 months to check whether the diabetes management was adequate. The findings of the audit, including any corrective actions, are to be sent to HDC within 12 months of the date of this report.

Follow-up actions

27. A copy of this report with details identifying the parties removed, except Health NZ, Waikato Hospital, and the clinical advisor, will be sent to Diabetes NZ and the Health Quality & Safety Commission Te Tāhū Hauora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

[7] A tool used to assess an acutely unwell patient systematically.

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA. HAUĀTANGA

Independent clinical advice to Health and Disability Commissioner

The HDC person responsible for the file will fill in all the details highlighted in teal.
The independent advisor is to insert the details of their report in the yellow highlighted areas.

Complaint:	**[redacted](dec.) / Health New Zealand | Te Whatu Ora - Waikato**
Our ref:	**C22HDC00109**
Independent advisor:	**Marion Picken**

I have been asked to provide clinical advice to HDC on case number C22HDC00109. I have read and agree to follow HDC's Guidelines for Independent Advisors.
I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.
I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	Diploma of Nursing Masters of Clinical Nursing 30 years Emergency Nursing – 15 years as Emergency CNE. Other areas are medical nurse educator and resuscitation Nurse Educator. College of Emergency Nurses (CEENZ)Triage Instructor Advanced Life Support Instructor (NZRC)
Documents provided by HDC:	1. Letter of complaint dated 13 January 2022 2. Waikato District's first response dated 8 April 2022 3. Waikato District's second response dated 15 November 2023 4. Clinical records from Waikato District covering the period December 2019 to [redacted] December 2019.
Referral instructions from HDC:	1. The appropriateness of the admission assessment and documentation done by clinical staff for Mr [redacted] on his arrival to Waikato Hospital emergency department (ED). 2. The appropriateness of Waikato Hospital's diabetic management over course of Mr[redacted]'s admission, inclusive of the handover between the ED and cardiac ward.

	3. The appropriateness of the cardiac management during Mr [redacted]'s admission, inclusive of whether he should have received cardiac monitoring either at the bedside or by telemetry. 4. The appropriateness of the overall management of the consumer in light of his age, frailty, cognitive impairment, including whether delirium should have been considered and screened for. 5. Recommendations on what additions could be made to policy documentation to improve care in the above areas in the future. 6. Any other matters you consider appropriate to comment on.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	*Compliant summary* *Mr [redacted] was admitted to Waikato Hospital ED 11th December 2019 with tingling down his arms which was treated as a cardiac event. He was diagnosed with a non-ST elevated Myocardial infarction (NSTEMI). Among his medical issues he had type two Diabetes – insulin dependent. He also had mild dementia. He is described by his family as 'a frail elderly man who had just suffered a cardiac episode".* *Mr [redacted] stayed overnight in ED where he seemed pain free. Mr [redacted]'s wife states the ED nurses had no an awareness of his diabetes and care needed..* *On the second evening whilst he was in the cardiac ward he experienced at hypoglycaemic event at 2130. BSL was low (4.4mmols). His nurse went and retrieved a sandwich and juice. She returned 15 minutes later and saw the door to Mr [redacted]'s toilet shut and assumed he was there. She left the food there and returned 10 minutes later – not finding him still assumed he was still in the toilet. 40 minutes later the nurse returned finding Mr [redacted] missing. She informed the nurse co-ordinator who then notified security and a search was started. At 2300 Mr [redacted] was found by other hospital staff in a collapsed state, face down in a stairwell, covered in blood, unresponsive. CPR was commenced. His BSL at this time was 1.8mmols. Resuscitation attempts were eventually stopped and Mr [redacted] was pronounced dead. The time from when the nurse last saw*

	him to the time of being found in a collapsed state was one and a half hours. *Security footage requested by Mr [redacted] family shows him at a vending machine which they believe he was trying to find food to eat. Mr [redacted]'s family are devastated and by what they call a completely avoidable death. They state that the staff on the cardiac ward :* 1. *Failed to access the level of risk of MR [redacted]'s rapidly declining BSL of their father and husband was the major reason for his death.* 2. *The staff nurse failed to ensure Mr [redacted] ate the sandwich and juice* 3. *The nurse failed in her responsibility to know of his whereabouts – he managed to leave the ward, walk from the cardiac and into a stairwell where he fell and later died.* 4. *She did not escalate to other staff MR [redacted] was missing for 40 minutes.* • *MR [redacted]'s family have felt 'stone walled' and that information has not been forthcoming from Waikato hospital.* <u>Waikato hospital response</u> The nurse allocated to Mr [redacted] in their notes after his cardiac arrest state that when she checked Mr [redacted]'s BSL at 2144 (discrepancy in time), went to get a carbohydrate snack – when they returned he wasn't in his bed and they assumed he was in the toilet. They went to assist another nurse. When they returned at 2200, Mr [redacted] could not be found so the nurse rang Mrs [redacted] to ask if he had a mobile phone they could ring. They tried searching for Mr [redacted] and then notified the co-coordinator who notified security to help search for him. The nurse notes that Mr [redacted] was found 'upstairs by the cafeteria unconscious. They commented that they had handed over to the night nurses to help find him as well as trying to call his family twice. A passing doctor found MR [redacted] in a stairwell face down in a pool of blood from a head injury. They for help and tried to resuscitate him. Mr [redacted] was in a Pulseless Activity Arrest (PEA). His BSL was noted to be 1.8mmols at this time and IM glucagon was administered 2316. The

	decision to stop CPR by the emergency team was made. The patient's family who he states were 'understandably v. upset'. In [redacted] *(Executive Director Waikato Hospital and Community Services)* letter written to [redacted] (HDC) she has: • Apologised for the delay in communication and the release of clinical records and Incident Review Report to the family. • Commented the nurse who was assigned to Mr [redacted] was junior therefore had knowledge and skill which were aligned with this. • Recognised that Mr [redacted] having dementia and being out of his normal environment and in a busy ward might have resulted in him being more agitated and increased delirium. • Acknowledges that Mr [redacted] tried finding his own food and left the ward via an unlocked back door. • A training session for nurses regarding management of Diabetes which included guidelines and policies and also management of dementia patients. .

Question 1: The appropriateness of the admission assessment and documentation done by clinical staff for Mr [redacted] on his arrival to Waikato Hospital emergency department (ED).	
List any sources of information reviewed other than the documents provided by HDC:	• CEENZ Triage tool • Guidelines for the implementation of the Australasian Triage Scale in Emergency Departments file:///H:/Downloads/Chrome/G24_Guidelines_on_Implementation_of_ATS%20(7).pdf • Diabetes - Hypoglycaemic management for inpatients https://silentone/content/DistrictDocs/Diabetes_Endocrine/DistrictWide/Medical_NursingStaffinformation/000000002207/__file__/000000002207.pdf • Waikato District Health Board DAIBETIC EMERGENCYIES: HYPOGLYCAEMIA. Definition: Capillary blood glucose (CBG) level < 4mmol/L • https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/Nursing/Registered%20nurse/NCNZ031-Competencies-RN-11.pdf • Nursing Council of New Zealand Code Of Conduct: Guidance: Documentation • https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/The%20Code%20of%20Conduct/Code%20of%20Conduct%20Booklet%20full.pdf

	• Nursing NZNZ Code Of Conduct: Principle 1, 1.10 Respect the dignity and individuality of all health consumers: 1:10 take steps to minimise risk and ensure your care does not harm the health or safety of health consumers
Advisor's opinion:	In my opinion the appropriateness of the Nursing admission assessment and documentation done by clinical staff for Mr [redacted] on his arrival to Waikato Hospital emergency department (ED) over all was poor and a ***moderate departure*** of accepted practice. The medical notes are precise and succinct – although difficult to read and sometime illegible. However they outline clearly in the medical history that Mr [redacted] had Type two diabetes and dementia. The Triage note has an Airway, Breathing, Circulation tick box system. The Triage note is straight forward and concise. I notice that Mr [redacted] had 'tingling down his arms' which took '3 lots of GTN', IV Fentanyl, ondansetron and aspirin' – I assume by ambulance staff. Mr [redacted] was given a Code 3 which is in line with the **Guidelines for the implementation of the Australasian Triage Scale in Emergency Departments** and appropriate. It appears his disposition after Triage was to a clinical area. The standard of nursing care by the ED nurses after Triage is poor. There is no documentation around what care Mr [redacted] received and very little evidence of a nursing assessment from the initial night nurse at 0340. There is a description of his pain but no mention of tasks undertaken – e.g bloods, ECG', if cardiac monitoring was attached etc. It is unknown if Mr [redacted] received a wash, offered a tooth brush to clean his teeth or assisted in anyway because nothing of his care is written in his notes. The overall documentation of the ED nurses is very poor and far from what I would consider acceptable. *The Nursing NZNC Code Of Conduct under Guidance: Documentation: "Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been"* did not occur here. Mr [redacted] was in ED from 0310 to 1345 (last vital signs recorded). His last recorded ED nursing notes were written at 0810. There is no mention of any medical history in the nursing notes that he was a Type two diabetes on insulin although this is clearly documented in the medical notes. In the printed 'Other relevant History' line 'Angina is written and Dabigatran -/ AF'. In the AM nursing notes there is no evidence that the ED nurses talked with Mr [redacted] Mrs [redacted] writes that her husband felt he had upset the nurse by asking for breakfast

	and the nurses did not know he was a diabetic when she asked them. This conversation was not documented in the nursing notes. ***MY EXPECTATIONS*** would be a documented nursing assessment of Mr [redacted] presentation at the time of his admission to ED including any past medical history, medications and allergies. An ABCDE assessment would have been appropriate inclusive of current medications and relevant medical history. In my opinion any conversation is very important to document especially with whanau. Most of the medical and nursing notes ***are illegible and very difficult to read***. The nurse's signature are illegible. This is unacceptable practice. Mr [redacted]'s vital signs were documented every two hours and EWS recorded as 0 once. In the EWS chart in the Glucose box there is no recording or documentation of this except what his wife has made in his diabetic booklet and insulin given.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	It is hard to say what standard of care in the ED Mr [redacted] received as the nurses ***documentation is so brief and illegible. Because of this I would say it was very poor as very little was written about it.*** On his arrival to Waikato ED, Mr [redacted] was assessed promptly by the ED doctors and the assessment written in the notes. In the Nursing NZNZ Code Of Conduct under Guidance: Documentation: "Keep clear and accurate records of the discussions you have, the assessments you make, the care and medicines you give, and how effective these have been". This did NOT happen here. Mrs [redacted] noted that the nurses were unaware that Mr [redacted] had Type 2 diabetes who need BSL's and insulin. MRs [redacted] took Mr [redacted]'s BSL and recorded it in his BSL monitoring book and administered his insulin. When she asked a nurse if they knew he was a Diabetic, they said "No'" and "They come in here and then go elsewhere". The communication from the nurse was abysmal and professionally poor. In the NZNC Code of Conduct - 1.10 " ***Take steps to minimise risk and ensure your care does not harm the health or safety of health consumers".*** The nurse could have asked Mrs [redacted] about Mr [redacted]'s diabetic management and recorded their conversation in the notes. She could have started a BSL chart and asked the medical staff to prescribe insulin.

	Nursing NZNZ Code Of Conduct: Principle 1, 1.10 Respect the dignity and individuality of all health consumers: 1:10 take steps to minimise risk and ensure your care does not harm the health or safety of health consumers. This did not happen here.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This a ***Severe departure*** from acceptable care or practice. The nurses documentation tells nothing of care given or an understanding that the nurses had undertaken a nursing assessment or asked him, retrieved old notes/ files or read the ED medical notes to describe how Mr [redacted] had presented to them and what his medical history and what medication he was on. The NZ nursing council in Pou three: Whanaungatanga and communications, Descriptor 3.6 states documentation if legible, relevant, accurate, professional and timely. This was not the case in Waikato ED at the time of Mr [redacted]'s admission. https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/Nursing/Registered%20nurse/NCNZ031-Competencies-RN-11.pdf There was no documentation of Mr [redacted] BSL except on his person BSL chart – the last was at Breakfast by Mrs [redacted]. The next documentation of his BSL is at 1730 12/12, 2019 which was when he had left ED. Again this this is a Severe departure from expected standards. Penmix and Novorapid insulin have been prescribed on the Adult medicine chart. The Penmix given at 1810 and Novorapid 2105 29/12/2019 which was when he had left ED.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	The care given to Mr [redacted] would be viewed by my peers as a severe departure from accepted practice. Prioritising nursing care on very vulnerable patients is vitally important. Again, it very difficult to know what care Mr [redacted] received as the ED nursing notes are so poor. My peers would expect a proper nursing assessment documented into the notes especially by the nurse who initially received MR [redacted] – ABCDE framework as above, including medication, allergies and medical history. They would expect documentation of any cares, conversations noted e.g "Mrs [redacted] has asked me if we are aware that Mr [redacted] is a Type 2 diabetic needing regular BSL and insulin administered'. *New Zealand Nursing Council (NZNC) states in Pou four: Pukengatanga and evidence-informed nursing practice states the evidence-informed nursing practice required registered nurses to use clinical skills, coupled with critical thinking and*

	informed by high quality and current evidence, to provide quality, safe nursing care. Evidence-informed practice prepared the nurse to differentially diagnose, plan care, identify appropriate interventions, lead the implementations and evaluate care provisions and outcomes". This was an expectation of NZNC was not meet. (https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/Nursing/Registered%20nurse/NCNZ031-Competencies-RN-11.pdf) My peers would ask me who actually nursed Mr [redacted] as the notes tell nothing of what their interactions were with him. The nurse's signatures are illegible. I consulted [redacted] Associate Charge Nurse Manager (ACNM), Te Pae Tiaki|ED Wellington Hospital about her expectations of nursing documentation. She said she would expect the nurse to document their initial assessment including how the patient appeared at this time of assessment. Record of an ABCDE assessment with pertinent information regularly recorded, including any conversations with them and /or whānau. Included there should be a nursing plan, such as ECG, Monitoring, routine bloods with Troponin etc. She also stated ***"If it wasn't documented – it did not happen"***. This is *a* comment constantly made in all hospitals, training centres and amongst staff. This applies above. ***My peers would have expected me to start a Glucose monitoring chart. Even if the ED was very busy on this day and as a nurse I was stretched –this would be a priority. My peers would be disappointed and question why the notes were so poor and ask an educator or senior to nurse to help me improve my documentation.***
Please outline any factors that may limit your assessment of the events.	The factors limiting my assessment at the time of his admission: • An understanding of the patient numbers and their acuity in ED at the time of Mr [redacted] s admission. • Understanding of patient –nurse ration in ED at that time • Understanding where in ED MR [redacted] was , e.g ED clinical area or a smaller ED unit before transferring to the Cardiac ward • Access to a Waikato Diabetic management chart for hypoglycaemic patients for diabetics on insulin.
Recommendations for improvement that may help to prevent a similar	• An education drive on the importance of nursing documentation and how to deliver this as well as including this in induction programme for new nurses to ED.

occurrence in future.	• An expectation and culture change within Waikato ED that nurses must improve their nursing documentation especially uisng proper nursing assessments e.g ABCDE tool and any history, allergies or medications – *EVERYTIME A NURSE RECIEVES A NEW PATIENT* • ***Waikato ED to change to an electronic system so nursing and medical notes and the person writing them are legible.*** • Senior nursing leaders to review nursing documentation on shift and have an expectation that it is current and relevant.
Question 2: The appropriateness of Waikato Hospital's diabetic management over course of Mr [redacted]'s admission, inclusive of the handover between the ED and cardiac ward.	
List any sources of informatio n reviewed other than the documents provided by HDC:	• Waikato District Health Board Diabetic Emergencies: Hypoglycaemia Capital & Coast Hutt Valley District health Board Diabetes – Hypoglycaemia management for adult inpatients https://silentone/content/DistrictDocs/Diabetes_Endocrine/DistrictWide/Medical_NursingStaffinformation/000000002207/_file_/000000002207.pdf • NZRC Adult collapse algorithm https://www.resus.org.nz/
Advisor's opinion:	The documentation of nursing handover is written in the ED nursing notes as "handover given" and an electronic SBARR – Nurse handover to Mr [redacted]'s medical history. It's unclear who wrote this – the receiving nurse or ED Nurse. The ***ED nurses management*** of Mr [redacted]s diabetes was non-existent, the nurses has not recognised he was a diabetic on insulin needing regular BSL's despite this being recorded in the medical notes and being told by Mrs [redacted]. This conversation was not reflected in the ED nursing notes. ***In the <u>Cardiac unit</u>*** management up until the time of MR [redacted] last BSL seems to have been managed well with regular BSL's recorded pre-meals. The insulin is charted in his Medicine's chart and has been administered satisfactorily. I see he has had 12 units at 1810 on the 2nd 12/2019 and then at ***'09'*** 12/12/2029 and 1845 12units. In his nursing care plan it is documented that he is a Type 2 Diabetic and that he is for a diabetic diet. In Mr [redacted]' patient to complete form' he documents he is a Type 2 diabetic. This is reflected in his Care plan which includes when and how often his BSL's and insulin should be administered.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/ material.	This was a ***Moderate departure*** from acceptable practice. The nurse caring for Mr [redacted] recognised that he needed a carbohydrate snack – went to retrieved it - couldn't find one in her own units fridge so took 15 minutes to return but did not ensure he ate it as she assumed he was in the toilet. We can establish that Mr [redacted] may have either forgotten she was retrieving the snack and/or felt so unwell with hypoglycaemic symptoms that he went to find his own food outside the ward and dying. The Diabetes – Hypoglycaemia management for adult inpatients at Capital and Coast, Hutt Valley DHB (I cannot access Waikato's protocol) https://silentone/content/DistrictDocs/Diabetes_Endocrine/DistrictWide/Medical_NursingStaffinformation/000000002207/_file_/000000002207.pdf for BSL > 4 – 6 mmol/L would be to give the patient a carbohydrate snack to stop his BSL falling and then follow this up with a repeat BSL an hour later. Although the nurse recognised this and retrieved a snack she did she did not ensure he ate this in front of her. It would have been very important to supervise MR [redacted] eat his snack because he had short term memory loss and may have forgotten that he| he were retrieving this for him. Had he been in the toilet and come into his room he may not have noticed the sandwich waiting for him unless the nurse had physically handed this to him. Assuming twice he was in the toilet around 25 minutes would be a delay in time Mr [redacted] consumed his snack which meant to BSL would drop further. The most important aspect would have been to knock on the door – call his name and make sure he was okay and ask him to eat this snack. On returning the second time and assuming he was still on the toilet (now 25 minutes) is too long for a diabetic patient to be alone in the bathroom. Not communicating with Mr [redacted] led to the cascade of terrible events as summarised above and was totally avoidable if the nurse had knocked on the door – checked in with Mr [redacted] and supervised him eating. A repeat BSL should have taken place 30 minutes after the snack or earlier if MR [redacted] displayed symptoms of ongoing hypoglycaemia. The management after that would be similar to the referenced protocol above.
Was there a departure from the standard of care or	A severe departure form accepted practice as documented above

accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I have consulted with Wellington Hospital Diabetic Clinical Nurse Specialist [redacted] who concurs the diabetes protocols and pathways will be fairly standardised throughout NZ and be at international standards and best practice. In the Waikato Emergency department -there was no nursing care around MR [redacted]'s Diabetes that has been documented. Mrs [redacted] asked the nurse if she knew he was Diabetic and she got a negative response and a strange ***'they come in and then go somewhere else'*** comment. Not, some along the lines of "no I didn't know – please tell me about this and how I can help". Mrs [redacted] did the BSL and administered the insulin. There is no ED BSL chart started. My peers would be disappointed and consider communication to the patient and his wife very poor. Mr [redacted] thought he had upset the nurse asking for breakfast. Mr peers would encourage our patients to request breakfast and reassure them if it were not there. They would expect to have read the medical notes and be informed that MR [redacted] was diabetic and needed treatment and food around this. My peers would be disappointed by the lack of thorough nursing documentation including if had he had experienced anymore tingling in his arms, what his medication and medical history. ***They would regard this as very basic aspect of professional nursing which was not done.*** It is documented in the ED nursing notes that handover had occurred - an electronic handover note ' SBARR – Nurse Handover updated 0 December 2019 1332. Under Situation it is written 1. Permanent Atrial fibrillation, 2. Previous CABG. Handwritten is TIA, T2DM etc as an afterthought. What is written in the electronic handover is very basic. Again my peers would consider this basic and the very minimum completed.

	My peers could consider that the ward nurses had had a better grasp on Mr [redacted]'s diabetes than the ED nurses. It was prescribed and a Capillary Glucose Results chart was started on 11/12/2019 at 1730 and BSL were recorded prior to every meal which was appropriate and expected nursing care. My peers consider that nurse who cared for Mr [redacted] on the night of his hypoglycaemic event as a cascade of terrible events. Although they recognised he need a snack - it took time to retrieve this (not her fault) and then she did not watch him eat this knowing his BSL could drop and to be an inexperienced nurse who did not communicate with her patient this led to catastrophic consequences. They would say that the added 15 minutes it took them to retrieve a snack might have meant MR [redacted] had dropped his BSL further and should have given him a hypo glucose snack as well as overseen him eating the sandwich. This would have been a priority for her/him over her other work. Knocking on the door /calling out Mr [redacted]'s name identified immediately he wasn't there and a search could have been made and his snack given. My peers would consider the nurse inexperienced and needing more support and education around Diabetic management.
Please outline any factors that may limit your assessment of the events.	• Not having access to Waikato Hospitals Hypoglycaemic Management for Diabetic emergencies 4mmols -10mmol/L • Not having access to the Waikato Vital signs chart during Mr [redacted]'s stay in the cardiac ward. • Not having access to the Incident Management Report • No access to Nursing notes prior except those post MR [redacted]'s cardiac arrest
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Nursing staff to have the knowledge and skills of how to manage a patient with hypoglycaemia events - especially with patients who are frail and elderly with dementia. • *Creating a nursing culture of having a low threshold to provide a nursing assistant or patient support who can either stay with patients who are confused or have Dementia or have regular check in on them to determine their whereabouts.* • **Creating a nursing culture where nurses communicate with their patients and whanau** and do not assume anything such as their patients whereabouts. Knock on the door – call to them, especially to patients who are frail with dementia.

	• Snacks for hypoglycaemic events give to patient to keep on their lockers.
Question 3: The appropriateness of the cardiac management during Mr [redacted]'s admission, inclusive of whether he should have received cardiac monitoring either at the bedside or by telemetry.	
List any sources of information reviewed other than the documents provided by HDC:	Dr. [redacted] Senior Medical Officer (SMO) at Te Pae Tiaki/ ED Wellington Hospital [redacted] Associate Charge Nurse Manager (ACNM) Health and Lung Unit Wellington Hospital https://silentone/content/DistrictDocs/Heart_LungUnitWd6S/CapitalCoast/Policies/000000101656/__file__/000000101656.pdf [redacted] ACNM te Pae Tiaki/ ED Wellington Hospital
Advisor's opinion:	• Mr [redacted] was seen by a doctor at within his triage time and in the medical notes an ECG recorded and appropriate blood tests, including a Trop T. • There is no mention in the nursing notes weither or not he was on telemetry in ED or was in the ED medical plan. According to Dr [redacted] in Te Pae Tiaki/ED Wellington hospital, any patient with STEMI/ NSTEMI needs to be on telemetry. • Whilst in ED Mr [redacted] was referred quickly to the Cardiology team. The next morning and had an angiogram, and the cardiologist commented on his findings . This is very good cardiac care. • I have no access to Waikato policy on cardiac monitoring but in the Heart & Lung unit at Wellington Hospital guideline states Post STEMI/NSTEMI must be cardiac monitored for 48 hours. It is unclear whether MR [redacted] was monitored or wearing a portable monitor. This is not documented in any nursing notes.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/ material.	The standard of care of his cardiac management by the cardiology team at the time of events seems ***acceptable.*** It is unclear whether or not MR [redacted] was on cardiac monitoring/telemetry as this Was not recorded in his nursing notes. Referring to Wellington Heart & Lung guidelines all patient that have had STEMI/NSTEMI need 48 hours of cardiac monitoring. This may have been one more barrier to him leaving. MR [redacted]'s Cardiac arrest management and documentation appears to be excellent. There was a good team response or what seems like senior doctors and

	nurses, CPR started fairly much immediately after discovering MR [redacted] A BSL taken as part of the reversible causes.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This was not a departure from acceptable practice
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would consider that Mr [redacted] NSTEMI was managed well. He was Triaged and seem quickly by Waikato ED's medical staff and referred onto the cardiology team then had an angiogram the next day. Again it is unclear about weither or not he was on cardiac monitoring.
Please outline any factors that may limit your assessment of the events.	• Access to Waikato cardiac monitoring policy/ guidelines • Admission nursing notes to ascertain weither or not MR [redacted] was on cardiac monitoring
Recommendations for Improvement that	• Documentation in nursing notes which would outline Mr [redacted]'s cardiac care

may help to prevent a similar occurrence in future.	
Question 4: The appropriateness of the overall management of the consumer in light of his age, frailty, cognitive impairment, including whether delirium should have been considered and screened for.	
List any sources of information reviewed other than the documents provided by HDC:	• Diabetes - Hypoglycaemic management for inpatients https://silentone/content/DistrictDocs/Diabetes_Endocrine/DistrictWide/Medical_NursingStaffinformation/000000002207/__file__/000000002207.pdf • Standards of Competence for Registrared Nurses https://www.nursingcouncil.org.nz/common/Uploaded%20files/Public/Nursing/Registered%20nurse/NCNZ031-Competencies-RN-11.pdf • ALERT course https://www.porthosp.nhs.uk/departments-and-services/alert-r#:~:text=Written%20to%20suit%20both%20primary,manage%20an%20acutely%20deteriorating%20person. • Just a routine operation: Elaine Bromley https://www.youtube.com/watch?v=JzlvgtPIof4
Advisor's opinion:	The medical staff seemed to have assessed quickly in ED, sent him for investigations and documented well. All medication was charted and the correct referral made to Cardiology. He was recognised to having a NSTEMI and had an angiogram the day after his admission which according to [redacted] ACMN reasonably fast. In my opinion I believe that MR [redacted] overall had poor nursing care. The nurse's care and management was substandard and poor in both ED as well as the cardiac ward at the time of the event. The ED nurse may have taken blood tests, recorded ECG's, spoken and explained all procedures etc to the [redacted]'s – **but this is not reflected in their notes**. All nursing documentation is substandard. The doctors clearly have written that Mr [redacted] had a diabetes and short term memory loss, mild dementia. Mrs [redacted] had written in her letter of complaint her husband was old and frail, shuffled when he walked and had short term memory loss. Being in busy, unfamiliar environment would have worsened this confusion. There seems to be no appreciation by the nurse for this. A screening for delirium would have been appropriate. He had not been settled the previous night before he died and in my opinion this would have been a red flag for the nurses to check on him more regularly or prioritise a Health Care Assistant to watch him again or to check in regularly with him.

	It was one and a half hours from the time the nurse last saw MR [redacted] to when he was found at the bottom of some stairs unconscious. Not calling for help earlier especially knowing he had short term memory loss is basic nursing. Focusing on raising Mr [redacted]'s BSL should have been a priority and knocking on the door and COMMUNICATING to ascertain Mr [redacted]s whereabouts is not difficult and again is as important as administering the sandwich snack.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/ material.	The standard of care at the time of events was poor and substandard. 1. **Diabetes:** Mr [redacted] should have received his carbohydrate snack immediately after the nurse recognised that his BS: was low and he stated he felt he was having an hypoglycaemic event as per C&CHV health board which would be similar to Waikato's management. https://silentone/content/DistrictDocs/Diabetes_Endocrine/DistrictWide/Medical_NursingStaffinformation/000000002207/_file_/000000002207.pdf 2. **Communication:** recognising that it was very important that Mr [redacted] needed management for his hypoglycaemia it was important that the nurse communicated to him a sandwich was waiting for him by knocking on the toilet door and calling his name. Immediately this would have ascertained weither he was in there or not. By doing this - the call for help could have been raised much earlier. 3. **Escalating help earlier.** On finding Mr [redacted] missing tried contacting his wife rather than contacting the Nurse in charge immediately who could have notified security immediately. 4. **Appreciation** by nursing staff on caring for patients with dementia/ short term memory loss. Although explanations maybe made – they could be forgotten quickly. Asking an unregulated staff member such as Health Care Assistant to wait with MR [redacted] 5. ***BEFORE the time of event I noted an excellent 'Patient to complete' form, a subjective assessment and objective assessment and nursing care plan. The care plan is individualised and clearly outlines that MR [redacted] has Type 2 Diabetes and needs TDS BSL and on insulin.***
Was there a departure from the	Severe departure from acceptable practice

standard of care or accepted stadnards ofpractice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	My peers would be so disappointed by this care MR [redacted] received for all the aspects outlined above: • The time it took the nurse to retrieve a sandwich – 15 minutes • No communication by the nurses to ascertain weither Mr [redacted] was in the toilet • An hour and a half from when the nurse last saw Mr [redacted] to when he was discovered by passing staff at unconscious. There was no appreciation that this man had dementia who stated he was worried he was having a hypoglycaemic event, he may have forgotten that she was searching for a sandwich and went off to find his own snack. • It took time for the nurse to escalate her concerns about Mr. [redacted]'s whereabouts to the nurse coordinator MR [redacted] was missing. My peers would questions why this was. Was she worried about being reprimanded for this? • Mr [redacted] walked past the nurse's station and through a door out of the ward – my peers would wonder why an elderly male in his pyjamas was up and about and not on telemetry. • Expert RN Nurse [redacted] Te Pae Tiaki/ ED with over 30 years' experience is in the opinion that that whilst the nurse recognised MR [redacted] was on the cusp of becoming hypoglycaemia they acted accordingly by obtaining some food to raise his BSL but failed to follow this through by ensuring he ate

	his sandwich. She goes onto say that while she cannot say that the hypoglycaemic event caused his death it was a contributing factor.
Please outline any factors that may limit your assessment of the events.	• Waikato Hospital Delirium screening tool • Hypoglycaemic management • Incident report Waikato Hospital
Recommendations for improvement that may help to prevent a similar occurrence in future.	• ONGOING Education/ awareness among staff about caring for elderly frail patients • **Emphasis on communicating with patients – not to assume anything** • ***Emphasis on calling for help early - ATTENDING ALERT COURSE*** • Snacks at any patients who may be at risk of hypoglycaemic events on their bed side table • All nurses to attend compulsory ALERT study day or some education about early escalation of any patient concern. • Examples of documentation and regular monitoring of this • All doors in Cardiac unit to have be electronic swipe doors – DONE • Increase in staff funding for more Care Partners • Increase in nursing FTE to increase nurse-patient ratio • Unsure if Waikato Hospital use the Trendcare tool. This could possibly be sued as evidence to increase their nursing numbers across all shifts.
Question 5: Recommendations on what additions could be made to policy documentation to improve care in the above areas in the future.	
List any sources of information reviewed other than the documents provided by HDC:	• Te Pae Tiaki/ ED orientation manual • Standard of documentation Waikato ED nurses • Delirium Capital and Coast District Health Board intensive Care https://silentone/content/DistrictDocs/ICUIntensiveCareUnit/CapitalCoast/PatientInformation/000000103602/__file__/000000103602.pdf • Cardiac monitoring in the Heart and Lung Unit ([redacted]) https://silentone/content/DistrictDocs/Heart_LungUnit[redacted]/CapitalCoast/Policies/000000101656/__file__/000000101656.pdf

	• Documentation, 2021 https://www.nzno.org.nz/Portals/0/publications/Guideline%20-NZNO%20Documentation,%202021.pdf
Advisor's opinion:	• I am unsure if Waikato hospital has a cardiac monitoring guideline - I would suggest Cardiac monitoring in the Heart and Lung Unit ([redacted]) • Nursing Documentation standards, awareness and implementation of expectations in ED. This would include examples of nursing documentation frameworks. • Regular auditing of nursing documentation standards
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	The standard of practice was not acceptable. Although the nurse recorded the BSL she/he and recognised that for his reading of 4.4mmol/L that he needed a carbohydrate snack – which she retrieved. She assumed Mr [redacted] would see it and eat it when he was out of the toilet. ***Administering this very important snack is similar to administering medicine – you have to stay and watch the patient consume it. This did not happen.***
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	This was a severe departure from acceptable practice

How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	A peer I consulted [redacted] (Expert Nurse Te Pae Tiaki/ ED) said this care was lacking. Although the nurses had the foresight to recognise that Mr [redacted] needed the sandwich they did not see him eating this. She wonders if this was due to work pressures and demands of other patient. They assumed he was in the toilet and didn't confirm his whereabouts. Mrs [redacted] said as a nurse you cannot assume anything with a patient who has dementia. They should have had more regular checks and observered more closely thus avoid a hypoglycaemic event.
Please outline any factors that may limit your assessment of the events.	• Waikato hypoglycaemic policy • Not having access to nursing notes prior to actual event • No access to Incident Management Report
Recommendations for improvement that may help to prevent a similar occurrence in future.	• Compulsory pathway for all Nurses training of all of the above suggestions
Question 6: Any other matters in this case that you consider warrant comment	
List any sources of information reviewed other than the documents provided by HDC:	• As mentioned above, this will be a very stressful and hard learning curve for Mr [redacted]s nurse. It's easy to put the entire blame on them. At this time they were in second year nursing with relatively little experience. No doubt this would have been a tough experience for them. • Prioritising care to vulnerable , frail patients is essential. • Not calling for help early and notifying senior nurses will lead to avoidable situations like we have seen with Mr [redacted]
Advisor's opinion:	***Emergency department*** ***The standard of nursing assessment and documentation is very poor.*** Much of the nursing notes are very brief and illegible. The nurse's signatures are unreadable which is not in-line with nurse -to-nurse handover or communicating what cares or task have

	been done. There is not proper nursing assessment in a structure. Mr [redacted] may have had excellent nursing care – but this is not reflected in the nursing notes or any kind of nursing assessment. His wife was surprised when she asked a nurse if they knew he was a diabetic which she said 'NO'. I am unsure of this conversation but stating 'they come and then they go' is terrible communication and disrespectful. [redacted] comments that 'opportunities were missed' as the nurse assumed MR [redacted] was in the toilet and didn't knock on the door of communicate to him is so poor. Communication with the patient and whanau is the basis of good nursing care. The events around Mr [redacted]s death must be a hard lesson for his nurse in so many ways – communicating properly with patients, prioritising care, calling for help early and caring for patients with dementia. But we have to raise the care of our patients and be accountable for our care and actions as nurses.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/ material.	Unacceptable
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate	Severe departure from acceptable care

depart ure; or • Severe depart ure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	As above
Please outline any factors that may limit your assessmen t of the events.	All tools as referenced above
Recommen dations for improvem ent that may help to prevent a similar occurrence in future.	As above

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature: 
Name: Marion Picken
Date of Advice: 23 April 2025

Appendix B: Comments from the immediate family member of Mr A

- I wish to thank the Commissioner's office for undertaking this investigation.
- After reviewing the preliminary findings it is my view that the central failures in this incident are:
    a. Lack of including family and patient in medical treatment plan, as well as not adjusting dosage for the impact of the hospitalizing cardiac incident likely led to over medication and severe hypoglycemic crisis resulting in patients death at 1.8mmol/L
    b. Failure of duty of care by Nursing staff to provide treatment that resulted in the reasonably foreseeable progression of severe hypoglycemic crisis and eventual death
- It is my view that dementia care, elderly care and comorbidity care are issues that are important in general, but did not directly cause the death of the patient.
- I wish to express my deep dissatisfaction with the care provided by the medical and nursing providers charged with direct duty of care. It is my view that those individuals failed to provide that duty of care for this patient and their actions and inaction directly led to the patient's death.
- While I see the multiple failures of the nursing staff to be the primary cause of death I also consider the environment in which the attending nurse worked likely to be deficient and I respectfully request further investigation be made into the areas of training and management to ensure that Health NZ employees are able to adequately provide care.
- I consider the failure to ensure that the patients rights were met is a shared one, that must also be borne by the hospital and Health NZ regarding its training, treatment guidelines and management practices.
- It is my heartfelt hope that if the individuals in this report continue to practice healthcare they are provided with the training, support, treatment options and management to avoid incidents in the future that result in unnecessary and traumatic deaths such as this.
- In particular I consider the failure to offer consistent monitoring of glucose levels through available CGM technology for higher-risk patients is a failure of health provision by the New Zealand health system.
- I consider the apparent deficient levels of nursing staff available in the ward at the time of this incident to be a failure of duty of care by Health NZ.
- I wish to express my deep regret that the Health NZ employees who encountered the patient outside of the ward in distress did not see an opportunity or duty to provide care.
- I wish to thank the Healthcare professionals who encountered the patient unconscious in a severe hypoglycemic crisis and for attempting life-saving intervention. I can only imagine what it must have been like to stumble across a lost patient dying in a stairwell late at night.
- Lastly, I request that this, my summary of comments, be included in full in the final findings of this investigation with the intention to show support for future patients and their families to advocate for their rights in ensuring appropriate treatment and duty of care.