District Health Board

Bupa Care Services NZ Limited

Registered Nurse, RN B

Registered Nurse, RN C

Registered Nurse, RN D

Enrolled Nurse, RN E

A Report by the

Deputy Health and Disability Commissioner

(Opinion 15HDC01543)

Table of contents

Executive summary ... 1

Complaint and investigation ... 3

Information gathered during investigation ... 4

Relevant standards ... 18

Responses to provisional opinion ... 18

Opinion: Bupa Care Services NZ Limited — breach ... 19

Opinion: RN B — adverse comment ... 20

Opinion: RN F — adverse comment ... 21

Opinion: RN C — breach ... 21

Opinion: RN D — breach ... 22

Opinion: RN E — breach ... 23

Opinion: The District Health Board — other comment ... 23

Recommendations ... 26

Follow-up actions ... 26

Appendix A: Independent in-house nursing advice to the Commissioner ... 29

Appendix B: Independent expert nursing advice to the Commissioner ... 36

Executive summary

1. Following the removal of a spinal abscess, Mrs A suffered from incomplete paraplegia. She relied on her wheelchair to move around, and a hoist and sling was needed when providing care. Her husband, Mr A, was her primary full-time carer.

2. On 21 Month2 2015,[1] Mr A arranged for Mrs A to stay at a rest home, owned and operated by Bupa Care Services (Bupa), for respite care from 3 Month3 to 22 Month3 while he took a break and went overseas.

3. Bupa's Short Stay Policy at the time required that potential respite residents have a Needs Assessment Service Coordination (NASC) assessment less than 12 months old and/or a GP review within the three months prior to admission.

4. When Mrs A was admitted on 3 Month3, her most recent NASC assessment had occurred in 2013. Accordingly, it did not note that in Month1, approximately six weeks prior to admission, Mrs A had been hospitalised for bilateral pneumonia and type 2 respiratory failure, and that subsequently she had been referred to the DHB respiratory clinic to assess her breathing and to investigate sleep apnoea.

5. Bupa reported that when the rest home's Clinical Manager, registered nurse (RN) E, contacted the NASC assessor regarding the age of the assessment, the assessor acknowledged that it was not current but said that "they had nothing further". Mr A did not communicate the respiratory issues that Mrs A had suffered in Month1 prior to her admission.

6. Bupa also reported that the rest home manager, Ms H, requested that Mrs A visit her doctor prior to admission, but this did not happen.

7. On 3 Month3, Mrs A was admitted to the rest home, initially by RN F. RN F noted that Mrs A's medications were not blister packed, and that a copy of her medication chart had not been provided by Mr and Mrs A.

8. At around 3pm, RN B started the afternoon shift at the rest home as the senior registered nurse on duty. RN F verbally delegated Mrs A's care to RN B. RN F said that she asked RN B to follow up with the admission paperwork and to complete Mrs A's baseline observations. Bupa told HDC that its expectation was for Mrs A's baseline observations (vital signs) to be completed by the admitting nurse (RN F), and for any assessments not completed by the admitting nurse to be handed over to the oncoming registered nurse (RN B) for completion. Bupa said that Mrs A's baseline observations were handed over to RN B to complete. However, no baseline observations for Mrs A were completed and recorded on admission.

9. Early in the hours of 4 Month3, RN C documented finding Mrs A sitting on the floor following a fall from her bed. Mrs A was assessed and her vitals were taken. Her progress notes record that she had oxygen saturations of 80% (normal range is 95–98%). RN C

[1] Relevant months are referred to as Month1–Month4 to protect privacy.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

completed an incident form outlining the events. She documented the 80% oxygen saturation level on the incident form.

10. RN C did not instigate oxygen therapy and initiate ongoing monitoring or timely escalation of the result to the GP, or ensure that this was handed over to the morning staff to carry out.

11. On 7 Month3, RN E reviewed the incident form for the above fall. She noticed that no baseline observations had been taken for Mrs A on admission. RN E therefore added into the Short Stay Admission Record the observations that had been taken on 4 Month3 (including the oxygen saturation of 80%). She did not investigate Mrs A's low oxygen saturation further, although it could not be explained by the fall.

12. On 10 Month3, RN D was the Duty Leader in the hospital wing for the afternoon and evening. At approximately 8pm, RN D documented in Mrs A's progress notes that Mrs A had appeared to be short of breath after her evening meal. Mrs A was observed sitting asleep in her wheelchair with her chin on her chest. RN D believed that because Mrs A was obese, her position could be blocking her airway. On assessment, RN D noted a blue tint to Mrs A's lips, and her oxygen saturation was found to be 67%.

13. In response to this, RN D administered oxygen until Mrs A's saturation increased to 95%, and sent a fax to her GP regarding the need for a review. No further observations were recorded for the remainder of the night.

14. On 11 Month3 at 7.30am, staff found that, sadly, Mrs A had passed away.

Findings

15. It was found that Bupa had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). Bupa was found to have failed in that responsibility and to have breached Right 4(1)[2] of the Code for the following reasons:

- Bupa's Short Term Stay Policy required potential respite care residents to have a NASC assessment that was less than 12 months old, and/or a GP review within three months prior to admission. Mrs A was accepted for respite care at the rest home without a recent NASC assessment or GP review. Bupa has made changes to ensure that this does not happen again.
- Mrs A's baseline observations (vital signs) were not taken on admission.
- Staff at the rest home failed to act on Mrs A's low oxygen saturations on multiple occasions. Staff need to think critically and respond appropriately to a resident's condition.
- The inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that did not support and assist staff sufficiently to do what was required of them.

16. It was found that RN C failed to provide services with reasonable care and skill to Mrs A on 4 Month3, in breach of Right 4(1) of the Code. RN C documented low oxygen saturations

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

yet failed to instigate the appropriate intervention (oxygen therapy) and initiate ongoing monitoring or timely escalation of the result to the GP, or ensure that this was handed over to the morning staff to carry out.

17. It was found that RN D failed to provide services with reasonable care and skill to Mrs A on 10 Month3, in breach of Right 4(1) of the Code. RN D responded to Mrs A's oxygen saturation level of 67% by administering oxygen until Mrs A's saturation increased to 95%, and by sending a fax to Mrs A's GP regarding the need for review. However, the appropriate action would have been to call 111 or arrange an urgent review by a GP.

18. RN E was found in breach of Right 4(1). As Clinical Manager, ultimately she was the person with primary responsibility for the care provided to Mrs A. In relation to Mrs A's fall on 4 Month3, when RN E reviewed the incident form on 7 Month3 she did not investigate Mrs A's low oxygen saturation further, although it could not be explained by the fall. Accordingly, RN E failed to provide services to Mrs A with reasonable care and skill.

19. Adverse comment was made that following the handover of a new client, RN B did not review the notes, including the Short Stay Admission Record, and ensure that all of the admission requirements had been completed.

20. RN F was criticised for not ensuring that clear direction was given to RN B to complete Mrs A's baseline observations. It was noted that at the time of events, RN F was in her first year of nursing practice and, as noted above, RN B should have been able to ascertain the information from reviewing the notes, as she was responsible for completing Mrs A's admission.

Recommendations

21. It was recommended that Bupa:

a) Consider the implementation of a system in a written format to capture outstanding tasks, including any ongoing monitoring requirements and any concerns of care staff that need to be handed over between shifts.
b) Consider the initiation of out-of-hours access to a senior nurse, especially for new graduate nurses who may be on a shift without a registered nurse colleague.
c) Provide a written apology to Mrs A's family for its breach of the Code.

22. In line with the recommendations in the provisional opinion, RN C, RN D, and RN E provided written letters of apology to Mrs A's family for their breaches of the Code.

Complaint and investigation

23. The Commissioner received a complaint from Mr A about the services provided by a rest home to his wife, Mrs A. The following issues were identified for investigation:

- *Whether Bupa Care Services NZ Limited provided [Mrs A] with an appropriate standard of care between 21 [Month2] and 11 [Month3].*

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *Whether [RN B] provided [Mrs A] with an appropriate standard of care between 3 [Month3] and 11 [Month3].*
- *Whether [RN C] provided [Mrs A] with an appropriate standard of care between 3 [Month3] and 11 [Month3].*
- *Whether [RN D] provided [Mrs A] with an appropriate standard of care between 3 [Month3] and 11 [Month3].*
- *Whether [the DHB] provided [Mrs A] with an appropriate standard of care between [Month1] and [Month3].*

24. The investigation was later extended to include the following:

- *Whether [RN E] provided [Mrs A] with an appropriate standard of care between 21 [Month2] and 11 [Month3].*

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

26. The parties directly involved in the investigation were:

Mr A	Complainant
Bupa	Group provider
The DHB	Group provider
RN B	Individual provider
RN C	Individual provider
RN D	Individual provider
RN E	Individual provider
RN F	Individual provider
Ms G	Clinical Needs Assessor
Ms H	Manager of the rest home

27. Information from the Coroner was also reviewed.

28. Expert advice was obtained from in-house clinical nursing advisor RN Dawn Carey (**Appendix A**) and RN Christine Howard-Brown (**Appendix B**).

Information gathered during investigation

Background

29. Mrs A (70 years old at the time of these events) had a series of health issues including an ovarian mass, type 2 diabetes, and hypertension (high blood pressure). Her medical notes also document that she was obese. Two years prior to these events, a spinal abscess was

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

identified and operated on; this left her with incomplete paraplegia,[3] reliant on a wheelchair to move around, and in need of care with a hoist and sling.

30. Mrs A's husband, Mr A, became Mrs A's primary full-time carer following her operation. External carers also visited Mrs A at home during the week to assist.

The DHB and the DHB's Needs Assessment Service

31. District health boards fund services, including home and community support services, to help individuals who are over the age of 65 years and have long-term disability or age-related health needs. Needs Assessment Service Coordination agencies (NASCs) operate the needs assessment and service coordination process on behalf of the relevant DHB. Every person who wishes to receive disability support services funded by a DHB must be needs assessed by the NASC. In the DHB's region, NASC services are provided by the Care Co-ordination Centre, which is a service managed by the provider arm of the DHB. In Mrs A's case, the home and community support services that she was receiving (the external carers) were provided by the service provider that had a contract with the DHB to provide those services.

32. The initial review and any reassessments are carried out in line with the NASC's Restorative Support Services in the Community Service Specification (the Support Services Specification document) and the Care Coordination Operations Manual (the Operations Manual).

33. The DHB's Support Services Specification document outlines a requirement for reviews to be undertaken to assess the suitability of the current support package to meet the user's "support" needs, and to provide an opportunity to reassess needs and modify support packages accordingly. Reviews may be undertaken by the NASC or the service provider. Where a review indicates change, a reassessment is undertaken. Triggers for a review or reassessment include the scheduled review date, change in support needs, or a request from the service user or the service user's family/caregiver.

34. The support needs available to be allocated to Mrs A could be increased by the home and community support service in response to changing needs if required.

35. Two years prior to these events, the NASC completed an InterRAI assessment for Mrs A. The DHB told HDC that this assessment is used for "all complex clients". The Operations Manual outlined the review and reassessment criteria. For someone with a very high level of care (a complex client), the manual indicates the need for an annual reassessment by a clinical assessor using the interRAI Home Care tool.

36. Despite what is written in the Operations Manual, the DHB told HDC that the practice at the time was for reassessment to be undertaken every three years, "unless a request was received for a reassessment earlier than this time period based on a change in the person's needs".

[3] Partial damage to the spinal cord, with some motor and sensory function remaining.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

37. Mrs A's InterRAI assessment documented that, at the time, Mrs A had no respiratory diseases or diagnoses, but she had a history of falls and required the use of bed rails. The recorded date for reassessment was in three years' time.

38. The DHB told HDC that following the InterRAI assessment, service reviews were undertaken to ensure that Mrs A's support package was meeting her needs. The DHB stated: "If her needs had changed she would have been referred back to NASC for a re-assessment."

39. Mrs A's rehabilitation notes from the DHB document that from Month1 she was beginning to show some improvement in the use of her lower limbs. Occasional falls were documented, generally when transferring from her wheelchair to a car.

40. On 24 Month1 2015, Mrs A consulted with a general practitioner (GP) at a medical centre (her usual general practitioner at the practice was another GP). Mrs A reported a progressive decline in her health over the previous two weeks. The GP referred Mrs A to the Emergency Department (ED) of a hospital. The referral note documents symptoms of a cold and a slight cough, and notes that Mrs A had become increasingly short of breath over the past 10 days. It also documents that Mr A had been describing Mrs A as displaying irrational behaviour, including "hallucinating and throwing food and drink away".

The hospital ED — diagnosis of pneumonia

41. Mrs A was taken to the hospital's ED and admitted to the medical ward on the same day. It is documented in the clinical notes that she had been unwell with upper respiratory tract infection symptoms for two weeks, delirious over the last two to three days, short of breath, and febrile[4] with rigors.[5]

42. A chest X-ray was performed, which identified a collapse of the left lower lobe of the lung and consolidation,[6] and a possible left-sided pleural effusion.[7] The radiology report documented: "Appearances are most consistent with multifocal pneumonia."

43. Mrs A's clinical notes document that she was treated for "bilateral pneumonia with type 2 respiratory failure". She was started on BiPaP[8] to improve hypercapnia[9] and oxygenation.[10] It was also documented that her type 2 respiratory failure was "likely to be multifactorial related to [obstructive sleep apnoea],[11] and her body habitus (being overweight)".

44. Mrs A's clinical condition improved and she was discharged on 29 Month1. Her discharge summary, which was given to her, noted that she was scheduled to have an outpatient follow-up appointment in the respiratory clinic to assess her breathing and to investigate sleep apnoea. It was further noted that at the follow-up appointment her use of "home oxygen" would be considered. It was also noted that she should have a repeat chest X-ray in

[4] Elevated body temperature (a fever).
[5] Episodes of shaking or exaggerated shivering, which can occur with a high fever.
[6] Inflammation of the lung. The most common cause of consolidation is pneumonia.
[7] Excess fluid around the lung.
[8] Bi-level Positive Airway Pressure (non-invasive ventilation for chronic obstructive pulmonary disease).
[9] Abnormally elevated carbon dioxide levels in the blood.
[10] Oxygen levels.
[11] Complete or partial obstruction of the upper airway during sleep.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

six weeks' time to confirm the clearance of pneumonia. It was documented that if there were any concerns in the meantime, Mrs A should see her GP or return to the hospital.

45. A semi-urgent referral for a respiratory assessment was made (received on 31 Month1),[12] and a chest X-ray was scheduled for 18 Month3.

46. The DHB told HDC:

> "Emergency Department and inpatient services will refer to the Care Coordination Centre [the NASC] for a review of any individual where they believe that their support needs have changed. Where this is the case, discharge summaries are also forwarded to the Care Coordination Centre as part of the referral. No referral was received [by the NASC] post inpatient admission for [Mrs A]."

47. As stated above, a reassessment by NASC of Mrs A's needs was not due until the following year. The NASC was not sent Mrs A's discharge report or provided with any information, as the hospital did not consider that Mrs A's needs had changed so as to require further reassessment or involvement by NASC.

48. The DHB told HDC that, while still in hospital (in Month1):

> "[Mrs A] was seen by the Ward Social Worker and Occupational Therapist during her admission. The Social Worker discussed the [current] care package with [Mrs A] and she was happy with the current services. The Occupational Therapist noted that [Mrs A] had a large care package in place and home equipment required. The ward would not routinely refer for a new NASC assessment but would rather make a clinical decision based on the assessments completed by nursing, medical and allied health."

49. Accordingly, the various services at the DHB (including the NASC) were unaware of Mrs A's most recent admission to hospital, or that she was awaiting sleep studies and assessment for non-invasive ventilation.

50. A Clinical Needs Assessor, Ms G from NASC, told HDC: "There were no notified changes or concerns reported to NASC from [the hospital], carer supports, Mr or Mrs A or any other health care provider to prompt any reassessment of [Mrs A]."

51. Ms G also told HDC:

> "Even if [Mrs A's earlier admission to hospital in Month1 with pneumonia] was known to the NASC service it would not have resulted in a reassessment of [Mrs A]. This is because the NASC service would have assumed, and is entitled to assume, that at the time of discharge from hospital that [Mrs A] had been discharged medically and appropriately and safely back to her home environment i.e that [Mrs A] was well enough and safe enough to be discharged home from the hospital at the time she was

[12] The appointment was to see a respiratory physician. Prior to seeing the respiratory physician, Mrs A was required to undertake a sleep study. The priority status of this was semi-urgent. The appointment with the physician himself was given routine status. The DHB told HDC that once the sleep study had been completed and reviewed, the priority to see the physician would have been adjusted if necessary to "urgent" or "semi-urgent".

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

discharged home. If there was some change in circumstances that came to light during the hospital admission that required contact be made by [the hospital] with the NASC service, then that contact would have been made. At the time of discharge, [Mrs A] was considered safe to return to her home with the carer support that was in place for her."

Consideration of respite care for Mrs A

52. Mr A told HDC that as he had been Mrs A's full-time carer for so long, the family wanted him to have a break. Mr A arranged to stay with one of his sons, who lives overseas, for two weeks. Mr A told HDC that he looked into respite care options for Mrs A but eventually decided to let the NASC select a place for her.

53. On 21 Month2, Mr A contacted the NASC's Office. Mrs A's allocated Clinical Needs Assessor was unavailable and the call was transferred to Ms G at the NASC Office. Ms G told HDC that Mr A informed her that he would be going away on holiday and wished to "activate" a "planned break" for while he was away. Ms G said that Mrs A's support package in place provided for "planned breaks" (respite care) so as to provide Mr A with relief from his lead carer role.

54. Ms G told HDC that Mrs A's notes had no alerts on the file other than documentation regarding two recent carer and physiotherapy support contacts with NASC.[13] Ms G said that the notes indicated improvements in Mrs A's health.

55. As stated above, the Clinical Needs Assessor and the NASC had not been informed by any source that Mrs A's needs had changed in any way. The DHB said:

> "[Accordingly,] the Clinical Needs Assessor had no reason to believe that there had been any functional changes that were requiring reassessment, and was following [the DHB's] current policy to not reassess on access to respite when this is part of the agreed support package."

56. On the same date, Ms G emailed Ms H, the rest home manager,[14] and arranged for Mrs A to stay at the rest home for respite care from 3 [Month3] to 22 [Month3]. Attached to the email was the InterRAI assessment that had been completed two years previously.

57. Bupa's Short Stay Policy requires that potential respite residents have a NASC assessment that is less than 12 months old and/or a GP review within the three months prior to admission.

58. Bupa told HDC that the rest home's Clinical Manager, RN E,[15] contacted the NASC assessor to point out that the assessment was quite old, and the assessor acknowledged that it was not current but said that "they had nothing further".

59. The DHB told HDC: "We have no record that any concerns were raised by [the rest home] prior to respite admission." Ms G told HDC that other than confirming with the rest home

[13] Earlier that year.
[14] The rest home was able to offer hospital-level care.
[15] Bupa told HDC that as the Clinical Manager of the rest home, RN E was the senior person having primary responsibility for the care provided to Mrs A.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

that Mrs A would be staying for a period of respite care, she "received no further contact or correspondence from the [rest home]".

60. RN E's response to HDC differed slightly from Bupa's. She stated:

> "I don't remember what date I reviewed the assessment. I recognised it was old, read it and added Mrs A's medical diagnoses from the assessment to our Bupa Problem List. I do not recall if I did anything further as I was aware that the [rest home manager] had asked [Mrs A's] family to take Mrs A to her GP prior to admission. In my experience when a resident sees their GP prior to admission, the GP will provide all recent relevant information."

61. In response to the "information gathered" section of my provisional opinion, Mr A said that he did not take his wife to the GP as he did not think it necessary, because she had seen her GP a month previously, and he "presumed a report would be forthcoming if requested".

62. Mrs A was allocated a two-week stay at the rest home. The rest home did not request that Mrs A have a reassessment by NASC.

63. Ms G told HDC:

> "[Mrs A] was already receiving hospital level care services at her home and the respite care that was being arranged was into a hospital level care facility with a Registered Nurse in attendance 24 hours i.e [Mrs A] was going into a more medically responsive and safer environment than [Mrs A's] home environment.
>
> There is nothing about [Mrs A's] admission to hospital a month earlier for pneumonia that would have prompted any different response from the NASC service in handling the request for a planned break for [Mr A]."

64. Furthermore, Ms G also told HDC:

> "Even if [a reassessment request] was received and NASC determined that it would undertake a reassessment, any reassessment would not have occurred with urgency as it would have been assumed that [Mrs A] was currently medically safe and being cared for and would have been carried out during the three week time frame that [Mrs A] was to be in at the facility [the rest home].
>
> Furthermore any reassessment would only be to establish if [Mrs A] should receive any higher level of care at her home or remain in a hospital level care facility. It is unlikely that [Mrs A's] recent hospital admission for pneumonia would have resulted in any change to her level of care. This is because she had been considered well enough to be discharged back home from hospital and she was already receiving the highest level of care available."

The rest home

65. During the week of 26 Month2, Mr and Mrs A visited the rest home before Mrs A was admitted. Mr A said that they felt that "it seemed fine in most respects, except no hand rails

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

on the bed and [Mrs A had been] used to one at home". Mr A told HDC: "[Mrs A] seemed happy to spend a couple of weeks there while I had a break."

66. Bupa told HDC that during this visit, Ms H (the rest home manager) requested that prior to admission Mrs A visit her doctor to complete some paperwork, including a medication chart for the medication she was taking. Bupa said that Mr A was asked to have Mrs A's medications blister packed for use when Mrs A arrived at the rest home.

67. In response to the "information gathered" section of my provisional opinion, Mr A said that Mrs A was capable of self medicating, and that the medications, while not blister packed, were prepared in plastic pill boxes and labelled, and that there was a list of the medication with dispensing times.

3 Month3

68. At around 2pm on 3 Month3, Mrs A was admitted to the rest home, initially by RN F.[16] RN F told HDC: "[Mrs A] was bright, alert and reactive." RN F also said that Mrs A "showed no clinical symptoms relating to confusion and SOB [shortness of breath] and no acute symptoms of being unwell".

69. Mr A told HDC that on admission they went through the induction process, including medication and catheter requirements, and activities.

70. RN F completed some of Mrs A's admission documentation at this time. RN F noted that Mrs A's medications were not blister packed and that a copy of Mrs A's medication chart had not been provided by Mr and Mrs A. RN F said that Mr A advised that they had not attended a GP appointment or had any medications blister packed.

71. Mr A left just before 3pm as he had to catch a flight. At around this time, RN B started the afternoon shift at the rest home as the senior registered nurse. RN F verbally delegated Mrs A's care to RN B. RN F asked RN B to follow up with the pharmacy and the GP to clarify Mrs A's medication requirements. RN F said that she also asked RN B to follow up with the admission paperwork and to complete Mrs A's baseline observations. RN F told HDC: "I did not reflect specifically this delegation regarding the observations in the progress note entry." She further said: "I knew that RN B had her 1500–2300 hr. shift to complete [the admission observations]."

72. At the end of her shift, RN F informed Ms H that Mrs A's medications had not been blister packed and that there was no medication chart to assist with administering her medications. Ms H noted that there was also no documentation outlining Mrs A's current medical issues, or any prescription to confirm the medications she was taking. Ms H rang Mr A, who was at the airport waiting to board his plane. He gave his consent for the rest home to arrange for Mrs A's medication to be blister packed.

73. At 3.32pm, RN F sent a fax to Mrs A's GP stating that the rest home had no medication chart or scripts for Mrs A's medications and asking him to chart the medications. This was followed up by RN B, and was completed by the GP that day.

[16] RN F was a new graduate nurse at the time and had been working at the rest home for approximately eight months.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

74. Bupa told HDC that it would have expected Mrs A's baseline observations (vital signs) to have been completed by the admitting nurse (RN F), and for any assessments not completed by the admitting nurse to be handed over to the oncoming registered nurse (RN B) for completion. Bupa said that Mrs A's baseline observations were handed over to RN B to complete.

75. RN B told HDC that she does not recall these events in much detail, but does remember seeing Mrs A on the day of her admission and recalls her being "happy and well at the time with no apparent difficulties such as shortness of breath or difficulty breathing". RN B said that RN F commenced the short-stay admission documentation, and her recollection is that RN F had already taken Mrs A's baseline observations.

76. No baseline observations for Mrs A were completed and recorded on admission.

77. Bupa told HDC that at the time of Mrs A's admission, none of the staff were informed by Mr and Mrs A that Mrs A had been admitted to hospital in Month1 and treated for bilateral pneumonia and provided with BiPap for 48 hours.

78. Bupa stated that other than the InterRAI assessment, no other information had been provided to the rest home regarding Mrs A's medical history. Bupa said that given that the InterRAI assessment and care plan report sent to them prior to Mrs A's admission were over two years old, it regrets not seeking more recent medical information from Mrs A's GP. Bupa stated that the rest home manager reported that "at the time the focus was on obtaining the medications to enable the staff to administer these correctly to [Mrs A]". Bupa told HDC: "We deeply regret that we … did not take this opportunity to discuss the medical history with the GP."

79. Bupa also acknowledged that staff did not ensure that the family provided all the current relevant information as requested prior to admission, as per its policy. It further acknowledged that Mrs A was admitted despite not having had a recent GP review, and with an interRAI assessment that was over two years old.

4 Month3

80. It is documented in Mrs A's progress notes at 3.15am on 4 Month3 that RN C found Mrs A sitting on the floor, and that Mrs A said that she had been sitting on the side of the bed and had slid off. It is recorded that Mrs A denied any pain and said that she had not hit her head. She was assessed and had her vital signs taken. Her progress notes record that she had oxygen saturations of 80% (normal range is 95–98%). It is documented that Mrs A was assisted back to bed and was comfortable. RN C then completed an incident form outlining the events. She documented the 80% oxygen saturation level on the incident form.

81. RN C told HDC:

> "[Mrs A] was not exhibiting any signs of lack of oxygen, like shortness of breath, blue lips, heart racing, restlessness or agitation. [Mrs A] was able to tell you if she was short of breath. During my time with [Mrs A] she was competent and able to clearly indicate to me how she was feeling and what she wanted."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

82. RN C further told HDC that Mrs A was visually checked regularly through the rest of the night, and that she appeared to be sleeping comfortably. However, this was not documented, and RN C acknowledges that she should have done this.

83. Mrs A's progress notes record that on 4 Month3 a sensor mat and "landing strip" were put in place "due to high falls risk". It is also noted that family were informed of Mrs A's fall. Bupa told HDC that at the time of Mrs A's fall, the rest home did not have a suitable bedrail or other such equipment to help to prevent a fall. Bupa stated:

> "The use of a bed rail for a resident with or without capacity requires formal assessment and 'approval' prior to its application … Should a resident with capacity request a bed rail or other such equipment, the qualified nurse would assess its use as an enabler.
>
> According to Mrs A's 2013 InterRAI assessment, a bedrail (or similar) was something she had been using for some time at home. Unfortunately this was not noted by staff and we believe that had it been, the admitting nurse would have spoken with [Mrs A] about what she was used to and a bedrail may have been arranged.
>
> It is unfortunate also that neither Mr nor Mrs [A] mentioned the use of a bedrail at home or requested one during her admission."

84. In response to the "information gathered" section of my provisional opinion, Mr A said: "Bed rails I am sure would have been mentioned at admission as it was an important piece of equipment at home."

5–9 Month3

85. During 5–7 Month3, Mrs A's progress notes record that she was well.

86. On the morning of 7 Month3, RN E reviewed the incident form for the above fall. It was her practice to review any incident forms following the weekend. She noticed that no baseline observations had been taken for Mrs A on admission. RN E therefore added into the Short Stay Admission Record the observations that had been taken on 4 Month3 (including the oxygen saturation of 80%). RN E did not document that she had recorded these observations in the Short Stay Admission Record, or clarify that the baseline observations were actually filled in on 7 Month3, even though the format of the Short Stay Admission Record is suggestive that the baseline observations were taken on admission.

87. RN E told HDC:

> "Whilst noting these down I was aware that the oxygen saturation was abnormal and [Mrs A] was tachycardic. I reviewed the progress notes to ascertain if [Mrs A] had been exerting herself or in any distress at the time the observations were taken and realised they were taken following her fall. The process of getting [Mrs A] safely up off the floor in addition to the fall could have exerted her and caused the observations to be abnormal. I also spoke to [Mrs A] this same morning. She was warm, pink and perfused and chatting without any noticeable shortness of breath. I asked her how she was feeling and she said 'fine'. She made light of the incident and said she was used to having a bed loop on her bed. During this interaction, I assessed she was also morbidly

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

obese as per her admission weight so I understood why her observations would have been abnormal post fall. As she presented in good health and appeared to be conversing with ease and appropriately, I did nothing further except order a sensor mat and bed loop to help prevent further falls and/or alert staff to the need for assistance in a timely fashion."

88. RN E documented on the "incident follow up and evaluation of actions taken" part of the incident form that no bed handles were available, but that some had been "ordered for [Mrs A's] use".

89. Bupa told HDC that on 14 Month3 a meeting was held between Mr A and Ms H. Bupa said that Mr A told the rest home manager that "on admission he had not mentioned his wife's use of a bedrail as he had thought they were standard like in hospital". However, in his complaint to HDC, Mr A said that "the [bed] rails had not been put up as discussed pre admission".

90. During the morning of 8 Month3, Mrs A was reported as eating and drinking well, although a caregiver wrote in Mrs A's care notes that Mrs A was saying things that did not make any sense, and that she seemed to be confused. The caregiver documented that a registered nurse had been informed.

91. There is no documented record of follow-up by a registered nurse regarding this report. Bupa told HDC: "Although the [caregiver] believed that she had verbally handed this over, during interview none of the 3 RNs could recall being informed of any concerns regarding [Mrs A's] condition."

92. Mrs A's progress notes for this day document that her intake of food and fluid was good, she had had visitors, and there were no concerns.

93. No further concerns or episodes of confusion were noted in the progress notes from 8 Month3 to 10 Month3.

10 Month3

94. On 10 Month3, RN D was the Duty Leader in the hospital wing for the afternoon and evening. She told HDC that this meant that she had responsibility, and was the "go-to person", for any issues. In the case of an emergency she was also the Warden/Co-ordinator. She also stated that she was a new graduate and had been working as a nurse for only 10 months.

95. At approximately 8pm, RN D documented in Mrs A's progress notes that Mrs A had appeared to be short of breath after her evening meal. Mrs A was observed sitting asleep in her wheelchair with her chin on her chest. RN D told HDC: "As [Mrs A] was an obese woman I believed she may have been blocking her airway in this position." RN D said that she woke up Mrs A, and she appeared to be "lethargic". Having assessed her, RN D noted that as well as being short of breath, Mrs A had a blue tint to her lips. Her oxygen saturation was found to be 67%. RN D told HDC that she also took Mrs A's other vital signs at the time and, although not recorded, RN D recalls that they were within the normal range.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

96. It is documented that RN D administered oxygen (via a Hudson Mask[17]) "with good effect". RN D told HDC that prior to administering oxygen to Mrs A she asked her whether she had received oxygen like this before, and Mrs A told her that she had. It is documented that Mrs A's oxygen saturation increased to 95%.

97. RN D told HDC that Mrs A was fully awake and communicating. RN D said that she questioned whether there might be some "unknown cause besides [Mrs A's] awkward positioning for the sudden drop in oxygen saturations", and she read Mrs A's file. RN D stated: "There was no mention in her file of any other diagnoses and it appeared to me that the drop in oxygen saturations had been due to her position."

98. RN D said that after over an hour on the oxygen mask, she weaned Mrs A off the oxygen. It is documented that Mrs A was maintaining a 93% oxygen saturation level, and that she was settled into bed. RN D told HDC that Mrs A was placed in a semi-Fowler's position (tilted back to approximately 30 degrees) to prevent her from positioning herself with her chin on her chest again. No further shortness of breath was noted. RN D told HDC that once Mrs A had been settled into bed, she (RN D) checked on Mrs A regularly to observe the pulse oximeter she says she left on Mrs A's finger, to ensure that she was maintaining the oxygen saturation. However, these observations were not documented.

99. As no further episodes of shortness of breath were noted by RN D during the remainder of her shift, and given that she believed Mrs A's baseline oxygen level had been 80% on admission, RN D did not consider that an urgent review by a GP or ED was necessary at that time.

100. RN D told HDC:

> "It appeared to me at the time that [Mrs A's] oxygen saturations had dropped when she had slept in an unusual position potentially restricting her airway. I decided that due to her bouncing back and maintaining 93% at room air and following reading her diagnoses as described in her notes that no emergency treatment was necessary."

101. RN D further stated:

> "As per Bupa Care Services oxygen therapy policy, oxygen therapy is only required in an emergency if oxygen saturations are below 93%, as [Mrs A] was sitting at this level and as she presented as orientated, pink and conversational I deemed it appropriate to wean off oxygen and that a fax to the GP for a review was sufficient."

102. RN D told HDC that she discussed her plan with an enrolled nurse (EN), "the EN in the rest home area", and that the enrolled nurse agreed with the plan and the rationale.

103. No further observations were recorded for the remainder of the night.

[17] A facemask covering the nose and mouth.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

104. To rule out a possible urinary tract infection, a urine sample was taken from Mrs A's supra-pubic catheter (SPC) that night. It was arranged for the sample to be sent for further testing in the morning, as moderate blood had been found in the sample.[18]

105. Mrs A's medical notes include a copy of the fax sent to her GP by RN D that night requesting advice and medication. The fax also notes that Mrs A was saying "random things at times".

106. RN D's shift ended at 11.15pm. She told HDC that she last checked on Mrs A shortly before handover, and Mrs A appeared to be settled in bed but was not asleep. RN D said that she did a final check of Mrs A's oxygen saturation and that it was 93%. This is not documented, and no further observations were recorded for the remainder of the night.

107. Bupa told HDC that during its investigation into these events, RN D said that in hindsight she considers that "it may have been appropriate to have sought further advice on [Mrs A's] management", and that, on reflection, it may have been appropriate to have ensured that someone monitored Mrs A's observations throughout the night.

108. In contrast to this statement, RN D told HDC that she gave a verbal handover to the night nurse, RN C, which included a request that Mrs A be monitored regularly.

109. RN C told HDC that she was told that Mrs A had been short of breath earlier in the day but that her oxygen saturation had come up to 93%, and that she was settled and had not had any further shortness of breath. RN C told HDC: "Nothing that was said to me indicated that [Mrs A] needed additional monitoring to the normal checks that all residents get during the night."

110. During most of that night RN C was busy with a dying patient who needed constant monitoring and observation from a registered nurse. RN C said that she was the only registered nurse on shift that night. She told HDC that the caregivers did not report any unusual events that night.

11 Month3

111. It is documented in Mrs A's care notes that at around 2am on 11 Month3 Mrs A asked to be transferred to a chair, but that when told the time she said that she would sleep some more instead. It is documented that she slept well afterwards.

112. RN C finished work at 7.15am. She told HDC that at no time during the night did any of the caregivers come to her with any concerns that required her to go to Mrs A and check on her immediately.

113. At 7.30am, staff went in to see Mrs A and, sadly, found that she had passed away.

114. During an interview following these events, the night caregiver advised Ms H that she had checked on Mrs A at approximately 5am, and that Mrs A was breathing and sleeping well. RN C told HDC that she had delegated one of the caregivers in the hospital wing (where

[18] A letter sent from Bupa to Mr A following these events states that the dipstick test was taken to check for infection as a possible cause for Mrs A's confusion.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Mrs A was residing) to do the medication round that morning, and the caregiver had told her that she had passed Mrs A's room twice at around 6am and had heard her snoring.

Further information

Bupa

115. Bupa told HDC that it regrets not seeking more recent medical information from Mrs A's GP when it realised that the InterRAI assessment and care plan report sent to them prior to Mrs A's admission were over two years old. Bupa stated: "[T]his process is now rigorously adhered to at [the rest home] in order to guarantee we have all the information we need to ensure the safety and care of the resident."

116. Bupa also told HDC that it acknowledges that aspects of the nurses' management of Mrs A's care "could be improved". It said:

> "[Mrs A's] oxygen saturation was lower than expected, and our nursing staff should have acted on these in a more responsive manner, checked this result at a later time if unsure of its accuracy, consulted [Mrs A] herself, and contact[ed] the GP for advice."

117. An internal investigation was carried out. Several changes were made following the review, and the registered nurses attended several relevant education sessions and courses. In particular, the following changes took place:

- On 24 Month3, Mrs A's case was discussed in a case review type format with the relevant staff. Most of the staff involved in Mrs A's care completed a formal reflection regarding their role in observing and planning her care.

- The registered nurses who were caring for Mrs A on the evening of 10 Month3 attended an external education session provided by the DHB regarding caring for the unstable patient. The learnings from this were then presented to other registered nurses in education sessions.

- The importance of carrying out more formal monitoring and mapping of recordings on the relevant TPR (temperature, pulse, and respiration) chart was reiterated during education sessions. Training days regarding critical thinking and recognising decline were also attended by Bupa's registered nurses.

- To help ensure that clients/family provide Bupa with all necessary information, changes were made to the confirmation letter that is sent to prospective short-stay clients. The letter now includes prompts regarding the sharing of information such as recent hospital admission, changes in condition, discharge summary information, and any equipment required by the client.

- A covering letter for the client's GP was developed, and this includes a request that the GP include all recent medical admission documentation prior to admission to the rest home.

- The rest home now declines any hospital-level respite admissions where the client has not been to his or her GP prior to coming in and providing a medical history.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- Bupa advocates the use of ISBAR[19] and states that this must now be used in any information handover situations, and the forms must be retained as part of the resident's/client's clinical file.

- Bupa has trialled the use of Clinical Review Meetings to maintain effective clinical oversight of residents — a block of time is set aside twice weekly to discuss and plan care for residents who fall under particular criteria, such as new admissions, residents who have had a fall or other significant incident, and residents whose condition is deteriorating. Bupa advised that this was implemented in all care homes from January 2017.

- Paperwork for all new residents is checked within the first 24 hours of placement, and nurses have been reminded to ensure that baseline observations are taken for all residents within the first 12 hours of arrival.

118. RN D provided HDC with a detailed list of further professional development she has undertaken, and the changes she has made to her practice.

The DHB

119. The DHB told HDC:

> "A request for re-assessment can be initiated by any health practitioner working with an individual if they determine that a person's change in condition requires this. A presentation to the Emergency Department or inpatient admission does not automatically trigger a need for an interRAI re-assessment."

120. Ms G told HDC:

> "If [the rest home] had of contacted NASC on [Mrs A's] admission citing concerns for her health, then I would have advised the care facility that the appropriate course of action in that event is to care for her medically via her GP or to admit her to a hospital. A request to NASC for an updated assessment or urgent reassessment of [Mrs A] would not have assisted the care facility in the care of [Mrs A's] apparent declining health."

121. Following these events, the DHB's Care Coordination Centre service implemented a "respite care check list" that is to be completed on request for respite care. The checklist includes checking the patient management system for any recent inpatient hospital admissions, and prompts specific questions regarding any changes in individual health status.

---

[19] Identify/introduction, Situation, Background, Assessment, Recommendations — an internationally recognised communication tool, and a framework for clinical conversations between health professionals.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Relevant standards

122. Principle 4 of the Nursing Council of New Zealand (NCNZ) *Code of conduct* (Wellington: NCNZ, 2012) refers to the maintenance of health consumer trust by providing safe and competent care. It includes the following:

"• 4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

- 4.2 Be readily accessible to health consumers and colleagues when you are on duty.
- 4.3 Keep your professional knowledge and skills up to date.
- 4.4 Recognise and work within the limits of your competence and your scope of practice.
- 4.5 Ask for advice and assistance from colleagues especially when care may be compromised by your lack of knowledge or skill.
- 4.6 Reflect on your own practice and evaluate care with colleagues.
- 4.7 Deliver care based on best available evidence and best practice.
- 4.8 Keep clear and accurate records.
- 4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines.
- 4.10 Practice in accordance with professional standards relating to safety and quality health care.
- 4.11 You must ensure the use of complementary or alternative therapies is safe and in the best interests of those in your care.
- 4.12 Offer assistance in an emergency that takes into account your own safety, your skill and the availability of other options."

Responses to provisional opinion

123. The parties were all given the opportunity to respond to relevant parts of my provisional opinion.

124. Mr A's comments have been incorporated into the report where relevant.

125. The DHB and its relevant staff had no additional comments to make in relation to the provisional opinion and proposed course of action. The DHB acknowledged and supported the findings.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

126. Bupa accepted both the findings and the proposed recommendations. It stated: "[I]n addition to the changes in practice that have already been achieved at [the rest home], we will work towards actioning the recommendations at a national level."

127. RN F had no further comment to make.

128. RN B raised some issues that have been addressed by the Deputy Commissioner in the cover letter issued to her with this report.

129. RN C, RN E, and RN D had no further comment to make, and provided letters of apology for forwarding to Mr A, in line with the recommendations made in the provisional report.

Opinion: Bupa Care Services NZ Limited — breach

130. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), Bupa has a responsibility to operate the rest home in a manner that provides its residents with services of an appropriate standard. The New Zealand Health and Disability Sector Standards (NZHDSS) also require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely and safe services to consumers.[20] I consider that there were several areas of concern at the rest home.

131. Mrs A was accepted for respite care by the rest home despite her not having had a recent medical review by her GP or a recent NASC assessment. I note that Bupa's Short Stay Policy required that potential respite care residents were to have a NASC assessment that was less than 12 months old, and/or a GP review within the three months prior to admission. I note that prior to Mrs A's admission, Bupa had requested that Mrs A visit her doctor to complete some paperwork, including a medication chart for the medication she was taking, and to arrange for her medications to be blister packed. Although it is not known whether Mr and Mrs A were told that they needed a GP review prior to Mrs A's admission, it became evident that a review had not been undertaken only once Mrs A was on site and being admitted. Bupa has also stated that the age of the NASC assessment was queried with the DHB, although there is no evidence that this occurred.

132. I am critical that the rest home accepted Mrs A for admission without a recent NASC assessment or GP review. However, I acknowledge that changes have been made by Bupa to ensure that this does not happen again, and I find the changes to be appropriate.

133. In addition to the above, two nurses (RN B and RN F) were involved in admitting Mrs A to the rest home, yet neither of them undertook to ensure that her baseline observations (vital signs) were taken on admission.

---

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

134. Furthermore, staff at the rest home individually and as a team failed to act on Mrs A's low oxygen saturations. I am concerned at the lack of critical thinking by staff in this respect. Staff need to assess, think critically, and respond appropriately to a resident's condition. In my view, the rest home failed in its duty of care to Mrs A for the following reasons:

- On three occasions, different registered nurses (RN C, RN D, and RN E) documented low oxygen saturations, and yet those nurses, and any other registered nurses who saw the low levels, failed to instigate the appropriate intervention, or to initiate any ongoing monitoring or timely escalation of concern.

- During the morning of 8 Month3, a caregiver wrote in Mrs A's care notes that Mrs A had been saying things that did not make any sense, and that she seemed to be confused. The caregiver documented that a registered nurse had been informed, but there is no record of follow-up by a registered nurse regarding this report. Bupa told HDC: "Although the [caregiver] believed that she had verbally handed this over, during interview none of the 3 RNs could recall being informed of any concerns regarding [Mrs A's] condition." While I am unable to make a finding on whether or not a registered nurse was told about this and, accordingly, which nurse and what if anything was done about it, I am critical that either no registered nurses read the notes or, if they did, that no action was taken on seeing the caregiver's report.

135. Overall, I accept the advice of RN Carey that the changes undertaken by Bupa are appropriate. However, as previously stated by this Office,[21] the inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that did not support and assist staff sufficiently to do what was required of them. Bupa as an organisation must bear overall responsibility for this.

136. In my view, Bupa had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code. In my opinion, for the reasons outlined above, Bupa failed in that responsibility and breached Right 4(1) of the Code.

Opinion: RN B — adverse comment

137. Bupa told HDC that it would have expected Mrs A's baseline observations to have been completed by the admitting registered nurse, and that any assessments not completed by the admitting nurse would be handed over to the oncoming registered nurse for completion. Bupa and RN F told HDC that Mrs A's baseline observations were handed over to RN B to complete. However, this did not happen. I note RN B's response that she believed that the observations had been undertaken by RN F, and that she had not been instructed to take them.

[21] 11HDC00686 and 15HDC00423.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

138. I am critical that following the handover of a new client, RN B — a senior nurse — did not review the notes, including the Short Stay Admission Record, and ensure that all of the admission requirements had been completed.

Opinion: RN F — adverse comment

139. Generally it is assumed that a patient's baseline observations will be completed by the admitting nurse — in this case, RN F. I note that Mrs A arrived at the rest home around the time the nursing shifts changed. I further note that Bupa and RN F told HDC that Mrs A's baseline observations were handed over to RN B to complete. However, contrary to this, RN B told HDC that she believed these had been undertaken by RN F, and that there was no direction to her to take them.

140. I am critical that if RN F was unable to take the observations, she did not ensure that clear direction was given to RN B to complete them. I do note that RN F was in her first year of nursing practice and, as noted above, RN B should have been able to ascertain the information from reviewing the notes, as she was responsible for completing Mrs A's admission. However, my criticism of RN F remains.

Opinion: RN C — breach

141. During the early hours of 4 Month3, RN C found Mrs A sitting on the floor after having slid off the bed. RN C noted that Mrs A had an oxygen saturation of 80%. RN C completed an incident form and included this observation.

142. RN C told HDC:

> "[Mrs A] was not exhibiting any signs of lack of oxygen, like shortness of breath, blue lips, heart racing, restlessness or agitation. [Mrs A] was able to tell you if she was short of breath. During my time with [Mrs A] she was competent and able to clearly indicate to me how she was feeling and what she wanted."

143. RN C further told HDC that Mrs A was visually checked regularly throughout the rest of the night, and that she appeared to be sleeping comfortably.

144. I note that my in-house clinical nursing advisor, RN Dawn Carey, advised me that Mrs A's low oxygen saturation reading should have been rechecked, and that if the reading remained abnormal, oxygen therapy should have been administered. In addition, RN Carey advised:

> "I consider that a schedule of ongoing monitoring of [Mrs A's] vital signs should have been commenced and that hand over should have included the need for [Mrs A's] GP to be contacted by telephone the next day."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

145. I am critical that RN C documented low oxygen saturations and failed to instigate the appropriate intervention (oxygen therapy) and initiate ongoing monitoring or timely escalation of this result to the GP or, as RN Carey advised, ensure that this was handed over to the morning staff to carry out.

146. I find that RN C failed to provide services with reasonable care and skill to Mrs A on 4 Month3. Accordingly, I find that RN C breached Right 4(1) of the Code.

Opinion: RN D — breach

147. On 10 Month3, RN D observed Mrs A sitting asleep in her wheelchair with her chin on her chest. RN D told HDC that she felt that Mrs A may have been blocking her airway in this position and, therefore, RN D woke her up. RN D told HDC that Mrs A appeared "lethargic" and short of breath, and that she had a blue tint to her lips.

148. Mrs A's oxygen saturation level was found to be 67%. RN D told HDC that Mrs A's other vital signs were within the normal range (although I note that these were not documented). RN D administered oxygen "with good effect", and Mrs A's saturation increased to 95%. I note that RN D said that Mrs A was by this time fully awake and communicating. RN D said that she read Mrs A's file, and that as there was nothing to indicate a reason for the drop in oxygen saturations, she assumed that it was due to Mrs A's position.

149. RN D said that after over an hour on oxygen, she weaned Mrs A off the oxygen. I note that it is documented that Mrs A was maintaining a 93% saturation level, and that no further shortness of breath was noted.

150. RN D told HDC that she did not believe that an urgent review by a GP or sending Mrs A to ED was necessary at that time, as there were no further episodes of shortness of breath, and she had assumed that Mrs A's baseline oxygen level had been 80% on admission (as discussed above, it has been ascertained that this was not an admission reading but a reading taken following a fall while at the rest home on 4 Month3).

151. It is noted that no further observations were recorded for the remainder of the night.

152. RN D told HDC that she deemed it appropriate to wean Mrs A off oxygen, and that a fax to the GP for a review was sufficient.

153. RN D told Bupa that in hindsight she considers that "it may have been appropriate to have sought further advice on Mrs A's management". RN D also said that, on reflection, it may have been appropriate to have monitored Mrs A's observations throughout the night.

154. While I note that RN D was in her first year of nursing practice, I accept the advice of RN Carey that Mrs A's reported oxygen saturation level of 67% "was significantly low and concerning". I further note RN Carey's advice that "a call to 111 or urgent review by her GP would have been an appropriate action". I agree.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

155. While I note that RN D felt that in line with Bupa's policy on oxygen therapy it is considered an emergency only if oxygen saturations fall below 93%, as Mrs A's level had fallen as low as 67% I do not find this to have been an appropriate response.

156. RN Carey advised me that RN D's response of sending a fax to notify the GP of Mrs A's need for medical review was not sufficient. I agree. An oxygen saturation of 67% was a significantly low reading, and it required the timely escalation of concern. Even if RN D thought at the time that Mrs A's baseline oxygen level had been 80% on admission, RN D still should have taken action on the observation of 67%.

157. While I note that RN D has undertaken relevant professional development since these events and made changes to her standard of care, I find that RN D failed to provide services with reasonable care and skill to Mrs A on 10 Month3. Accordingly, I find that RN D breached Right 4(1) of the Code.

Opinion: RN E — breach

158. RN E, as Clinical Manager, was ultimately the person with primary responsibility for the care provided to Mrs A.

159. It is alarming that not only as a registered nurse, but also in her capacity as the Clinical Manager, on noting that Mrs A's oxygen saturation had been documented on 4 Month3 as 80%, RN E omitted to look into this any further. In my view, this is a departure from the accepted standards of care.

160. I accept RN Carey's advice that the review of Mrs A's fall on 7 Month3 by RN E provided a further opportunity to initiate appropriate actions "to evaluate the veracity and significance of the recorded vital signs of 4 [Month3]". I agree.

161. I am critical that this did not occur, and I accept the advice of RN Carey that the low oxygen saturation level recorded on 4 Month3 could not be explained by Mrs A's fall. I find that on 7 Month3, RN E, as the Clinical Manager, failed to provide services to Mrs A with reasonable care and skill. Accordingly, I find that RN E breached Right 4(1) of the Code.

Opinion: The District Health Board — other comment

The DHB — the hospital

162. As part of this investigation I obtained expert clinical nursing advice from RN Christine Howard-Brown. She advised me that she considered the care provided to Mrs A by the DHB, in its capacity as the hospital, to have been reasonable in the circumstances. I agree.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Month1 — discharge from hospital

163. When Mrs A was discharged from the hospital on 29 Month1, a copy of her discharge summary was not sent to the NASC service. RN Howard-Brown advised me that this represents usual practice, as NASCs do not routinely receive discharge summaries.

164. RN Howard-Brown further advised that notification to the NASC occurs only where needs have changed necessitating a review or reassessment (or where an initial assessment was required to establish home and community support services). She said that in those situations, typically the home and community support provider would be contacted as part of the discharge planning process.

165. RN Howard-Brown advised that it would be the responsibility of the home and community support provider to notify the NASC in the event that a client's needs exceeded the maximum package of hours allocated to the client, or where the level of need was significantly different from that assessed previously.

166. The NASC was not contacted in Mrs A's case. Therefore, unless Mr and Mrs A were to share Mrs A's discharge summary with the NASC, no specific handover information would be available from the hospital to the service.

The DHB follow-up services following discharge — no breach

167. Mrs A's discharge summary included the plan for a repeat chest X-ray in six weeks' time and an outpatient follow-up in a respiratory clinic (in four to six weeks' time) to consider the possibility of home non-invasive ventilation once she had recovered from pneumonia.

168. A semi-urgent respiratory referral was requested for a sleep study, and a chest X-ray was scheduled for Mrs A on 18 Month3, eight weeks following discharge.

169. RN Howard-Brown advised me that it is not uncommon that follow-up services by a DHB occur two to four weeks later than intended, owing to waiting lists and prioritisation processes. She further advised that it was reasonable that a semi-urgent request was made for the sleep study and that the subsequent follow-up would occur outside of the timeframe indicted in the discharge summary.

170. I further note that there were safeguards should Mrs A deteriorate whilst waiting for follow-up care from the DHB. The discharge summary stated that if Mrs A had any concerns, she should see her GP or return to the hospital. RN Howard-Brown advised that this is consistent with accepted practice. I accept this advice and have no concerns regarding the DHB's follow-up services.

NASC review and reassessment process

Prior to and following discharge in Month1

171. In 2013, an interRAI Home Care assessment and care plan were completed for Mrs A. Following this, two annual telephone reviews were completed each year by the NASC. Both resulted in renewal of Mrs A's existing support package.

172. The Home and Community Support Service also undertook service reviews at six-monthly intervals, all of which occurred prior to Mrs A's hospital admission in Month1. The purpose

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

of the reviews was to ensure that Mrs A's support package was meeting her needs. Mrs A's notes indicated some improvement in her health since the inter-RAI assessment.

173. RN Howard-Brown advised that as there was no notification to the NASC that a review or reassessment was required (by the hospital, the home and community support provider, the general practitioner, or Mr or Mrs A), there was no indication for the NASC to initiate a review or reassessment on discharge from hospital.

174. According to the NASC's Operations Manual, Mrs A required an annual reassessment by a clinical assessor using the interRAI Home Care tool. As noted above, an annual telephone review had been completed in relation to Mrs A, rather than an annual reassessment.

175. RN Howard-Brown advised that not undertaking an annual reassessment where needs appear unchanged through the review process, despite the date for a reassessment being due, could be considered a mild departure from expected practice. She stated: "The reason why this might be considered mild rather than moderate is a national move to reduce the number of reassessments a person is subject to unless there is an indication for a reassessment." RN Howard-Brown further advised that as Mrs A was having a six-monthly review by a registered nurse from the home and community support provider and an annual review by the NASC, it is reasonable that a full reassessment had not been completed each year, in accordance with the Operations Manual. I accept this advice and am not critical that a full reassessment had not been completed.

Prior to Mrs A going into respite care

176. Despite there being no indication for the NASC to initiate a review or reassessment on discharge from hospital, RN Howard-Brown advised that it is reasonable to expect that a reassessment would have been completed as part of the preparation for Mrs A going into respite care. RN Howard-Brown stated: "There are national expectations that interRAI homecare assessments are kept current as they provide valuable information to inform care planning and delivery of services."

177. RN Howard-Brown further advised that Ms G, as the Clinical Needs Assessor and registered health professional who facilitated Mrs A's respite care request with the rest home, would be expected to enquire as to whether there had been any change in Mrs A's health status and needs since her last review. RN Howard-Brown stated:

> "Through this enquiry, the Clinical Needs Assessor should have ascertained that there had been a recent hospital admission and that a reassessment was warranted especially as reviews had only been completed in the last two years."

178. RN Howard-Brown advised that not completing a reassessment prior to respite care represents a moderate departure from expected practice. She stated that this was especially so given that concerns were reportedly raised with the NASC by the rest home prior to the respite care admission. However, in light of the conflicting evidence I am unable to make a finding on whether or not any concerns were raised.

179. I appreciate that it is through the needs assessment/NASC process that information should be gathered in order to determine a client's needs. Rest homes need to be able to rely on

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

these assessments to determine whether the care and support required can be met, and to identify risks. I accept that not having all of the information prior to Mrs A's admission limited the rest home's ability to develop an appropriate care plan and to ensure that the right services were in place for her. However, overall I accept that Ms G had no reason to believe that there had been any changes that necessitated reassessment, and that the DHB's policy in place at the time not to reassess on access to respite care when it is part of the agreed support package, was followed. I further note Ms G's response that it is unlikely that Mrs A's recent hospital admission for pneumonia would have resulted in any change to her level of care because she had been considered well enough to be discharged back home from hospital, and she was already receiving the highest level of care available. As noted by Ms G, Mrs A was going to a hospital-level care facility with registered nurses in attendance 24 hours a day.

180. Accordingly, I am not critical of the DHB and do not find it in breach of the Code.

Recommendations

181. I recommend that Bupa:

a) Consider the implementation of a system in a written format to capture outstanding tasks, including any ongoing monitoring requirements and any concerns of care staff that need to be handed over between shifts, and report back to this Office on the consideration within three months of the date of this report.

b) Consider the initiation of out-of-hours access to a senior nurse, especially for new graduate nurses who may be on a shift without a registered nurse colleague, and report back to this Office on the consideration within three months of the date of this report.

c) Provide a written apology to Mrs A's family for its breaches of the Code. The apology is to be sent to this Office within three weeks of the date of this report, for forwarding to [Mrs A's] family.

182. As noted above, in response to the recommendations made in the provisional opinion, RN C, RN E, and RN D provided letters of apology for forwarding to Mr A.

Follow-up actions

183. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services New Zealand Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of RN E's, RN D's, RN B's, and RN C's name.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

184. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Bupa Care Services New Zealand Limited, will be sent to HQSC and the NZ Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix A: Independent in-house nursing advice to the Commissioner

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

"1. Thank you for the request that I provide clinical nursing advice in relation to the complaint from [Mr A] about the care provided to his late wife, [Mrs A] by [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.

2. I have reviewed the following documents available on file: complaint; response from Bupa Care Services (BCS) including [Mrs A's] clinical [rest home] file, InterRAI homecare assessment and care plan report (… 2013), relevant organisational policies, Coronial Autopsy report (28 [Month3]), discharge summary from [the DHB] dated 24 [Month1].

3. Background
[Mrs A], aged 70 years of age was admitted to [the rest home] for a short period of respite care in [Month3]. She was an incomplete paraplegic following an epidural abscess; required a sling hoist to transfer and a wheelchair to mobilise. Other medical conditions included type 2 diabetes, osteoarthritis, and ovarian mass. At approximately 7.30am on 11 [Month3], morning care staff found [Mrs A] deceased. A post mortem examination determined cardiac arrhythmia as the cause of death.

[Mr A] has expressed concerns about the standard of care provided to his wife at [the rest home]. These relate to fall prevention and the response of nursing staff to incidences of shortness of breath and low oxygen saturation levels.

4. BCS response reports:

i. [The rest home] was not provided with relevant and current information concerning [Mrs A's] recent medical history.
ii. Consistent with Sector standards bedrails are not routinely placed on a resident's bed. Prior to her fall event, staff did not note that [Mrs A's] use of a bedrail was recorded in her 2013 InterRAI assessment.
iii. An acknowledgement that nursing staff could have better managed aspects of [Mrs A's] care —
   a) May have been appropriate for the RN to have talked to [Mrs A] about her low oxygen saturations (SpO_2) on admission. The [rest home manager] has also previously apologised for not considering arranging a GP review.
   b) There was no RN review on 8 [Month3] following a care giver documenting that [Mrs A] seemed confused.
   c) The management and documentation relating on 10 [Month3] (night shift).
iv. Completed remedial actions —
   a) [Mrs A's] case was reviewed and presented to qualified staff.
   b) Each of the staff involved in her care have completed a formal reflection regarding their role in her care.
   c) The RN who was caring for [Mrs A] on the evening of 10 [Month3], has attended an external education session focussed on the care of an unstable

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

patient. This RN has gone on to share the knowledge gained by presenting to the other qualified staff.

d) The importance of carrying out formal vital sign monitoring and documenting this information on the relevant TPR chart has been reiterated to qualified staff.

e) Changes have been made to the BCS confirmation letter which is sent to prospective short stay clients. This letter now includes prompts regarding recent medical discharge information and any equipment that they use regularly and would be required by them during their admission.

Comment: I have reviewed this letter template and note that it is consistent with the response.

f) A covering 'letter' for the client's GP has been developed and is being trialled by BCS.

Comment: I have reviewed this letter template and note that it is consistent with the response.

g) [The rest home] now declines any hospital level respite admissions where the client has not been to their GP prior to coming in and the requested information is not available.

5. [The DHB] InterRAI homecare assessment and care plan report (… 2013) is reported as being emailed to BCS from NASC with a request for respite care for [Mrs A].

The assessment and care plan details:

i. No respiratory diseases or diagnoses.
ii. A history of falls and use of bed rails.
iii. Recorded date for reassessment is … 2016.

Comment: I would have expected re-assessment of needs to occur more frequently than three yearly. I would recommend that [the DHB] is asked to comment on the NASC re-assessment schedule.

6. [The DHB] discharge summary reports:

i. [Mrs A] was referred to hospital by her GP due to a two week period of progressive decline and URTI symptoms.
ii. She was admitted to the medical ward and diagnosed with bilateral pneumonia with type 2 respiratory failure (T2RF) and required non invasive ventilation (NIV) for 48 hours.
iii. Arterial blood gas analysis indicated chronic T2RF[1]. Previous pulmonary function tests were consistent with restrictive lung disease. [Mrs A's] chronic T2RF was deemed to be multifactorial, related to obstructive sleep apnoea and obesity.

[1] T2RF is characterized by both hypoxemia and hypercapnia. Chronic T2RF is a longterm condition which develops over time.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

iv. Discharge plan included chest x-ray and follow up with respiratory specialist concerning management of chronic T2RF — work up for possibility of home NIV — in 6 weeks.

Comment: The BCS response reports that during a meeting on 21 [Month4], [Mrs A's] GP presented a copy of the [DHB] discharge summary. BCS report that upon acceptance and admission to [the rest home], they were unaware that [Mrs A] had been admitted to hospital in [Month1] and were unaware of her respiratory health status. I would recommend that [the DHB] is asked whether an appointment date for [Mrs A's] specialist review had been actioned prior to her death.

7. BCS Policies

i. Short Stay — Residents Policy was reviewed in February 2015. It details the expected actions and considerations when accepting and admitting a person for short stay care. The policy includes a screening tool — admission decision tree — to guide the [rest home] or Clinical Manager in determining possible clinical risk factors, how to manage these and ultimately whether the admission should proceed or not.

Comment: I consider that the decision tree is an excellent guide and resource.

ii. Falls — Prevention and Management Policy was reviewed in … 2015. It includes falls risk assessment, prevention strategies, post fall assessment and management. The policy includes a post fall flow chart and assessment guideline which highlights special considerations such as anticoagulant medications.

Comment: I consider that the post fall flow chart and assessment (pages 5 and 6) to be an excellent resource.

iii. Oxygen Policy was reviewed in September 2012. It details the expectations concerning oxygen administration, normal range of oxygen saturations, monitoring requirements when administering oxygen, safety concerns, and concentrator and regulator use.

Comment: In my opinion the submitted policies are comprehensive and consistent with accepted standards.

8. [The rest home] Clinical Records

i. [Mrs A] was admitted to [the rest home] on … 3 [Month3].

Comment: The Short Stay Policy requires that potential respite residents have a NASC assessment that is less than 12 months old and/or a GP review within the three months prior. I note that [Mrs A] was accepted despite not having been reviewed by her GP and having a NASC assessment that was over two years old. I acknowledge that the BCS response reports that the need for a GP review prior to admission was discussed with Mr and [Mrs A]. Also that [the rest home] were only made aware that the review and medication charting were outstanding following the [rest home manager] telephoning [Mr A] at approximately 4.30pm. As [Mr A] was at the airport waiting to board a flight

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

the decision was made to fax the GP requesting a medication chart be completed.

ii. Baseline observations were *weight 121.2kgs, BP 110/70, pulse 101, respiration rate 20, $Sp0_2$ 80%.*

Comment: The reported SpO_2 is lower than expected. If the RN determined that this was an accurate recording, oxygen therapy should have been administered. As [Mrs A] was unknown to [the rest home], I consider that nursing staff should have discussed the result with the competent resident, her husband and contacted her GP for input. If the RN determined that the accuracy of the reading was impaired — nail polish, cold hands — then this should have been noted and [Mrs A's] SpO_2 rechecked later.

iii. During the early hours of … 4 [Month3], [Mrs A] sustained a fall … *She said she had been sitting on the side of her bed and she slid off* ... With the exception of SpO_2 80%, reported vital signs are unremarkable. Other actions include an assessment for injuries and pain, completion of accident report form and communication with [Mrs A's] son. Also a landing strip and a sensor mat were placed beside [Mrs A's] bed and bed handles were ordered.

Comment: If the RN determined that this was an accurate recording, oxygen therapy should have been administered. I would consider that there was a need to monitor [Mrs A's] oxygen saturations regularly and seek a GP review. In my opinion the care provided in relation to fall prevention and management was consistent with accepted standards.

iv. 5–7 [Month3]: Contemporaneous documentation reports [Mrs A] as well and participating in cares.

v. 8 [Month3]: Care giver notes report ... *[Mrs A] was saying things this morning that didn't make any sense. Seemed confused ... RN informed. Had good diet and fluid intake.*

Comment: The BCS response reported interviewing the staff involved and that although the care giver believed that she had verbally handed over that [Mrs A] seemed confused, none of the three RNs could recall being informed of any concerns.

vi. Subsequent documentation reports [Mrs A] participating in cares with no further concerns or episodes of confusion being noted.

vii. 10 [Month3] *23.45hrs: After tea appeared SOB with blue tint to lips. SpO_2 67% O2 given via HM at 3L with good effect — SpO_2 up to 95%.* [O_2] *Weaned off and SpO_2 maintained at 93%, settled into bed and no further SOB noted. Urine dipsticked* ... A fax sent to [Mrs A's] GP is on file. The information on this is consistent with the progress notes entry. With the exception of a raised respiration rate — 24 — documented vital signs at 11.30pm are unremarkable.

Comment: I agree that it was appropriate that the RN commenced oxygen therapy. However, I consider that [Mrs A's] reported SpO_2 to be significantly

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

low and concerning. In my opinion, a call to 111 or urgent review by her GP would have been appropriate actions. This does not infer that the failure to make such contact caused [Mrs A's] death.

viii. Care giver documentation reports that at approximately 2am, [Mrs A] asked to be transferred to the chair but when told the time, she said she would sleep some more instead.

ix. At approximately 7.30am, morning staff found [Mrs A] deceased in her bed. The night duty care giver was interviewed and reports sighting her at approximately 5am and she was sleeping and breathing well at this time.

9. Clinical advice
Assessment and management of abnormal vital signs — I consider that the nursing care provided to [Mrs A] departed from accepted standards. I am critical that a RN would document low oxygen saturations on 3 and 4 [Month3] without instigating the appropriate intervention (oxygen therapy). I am also critical that abnormal vital signs would be recorded by a RN on 3, 4 and 10 [Month3] without the initiation of ongoing monitoring or timely escalation of concerns. In my opinion, these failures are moderate departures from accepted nursing standards[2] and specifically Principle 4.

In my opinion the identified remedial actions by BCS are appropriate. However, I am unsure whether the dissemination of the learnings from this case was wider than the qualified staff team of [the rest home]. If not already done so, I would recommend that they are shared across BCS's aged care facilities. I would also recommend that BCS consider including the TPR charts in their auditing schedule.

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

On 24 January 2018 RN Carey provided the further advice:

"1.Thank you for the request that I provide additional clinical nursing advice in relation to the complaint from [Mr A] about the care provided to his late wife, [Mrs A] by [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 report should be read in conjunction with my previous advice of 11 March 2016.

2. I have reviewed the following documents: my advice of 11 March 2016; response from Bupa Care Services (BCS) dated 30 November 2016, 1 May 2017 and 7 November 2017 including attachments, emails 24 August 2016 and 25 August 2016 between HDC Senior Legal Investigator … and BCS Clinical Lead — Quality Assurance …; statement from [RN D] (RN), dated 2 February 2016; response from NZNO Lawyer …, dated 12 April 2017 including statement from [RN B] (RN);

[2] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

response from [a] Community Law Centre Solicitor …, dated 28 November 2016 including response from [RN C] (RN); statement from [RN F] (RN), dated 20 October 2017; response from [RN E] (undated).

3. Following a review of the further information provided, I note the following:

   i. The vital signs recorded on [Mrs A's] short stay admission were transcribed by [RN E]. This transcription occurred on 7 [Month3] and were taken from the incident form completed by [RN C] following [Mrs A's] unwitnessed fall/slip on 4 [Month3].

   ii. The responses dispute what was communicated in the verbal nursing shift handovers on 3 [Month3] and 10 [Month3].

   iii. [RN D] and [RN F] were within their first year of RN practice.

   iv. [RN C] advises that on her night duties, she was the sole RN and responsible for residents in the Hospital Wing, Dementia Wing and Rest Home Wing. She has advised that over the course of the night duty on 10 [Month3], she based herself in the Rest Home Wing as there was an end of life care resident.

   v. BCS have provided a further update on their implementation of the identified remedial actions both within [the rest home] and across Bupa aged care facilities. In my opinion, the changes undertaken by BCS are appropriate.

   vi. BCS have provided a copy of their Progress Notes Policy. This policy was in place during [Mrs A's] period of care at [the rest home]. I consider this Policy to be consistent with industry sector standards and expectations.

4. Clinical advice

I continue to hold the opinion that the nursing care provided to [Mrs A] in relation to assessment and management of abnormal vital signs moderately departed from accepted nursing standards[3] and specifically Principle 4.

[RN C] — On the 4 [Month3], I consider that [Mrs A's] low oxygen saturation reading should have been rechecked and if the reading was consistently abnormal, low level oxygen therapy should have been initiated. In addition, I consider that a schedule of ongoing monitoring of [Mrs A's] vital signs should have been commenced and that hand over should have included the need for [Mrs A's] GP to be contacted by telephone the next day.

[RN E] — I consider that the review of [Mrs A's] fall event on 7 [Month3], provided a further opportunity to initiate appropriate actions to evaluate the veracity and significance of the recorded vital signs of 4 [Month3]. I am critical that this did not occur and disagree with [RN E's] evaluation that [Mrs A's] low oxygen saturations level could be explained by the fall event.

[RN D] — I remain critical of the response to [Mrs A's] abnormal vital signs on 10 [Month3]. I continue to hold the opinion that a call to 111 or urgent review by her GP

[3] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).

was warranted. I disagree with a fax being used to notify the GP of [Mrs A's] need for medical review.

5. Recommendations

   i. If not already remedied, I would suggest that BCS consider implementing a way of capturing outstanding tasks that need to be handed over in a written format so that nursing staff are not reliant on recall. I note that in this case the responses dispute whether outstanding tasks, ongoing monitoring requirements or the concerns of care staff were handed over between shifts.
   ii. If not already implemented, I would suggest that BCS consider initiating out of hours access to a senior nurse especially for new graduate nurses who may be on shift without a RN colleague.

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

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix B: Independent expert nursing advice to the Commissioner

"Thank you for the Deputy Commissioner's request for an opinion about the care provided to [Mrs A] by [the DHB].

I am a registered nurse, lead quality auditor and hold a Masters of Business Administration. I have worked in secondary and tertiary care hospitals including community services as a clinical nurse specialist, nursing advisor and duty manager before I commenced working as a quality auditor in health and disability services in 2003. The majority of my experience in aged residential care relates to service reviews, programme evaluations, service improvement initiatives, audits and inspections undertaken in the last twelve years. My experience has extended to contributing to reviews and service improvements across several Needs Assessment and Service Coordination Services (NASCs). I am also a part time PhD candidate at Otago University. My thesis relates to primary healthcare and aged residential care.

To the best of my knowledge I have no personal or professional conflict of interest in providing this advice. My advice is limited to the DHB/NASC care provided as the Commissioner has sought separate advice about nursing care provided by Bupa Care Services/[the rest home]. Approximately two years ago, I completed an evaluation of the implementation for Bupa Care Services (Corporate). I have also participated in a Ministry of Health observed audit of the certification audit of [the] District Health Board in 2013.

Background
[Mrs A] was hospitalised with pneumonia at [the hospital] on 24 [Month1]. She was discharged home on 29 [Month1].

A few weeks later, [the DHB's] NASC helped find respite care for [Mrs A] at [the rest home], owned and operated by Bupa Care Services (Bupa) so that her husband, [Mr A] (her lead carer) could go away overseas for a few weeks. [Mrs A] commenced her respite stay on 3 [Month3].

[The rest home] told HDC that the NASC sent through a NASC assessment form dated nearly three years earlier and when queried whether there was anything more up-to-date, was told by the NASC that they did not have any updated information.

[The rest home] says it was not told that [Mrs A] had recently been admitted to hospital with pneumonia by either Mr and [Mrs A] or [the DHB].

While at [the rest home], [Mrs A] had low oxygen saturations and started to appear confused, she passed away on 11 [Month3].

Documents reviewed
I have reviewed the following documents before providing my advice:

1. Complaint.
2. [Mrs A's] [DHB] Clinical notes and two responses from [the DHB] dated 15 April 2016 and 13 September 2016.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

3. [Mrs A's] care notes from [the rest home] including a copy of her InterRAI assessment.
4. A copy of Bupa's Short Stay/Respite Policy.
5. Copy of letter sent to [Mr A] after these events from [the rest home].
6. Copy of response to HDC from Bupa.
7. Draft Information Gathered to provide background (written by Legal Investigator …).
8. Copy of response to HDC from [the DHB] further to a request for additional information dated 30 September 2016
9. Copy of [the DHB] Care Coordination Centre respite allocation letter to [the rest home] dated 29 September 2016 but referring to services effective 3 [Month3]–22 [Month3]
10. Copy of [the DHB] Care Coordination Centre respite allocation letter to [Mrs A] dated 29 September 2016 but referring to services effective 3 [Month3]–22 [Month3]
11. Copy of [the DHB] Care Coordination Centre Operations Manual (last updated 9 September 2013)
12. Copy of [the DHB] Home and Community Support Services Service Provision Agreement (June 2013)
13. Copy of the … Restorative Support Services in the Community Service Specification, Schedule 1 of the Health of Older People Service Schedule (May 2013)
14. Copy of response to HDC from [the DHB] further to a request for additional information dated 12 October 2016
15. Copy of [the DHB] Home and Community Support Services generated Care Plan and continuation notes for [Mrs A]
16. Ministry of Health Disability Support Services Needs Assessment and Service Co-ordination (DSS1040) Service Description (September 2007)
17. Needs Assessment and Support Services for Older People: What you need to know (May 2011)
18. Job description Clinical Needs Assessor [the] District Health Board
19. HDC's Guidelines for Independent Advisors.

Expert advice

I note this Office has obtained separate advice about the nursing care, and the care provided by Bupa Care Services/[the rest home]. The scope of this advice requested is limited to the DHB and NASC (Care Coordination Service) care.

For clarity, I have distinguished between [the DHB] (the hospital) and the NASC (the Care Coordination Service also provided by [the DHB]).

Following the review of the above documentation I consider the care provided to [Mrs A] by [the DHB] (the hospital) was reasonable in the circumstances; however, I have concerns as to the care provided by the NASC (the Care Coordination Service) particularly post [Mrs A's] discharge from hospital. I have made specific comments below.

1. The reasonableness of the care provided by [the DHB] to [Mrs A] once she was discharged from [the] Hospital on 29 [Month1].

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Discharge processes
A discharge summary for [Mr A] was comprehensively completed on the date of discharge and included clinical information, discharge medications, a plan following discharge and recommendations for the patient consistent with accepted practice. It was addressed to the general practitioner and was given to [Mrs A] on discharge. This represents usual practice as unless the patient is being discharged to a rest home, a copy of the discharge summary would not be copied to them. NASCs also do not routinely receive discharge summaries.

Nursing staff completing the discharge process, usually complete a checklist which prompts completion of activities needed for a safe discharge. The checklist in [Mrs A's] case was partially completed. It would be usual for notification to the NASC to occur only where needs had changed necessitating a review or reassessment or where an initial assessment was required to establish home and community support services. In these situations, the NASC is usually contacted a day or two prior to discharge if a visit is required to prepare for discharge or a referral emailed or faxed to the service on discharge so a review or reassessment can occur once the patient is back home.

The home and community support provider would typically be contacted as part of the discharge planning process to ensure services can be resumed. The home and community support provider would then request any additional information needed as part of this process. There is no indication that the home and community support provider was contacted in [Mrs A's] case, so no specific handover information would be available from the hospital to the service, unless [Mrs A] shared her discharge summary with them.

As [Mrs A's] support needs allocation had a flexible component, the home and community support service could increase hours in response to changing needs if required. For example if there were increased support needs required following discharge from hospital. It would be the responsibility of the home and community support provider to notify the NASC in the event that needs exceeded the maximum package of hours or where the level of need was significantly different from that previously assessed. NASCs typically try to include flexibility to increase and decrease assessed hours to avoid unnecessary reviews and reassessments. This enables the home and community support provider to be more responsive avoiding delays in providing services whilst waiting for an assessment and approvals.

DHB follow-up services
The plan on discharge (as per the discharge summary) included a repeat chest x-ray in six weeks and an outpatient follow-up in a respiratory clinic with [a respiratory physician] to work up the possibility of home non-invasive ventilation once recovered from pneumonia (in four–six weeks' time).

A semi-urgent respiratory referral prioritisation form was completed on 31 Month1 for a sleep study. The form is not signed and the administration use checklist portion was not completed. [The DHB] advised in a response letter to HDC that a semi-urgent referral indicates a wait of two to four months. [The DHB] also advised that there had been an anomaly in that the paper referral prioritisation form was for a semi-urgent appointment but their database had this marked routine. [The DHB] noted however, that [Mrs A] would still have been seen in the semi-urgent timeframe based on its waitlist at the time and the indication of six weeks as per the discharge summary was not an accurate estimate.

HDC

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Following reporting of the sleep study, [the DHB] advised that [Mrs A] would have then been seen at an outpatient clinic.

[Mrs A] had not been scheduled for a sleep study or an outpatient clinic to see a respiratory physician as at the time of her death (seven weeks post discharge).

A chest x-ray was scheduled for [Mrs A] on 18 [Month3], eight weeks following discharge. It is reported by [the DHB] that this appointment was rescheduled at [Mrs A's] request for later in the month (presumably so the chest x-ray did not coincide with her respite care).

It is not uncommon that follow-up services by a DHB occur two to four weeks later than intended due to waiting lists and prioritisation processes.

If [the respiratory physician] intended to reassess [Mrs A] in four to six weeks' time, she would have needed an urgent referral for a sleep study (completion within two weeks) if this was required before the outpatient clinic appointment. However, [Mrs A] did not fit the prioritisation referral criteria for an urgent sleep study and if completion occurred within two weeks, this may not have been sufficient time for the pneumonia to fully resolve to provide a baseline test result. It is therefore reasonable that a semi-urgent request was made for the sleep study and subsequent follow-up would occur outside of the timeframe indicted in the discharge summary.

Consistent with accepted practice, there were two safeguards should [Mrs A] deteriorate whilst waiting for follow-up care from the DHB as the discharge summary stated in the section specific to recommendations for the patient that if there were any concerns held by the patient then they should see their general practitioner or return to the hospital.

Needs Assessment Process

A Care Coordination Service enrolled nurse completed an interRAI Home Care assessment and care plan [in] 2013. There were no interRAI reassessments subsequent to the initial assessment. There were two annual telephone reviews completed … each year by the Care Coordination Service. Both resulted in renewal of the existing support package.

The Home and Community Support Service also undertook service reviews at six monthly intervals, all of which occurred prior to the hospital admission in [Month1]. The purpose of the reviews was to ensure [Mrs A's] support package was meeting her needs. Notes indicate some improvement over the period … with two requests for additional time for physiotherapy in 2014.

Based on information reviewed, it is probable that if a reassessment had been done in … 2015 that it would have reflected needs being similar to the … 2013 assessment.

As there was no notification to the Care Coordination Service that a review or reassessment was required (by the hospital, the home and community support provider, the general practitioner or Mr or [Mrs A]), there was no indication for the Care Coordination Service to initiate a review or reassessment on discharge from hospital.

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

NASC review and reassessment process

The requirements of the … Restorative Support Services in the Community Service Specification outlines a requirement for service reviews to be undertaken to assess the suitability of the support package to meet the service user's support needs; and to provide an opportunity to reassess needs and modify support packages accordingly. Reviews may be undertaken by the NASC (Care Coordination Service) or the service provider (home and community support service). Where a review indicates change, a reassessment is undertaken. Triggers for a review or reassessment include the scheduled review date, change in support needs or request from the service user or their family/caregiver.

The Care Coordination Operations Manual includes review and reassessment criteria. For someone with [Mrs A's] very high level of care, the manual indicates the need for an annual reassessment by a clinical assessor using the interRAI Home Care tool.

An annual phone review had been completed, rather than an annual reassessment.

Not undertaking an annual reassessment where needs appear unchanged through the review process despite the date for a reassessment being due could be considered a mild departure from expected practice. The reason why this might be considered mild rather than moderate is a national move to reduce the number of reassessments a person is subject to unless there is an indication for a reassessment. For example people with disabilities who are otherwise stable are required to have a reassessment at least every three years. As [Mrs A] was having a six monthly review by a registered nurse from the home and community support provider and an annual review by the Care Coordination Service, it is reasonable that a full reassessment had not been completed (… each year) in accordance with the Operations Manual.

2. Whether [the DHB] should have initiated a new NASC assessment/InterRAI assessment knowing [Mrs A] was about to go into respite care;

It is reasonable to expect that a reassessment would have been completed as part of the preparation for respite care. In not completing a reassessment this does not meet the standard of care expected. This was at the time, viewed by [the rest home] as a departure from expected practice.

There are national expectations that interRAI homecare assessments are kept current as they provide valuable information to inform care planning and delivery of services.

Request for respite care

[Mr A] contacted the Care Coordination Service to request respite care for [Mrs A] in [Month2]. A record by [Ms G], Clinical Needs Assessor noted [Mrs A] required hospital level care and the assessment details were emailed to [the rest home]. The Care Coordination Service sent a respite care notification letter to [Mrs A], and another to [the rest home] which confirmed the funding and allocation arrangements.

As there was a current package in place that allowed for respite care, the Clinical Needs Assessor completed their service coordination function of their role. However, it is reasonable to expect that the Clinical Needs Assessor in their role and as a registered health professional in health, allied health or social work with a current practising certificate they

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

would enquire as to whether there had been any change in [Mrs A's] health status and needs since her last review. Through this enquiry, the Clinical Needs Assessor should have ascertained that there had been a recent hospital admission and that a reassessment was warranted especially as reviews had only been completed in the last two years. Even if [Mr A] had omitted to provide any information about the recent hospital admission, [the rest home] brought to the attention of the Care Coordination Service that the interRAI home care assessment and care plan were likely to be out of date given they were dated … 2013 (and requested a current assessment).

In the circumstances described, not completing a reassessment prior to respite care represents a moderate departure from expected practice, especially given concerns were reportedly raised by [the rest home] with the Care Coordination Service prior to the respite admission. If [the rest home] had requested an assessment, the Care Coordination Service had an obligation to complete one.

3. Whether [the DHB] should have initiated a new NASC assessment/InterRAI assessment knowing [Mrs A] had recently been admitted to hospital with pneumonia;

If the Care Coordination Service was made aware of the admission to hospital, then it would be reasonable to expect a further review or reassessment would be completed.

If the Care Coordination Service had received the discharge summary, the Clinical Needs Assessor would have been alerted to a probable change in condition related to the assessment for home oxygen or non-invasive ventilation. This would most certainly have resulted in a reassessment (irrespective of whether there was a current interRAI homecare assessment prior to admission).

4. Whether the NASC should have been provided with [Mrs A's] recent hospital information with pneumonia, and/or if it had a responsibility to check whether there was any recent medical information of relevance;

As mentioned, there is not a clear policy that a NASC is provided with discharge information or discharge summaries for patients that are receiving home and community supports. Information is provided where an assessment is required in hospital or shortly following discharge to put services in place or to significantly change supports. It would however, be a matter of good practice for this information to be provided and represents an opportunity for improvement across the health sector (not just this DHB). Access by NASCs to hospital patient records is limited. This means that unless the patient, a family member, provider (such as a home and community support provider), general practitioner or the hospital brings medical information of relevance to the attention of the NASC, they have no method of using this to trigger a review or reassessment.

The NASC has a responsibility to liaise as appropriate with a person's general practitioner (as per the Operations Manual) when completing an assessment (or reassessment).

5. Whether [the DHB] should have told [the rest home] that [Mrs A] had recently been admitted to hospital with pneumonia.

[Mrs A] was not discharged from the hospital to [the rest home] so the DHB had no obligation to provide information directly to [the rest home].

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

The Care Coordination Service if they had ascertained that [Mrs A] had been recently discharged from hospital and was awaiting sleep studies and assessment for non-invasive ventilation should certainly have brought this to the attention of [the rest home] as part of the referral process. I am confident that this would be the view of my peers and those of other NASCs.

Yours sincerely

Christine Howard-Brown."

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.