HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate escalation of care in aged residential care home

1. On 1 December 2021 the Health and Disability Commissioner (HDC) received a complaint from Mrs B concerning the standard of care that her late father, Mr A, received from Oceania Care Company Limited Eldon Rest Home (Eldon) when he experienced a respiratory illness beginning on 25 July 2021. Mr A died from his illness in early August 2021 at the age of 92 years. I extend my sincere condolences to Mr A's whānau.

Information gathered

2. Mr A was admitted to Eldon on 7 December 2020 due to increasing health needs. He had a history of congestive heart failure, dementia, prostate cancer, panhypopituitarism,[1] and chronic pain. Mrs B was Mr A's (activated) enduring power of attorney (EPOA)[2] for care and welfare. Mr A also had an advance directive, signed and dated 6 December 2020, stating that he wished to receive treatments that improved his comfort and dignity rather than treatments to prolong his life.

3. On 25 July 2021, Mr A developed upper respiratory tract infection symptoms. Mrs B, who had visited in the morning, alerted staff to Mr A's cough and her observation that he was not as alert as usual. Staff told Mrs B that Mr A would be added to the list to be seen by general practitioner (GP) Dr C[3] the following day during the usual GP round. Staff observed that Mr A had a cough and green phlegm. The nurse who saw Mr A that evening recorded that he was restless, wandering, and confused.

4. Eldon told HDC that, although nurses had the option to escalate Mr A's care to his GP based on his symptoms observed on 25 July 2021, it was instead decided to continue monitoring and add Mr A to the GP round list for the following day.

5. Dr C saw Mr A in the early afternoon of 26 July 2021. Dr C made a suspected diagnosis of a viral upper respiratory tract infection. Cough medicine and antihistamine medications were prescribed to provide symptom relief.

6. In response to the provisional opinion, Mrs B told HDC that she was told by Eldon after the appointment that everything was under control and that Mr A's hydrocortisone protocol had been enacted when in fact it had not.

[1] A deficiency in the hormones that are produced by the pituitary gland. To manage this condition, Mr A was on long-term steroid replacement (hydrocortisone). A panhypopituitarism protocol was also in place to increase Mr A's dose of hydrocortisone in the event of a viral illness or similar condition.
[2] A person appointed to make decisions (an 'attorney') on behalf of another person (the 'donor') regarding care and welfare. An EPOA can be activated only if the donor is assessed by a medical practitioner to be mentally incapable of making decisions about their own care and welfare.
[3] At the time a newly contracted GP for Eldon residents.

7. Mr A's condition was considered by Eldon staff to be stable on 27 July 2021.

8. On 28 July 2021, Mr A developed a fever; at 9.15am his temperature was normal at 36.7°C but at 10.15am it had risen to 38.1°C. Eldon staff arranged another GP review.

9. Dr C saw Mr A at 2.21pm on 28 July 2021. Mr A was observed to be short of breath, and a lower respiratory tract infection was suspected. Dr C started Mr A on antibiotics and instructed staff to increase his hydrocortisone medication, as per the panhypopituitarism protocol, and to continue to monitor his symptoms and review if worsening.

10. In response to the provisional opinion, Mrs B noted that Mr A was not administered the increased dose of hydrocortisone and antibiotics until 5.47pm and 9.21pm, respectively, on 28 July 2021.

11. Mrs B was not present at either of Mr A's appointments with Dr C, which she said denied her the opportunity to advocate for her father. In response to the provisional opinion, Mrs B told HDC that she was instructed to arrive at 9am on 26 July 2021 so she could attend the GP appointment. She arrived at Eldon at 8.30am that day and waited for three hours before leaving. Mrs B again waited for three hours in an attempt to attend the GP appointment on 28 July 2021. Mrs B told HDC that she asked Eldon staff to arrange for her to attend appointments remotely, showing staff how to use the speakerphone function on Mr A's personal phone, but this did not occur. Mrs B said that when she asked for Dr C's contact details, Eldon staff did not supply this.

12. Eldon told HDC that it cannot recall Mrs B's request to be present at the appointments but that she was updated following each appointment.

13. At 1.30am on 29 July 2021, Mr A was found to be 'unsettled' and 'wandering'. He had continued to deteriorate, showing symptoms of fever, respiratory distress, and hypoxia.[4] Half-hourly checks were initiated by Eldon staff.

14. At 7.30am on 29 July 2021, Mr A was found walking along the corridor and 'very unsettled'. Oxygen was administered, but Mr A was restless and removed the nasal prongs. An ambulance was called at approximately 8am and Mr A's whānau informed.

15. Mrs B said that Eldon staff did not provide a handover to ambulance staff and that she had to insist that an Eldon staff member accompany her father in the ambulance to hospital.

16. Mr A was admitted to hospital and diagnosed with community-acquired bacterial pneumonia and sepsis, and it was considered that he was unlikely to survive this illness. It was agreed that the focus of treatment should be on palliative care[5] only, and Mr A died in early August 2021. Again, I offer my sincere condolences to Mr A's whānau for their loss.

[4] Insufficient oxygen levels in the tissues. Symptoms include confusion, restlessness, and elevated heart rate.
[5] Treatment focused primarily on optimising quality of life and reducing pain.

Aged-care advice

17. I sought in-house aged-care advice from nurse practitioner Dr Isabella Wright. Dr Wright identified several departures from accepted standards in the care provided to Mr A by Eldon.

18. Dr Wright considers that there were delays in the identification and escalation of care for Mr A's respiratory illness from 25 July 2021, and she is moderately critical of this aspect of the care. Dr Wright noted that Mr A displayed symptoms of acute respiratory illness on 25 July 2021, and Dr C was not notified until the following day. Dr Wright advised that it would be expected practice for Mr A's GP to have been notified on 25 July 2021.

19. Dr Wright is critical of the failure to adhere to Mr A's panhypopituitarism protocol. Dr Wright noted that there was a three-day delay before Mr A was commenced on additional hydrocortisone medication, as per the protocol's instructions in the event of acute illness. Dr Wright considered that additional hydrocortisone treatment should have been started on 25 July 2021 when Mr A first showed symptoms of an acute illness. Dr Wright was also critical of the lack of detail in Mr A's care plan concerning the management of panhypopituitarism, which she considers a complex medical condition. Dr Wright considered this to be a mild departure from accepted standards.

20. Dr Wright considered that there was inadequate support provided by Eldon to enable Mrs B, who was Mr A's activated EPOA and advocate, to attend GP appointments. Dr Wright noted that Mrs B requested to meet with Dr C on 28 July 2021, but this did not occur. Dr Wright also said that it is unclear why, given the advance care directive in place and the family's concerns, a case conference was not held between Eldon's clinical manager, Dr C, and Mrs B on 28 July 2021 to discuss Mr A's ongoing care and management. Dr Wright is critical of Eldon's communication and lack of support to facilitate Mrs B's participation in her father's care.

21. Dr Wright was also critical of the lack of evidence of appropriate protocols in place at Eldon for medical emergencies. Dr Wright noted that Eldon's policy regarding the use of oxygen could be improved.

22. Dr Wright made several recommendations for improvements that Eldon could make to address the criticisms outlined in her report. These were:

a) Improve escalation of acute changes in a person's condition with use of the ISBAR tool;[6]

b) Implement medical emergency protocols;

c) Review the care planning process to ensure that individual needs are identified clearly; and

d) Staff to complete education on communication with and about older people and their whānau.

[6] A communication framework for application between health practitioners, which stands for: introduction, situation, background, assessment, recommendation.

Responses to provisional decision

23. Mrs B was given the opportunity to comment on the 'Information gathered' section of the provisional opinion. Her comments have been incorporated into this report where relevant, as well as being addressed in separate correspondence to her.

24. Eldon was given the opportunity to comment on the provisional opinion. Eldon advised that it accepts the findings of this report, including the recommendations and follow-up actions.

25. Eldon also advised that its care home has seen a change in senior leadership since the events of this complaint, and Oceania Care Company Limited has completed a clinical review of its care services, resulting in a new clinical directorate function and structure. Eldon said that the new structure ensures better clinical governance oversight and support for its care centres.

Opinion: Eldon — breach

26. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to have services provided with reasonable care and skill. Based on the advice provided by Dr Wright, it is evident that several aspects of the care provided to Mr A did not meet accepted standards.

27. I accept Dr Wright's advice and, accordingly, I am critical of the following:

a) The delay in the identification and escalation of care for Mr A's acute respiratory illness;

b) The failure to adhere to Mr A's panhypopituitarism protocol in a timely manner;

c) Inadequate care planning documentation concerning the management of Mr A's panhypopituitarism condition;

d) Inadequate support provided to allow Mr A's activated EPOA to attend GP appointments and be involved in his care; and

e) The lack of appropriate protocols for medical emergencies.

28. In light of the above, it is evident that Eldon did not provide services to Mr A with reasonable care and skill. I therefore consider that Eldon breached Right 4(1) of the Code.

Changes made since events

29. Upon receipt of Mrs B's complaint, Eldon completed an internal investigation into the concerns raised. The following remedial actions were taken in response to this event:

a) Education on the acute deterioration of a resident was provided to clinical staff;

b) The Clinical Manager is to review all reported infections monthly to ensure that appropriate follow-up has occurred;

c) The Stop and Watch tool[7] was introduced, and education was provided to staff;

[7] A tool used by health practitioners to identify and respond to acute deterioration.

d) An organisational review of processes surrounding end-of-life cares was undertaken to improve this aspect of care and enhance communication between staff and whānau;

e) An escalation pathway was developed to guide staff in the event of acute deterioration of a resident;

f) The organisation's Oxygen policy was updated to guide staff in the event of acute deterioration of a resident; and

g) Monthly clinical quality forums are held for clinical staff to share learnings and discuss best practice.

Recommendations and follow-up actions

30. I recommend that Eldon provide a formal written apology to Mr A's whānau for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's whānau.

31. I recommend that Eldon provide an update on the progress of each of the changes it has made, or is in the process of implementing, in response to these events (set out above), including details of any training or education provided to staff regarding the changes. This report is to be provided to HDC within six months of the date of this report.

32. A copy of this report with details identifying the parties removed, except Oceania Care Company Limited Eldon Rest Home (Eldon) and the advisor on this case, will be sent to HealthCERT and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Dr Isabella Wright:

'**CLINICAL ADVICE — AGED CARE**

CONSUMER	**:**	[Mr A]
PROVIDER	**:**	Eldon Lodge Rest Home, Oceania Group
FILE NUMBER	**:**	C21HDC03028
DATE	**:**	21 February 2023

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Eldon Lodge 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 agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **Documents reviewed**
   - Consumer complaint submitted by Mr [A]'s daughter
   - Eldon Lodge complaint response with supporting organisational policies
   - Clinical documentation relating to Mr [A] including nursing assessments, nursing care plan, nursing and medical notes, medication records, weight monitoring forms and record of communication with EPOA
   - An external certification audit report completed May 2021
   - Additional clinical documentation provided on 9/2/2023

3. **Complaint**

Mr [A]'s daughter and EPOA, Mrs [B], has expressed concern about the care her father received from Eldon Lodge Rest Home prior to his death [in early] August 2021. Mrs [B] is concerned that the care provided by Eldon Lodge was below the standard of care, and that their failure to provide appropriate treatment in a timely fashion caused Mr [A]'s death.

4. **Review of clinical records**

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

- Mr [A]'s medication regimen and whether this was administered appropriately.
- The management of Mr [A]'s weight.
- The care provided to Mr [A] from 25 July 2021 until his hospitalisation, including the coordination of care with Mr [A]'s GP and whether there was any indication for escalation prior to 29 July 2021.

Background

Mr [A], aged 92 years, was admitted to the rest home community at Eldon Lodge from his own home on 7 December 2020 due to increasing healthcare needs. His medical history included congestive heart failure, dementia, prostate cancer, panhypopituitarism requiring long-term steroid medication, and chronic pain.

According to clinical file information, Mr [A] required moderate assistance with personal care requirements. He was independently mobile with the assistance of a walking stick and engaged in a range of care home activities. He required supervision with meals and supportive care and redirection from rest home staff related to his history of cognitive impairment.

On 25 July 2021, Mr [A] presented with upper respiratory symptoms. On 26 July 2021, he was seen by his general practitioner (GP) and prescribed an antihistamine and cough syrup medication. On 28 July 2021, Mr [A] was seen by his GP and commenced on antibiotic therapy. On 29 July, Mr [A] was transferred to hospital via ambulance with symptoms of fever, respiratory distress, and hypoxia, and diagnosed with community-acquired bacterial pneumonia. A decision was made for supportive comfort care, and Mr [A] passed away [in early] August 2021. I extend my condolences to Mr [A]'s family.

a) Mr [A]'s medication regimen and whether this was administered appropriately

On review of the clinical file documentation, including medication administration records, it appears Mr [A] received all prescribed medication as charted by the GP during the timeframe in question. There are no entries on the electronic administration record by nursing staff that refer to Mr [A]'s regular prescribed medications being withheld or refused during the month of July 2021. While the electronic short course prescription record was not included in the evidence bundle, the electronic short course medication administration record reflects that Mr [A] received the prescribed additional medications as outlined in the GP consultation records on 26 July and 28 July 2021:

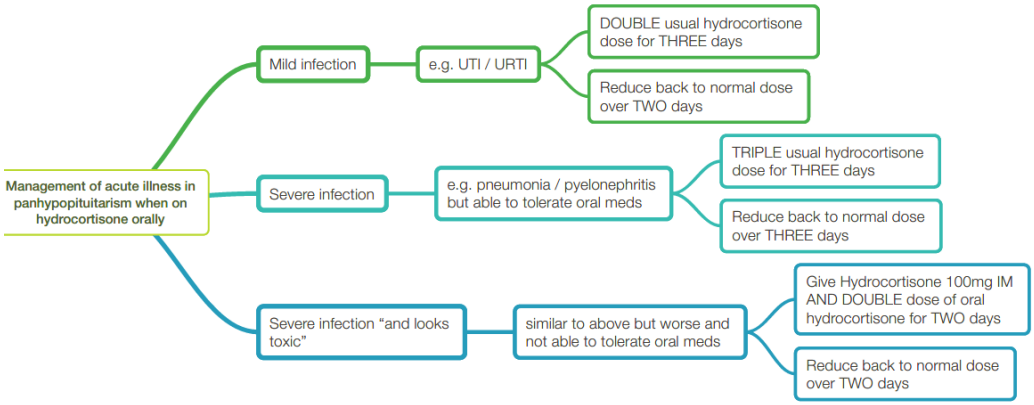
- 26 July: Likely viral URTI, charted anti-tussive and cetirizine for symptoms.
- 28 July: Possible LRTI, start Augmentin, increase hydrocortisone.

Panhypopituitarism protocol

According to Lippincott Nursing 2022, panhypopituitarism refers to decreased secretion of pituitary hormones related to diseases of the hypothalamus or pituitary gland. It is a chronic disorder that can cause an exaggerated inflammatory response related to a cortisol deficiency and increase vulnerability to infection.

As evidenced in Enclosure 1: Medication Regime, Mr [A] was prescribed regular oral hydrocortisone three times daily in varied doses. His PRN [as needed] medication prescription, page 3, provides instructions and indications for additional doses of hydrocortisone, referencing his panhypopituitarism protocol, page 4. The flow diagram provides clinical guidance for medication titration in the event of acute illness, such as a respiratory tract infection.

Following the GP visit on 28 July 2021, the medication administration record shows that Mr [A] received his regular dose of oral hydrocortisone 2.5mg at 16.03hrs followed by an additional PRN dose of hydrocortisone 2.5mg at 1747hrs, as per GP's orders.



I note Mr [A]'s nursing care plan does not provide specific guidance concerning the management of panhypopituitarism, the potential impacts to inflammatory responses, and related nursing responsibilities to care and safety needs. While the medication prescription provides an alert to long-term steroid use, it would be accepted practice to reflect complex medical needs within the InterRAI assessment and nursing care plan. From the evidence reviewed to respond to this question, it appears that Mr [A]'s medication regimen and administration was appropriate but lacked documentation in InterRAI and nursing care plans and would be viewed similarly by my peers. **Departure from accepted practice: Mild.**

Further clinical advice in relation to medication management

There is evidence of concern raised by Mr [A]'s EPOA, Mrs [B], in care record entries and resident case conference meeting minutes 8 July 2021 regarding the appropriate timing of administration and suitability of medications. Points of concern relate to the application of topical Antiflamme and administration of oral omeprazole, M-Eslon, and fentanyl. The organisation's Medication Management policy provides comprehensive guidance regarding administration and documentation responsibilities. As outlined in the policy, the medication-competent staff member is responsible for administering medications to residents as per the prescriber's instructions. According to Mr [A]'s medication prescription, omeprazole was prescribed daily at breakfast. Published consumer health guidance indicates the medication may be taken with or without food, in accordance with the prescriber's orders. I note the RN escalated these concerns to the GP for review and adjustment, which is in line with accepted practice standards.

On 28 July 2021, Mr [A] presented with shortness of breath and oxygen saturation levels of 88%. As reflected in nursing progress notes and the medication administration record, the duty registered nurse administered oxygen at 4L/minute via nasal prongs, as a nurse-initiated medication, prior to paramedic support.

The Medication Management policy (reviewed September 2021) does not provide specific information related to short-course medications, nurse-initiated medications, or oxygen management, particularly during medical emergencies. As outlined in Medicines Care Guides for Residential Aged Care 2011, referenced in the policy, oxygen should be treated like any other medication for administration and prescribed on the medication chart with orders for specific monitoring and supported by guidance in a nursing care plan. As an improvement opportunity, I recommend strengthening the policy to address the identified discussion points.

b) The management of Mr [A]'s weight

The interRAI assessments completed 17 December 2020 and 13 June 2021 indicate Mr [A] tolerated a normal diet and was able to eat and drink with moderate assistance from staff. Nursing notes indicate he required supervision and redirection from staff due to cognitive impairment. As outlined in his care plan, Mr [A] had breakfast and dinner in his bedroom to reduce distractions and his midday meal in the dining room with peers.

Clinical records and the nutritional requirements form show Mr [A] was on a restricted fluids plan of two litres daily due to congestive heart failure. GP notes refer to pitting oedema with observations of lower leg swelling from toe to knee, and Mr [A] was on prescribed diuretic therapy to support this. There is discussion of fluid monitoring charts and monthly weighs being completed by staff during Mr [A]'s admission to the care home. This is in line with the *Nutrition and Hydration policy* (2021), which outlines care responsibilities with weight management. The policy provides guidance regarding unplanned weight loss and related nursing interventions. This approach is in line with the Health Quality & Safety Commission's Frailty Care Guides, which provide guidance about accepted practice standards to support clinical judgement and inform staff practice (HQSC, 2019).

According to the weight record form, Mr [A]'s weight on admission was 81kg with a BMI [body mass index] of 27.94. His weight declined to 77.4kg in February, then 76.8kg in March 2021. Mr [A]'s EPOA expressed concern to staff about his weight loss, and he was commenced on Ensure, a nutritional supplement, by the GP on 3 March 2021. Medication administration records indicate he received the supplement twice daily as prescribed. The nutritional profile and nursing care plan shows Mr [A] was offered a high-calorie diet with snacks as per accepted practice standards. This is supported in resident survey findings and meeting minutes.

Monthly weight records show Mr [A]'s weight continued to decline between March and July 2021 to 71.7kg. It is unclear why the frequency of weighing was not increased as per policy guidelines for unintentional weight loss during this timeframe; however, there is evidence of regular GP review and discussion of weight variation during visits. There is evidence in clinical notes in June 2021 of external consultation with a community-based aged care Nurse Practitioner regarding Mr [A]'s weight management.

From the evidence reviewed to respond to this question, it appears Mr [A]'s weight management was in line with acceptable practice and would be viewed similarly by my peers. **Departure from accepted practice: Nil**

c) Whether the identification and escalation of care concerns was timely.

The clinical records show Mr [A] was regularly seen by medical practitioners during his admission to the care home. As his needs changed, wider support was sought from allied health professionals to provide clinical input to his care. GP notes reflect his weight was trending down with increasing periods of restlessness and confusion and changes in mood and behaviour. A referral was sent to Mental Health Services for Older People on 6 June 2021 with the view to have Mr [A] assessed for a higher level of care. He was seen by a team member on 24 June 2021, supported by his daughter and EPOA. Dr's notes 6 July reflect the involvement by Older Adult, Rehabilitation and Allied Health Services (ORA) in Mr [A]'s care. The care record reflects that Mr [A] was last seen by his regular GP on 6 July. He was seen by a new GP on 26 July 2021.

Mrs [B] has expressed specific concern regarding the care provided to Mr [A] from 25 July 2021 until his hospitalisation on 29 July 2021, including the coordination of care with Mr [A]'s GP and whether there was any indication for escalation prior to 29 July 2021.

Mr [A]'s Advance Directive Form and Future Care Directions, signed and dated 6 December 2020, elects to *receive treatments which look after my comfort and dignity rather than treatments to prolong my life. I do not want to be resuscitated.*

The document reflects a Do not attempt resuscitation (DNR) order signed by his GP 19 January 21. Part D. 'Desired level of care in the event of acute medical illnesses' reflects a decision for comfort care, no hospitalisation unless there is traumatic injury, and no antibiotic therapy — not to prolong life but only for comfort.

Entries from qualified and care staff in the care record in July 2021 indicate Mr [A] was experiencing episodes of confusion and unwellness prior to being seen by the GP on 26 July. An RN entry on 2 July states his daughter reported her father was "out of sorts", sleepy and confused, querying medication involvement. During the timeframe in question, nursing progress notes reflect ongoing concern raised by Mr [A]'s daughter regarding his health status. An entry on 25 July, AM shift, states that Mr [A]'s daughter expressed concern about a "rattly" cough, and that he was not as aware as usual. The RN reported a mild cough with green sputum, mild nosebleed, and observed reduced mobility. The RN on PM shift reported restlessness with wandering behaviour and confusion. Nursing assessment occurred and PRN antipsychotic medication was administered.

On 26 July, an RN entry states Mr [A] appeared generally unwell and was seen by his GP regarding cough and cold symptoms. Dr's notes indicate Mr [A] had a likely viral upper respiratory tract infection (URTI) and was prescribed an antihistamine and cough syrup. There is no discussion within the clinical record regarding indications to commence the hydrocortisone protocol. Due to a change in clinic time, Mrs [B] was unable to be present for the GP visit. As outlined in the consumer correspondence, Mrs [B] asked to participate in Mr [A]'s GP consultation via telephone; however, the family contact record indicates Mrs [B] was updated after the GP visit.

There is no entry in the submitted electronic care record for 27 July 2021. The timeline within the provider response letter refers to the delivery of personal care and administration of prescribed medications; however, there is no discussion of Mr [A]'s health status or vital signs.

Entries in the care record for 28 July 2021 reflect family concern with Mr [A]'s health. RN statements describe a productive, chesty cough with excess phlegm and nasal discharge. Vital signs indicate a raised temperature of 38.1°C, oxygen saturation levels on room air at 92%, a heart rate of 50 bpm, and respiration rate of 23/min. There is no record of a blood pressure reading during this time. The clinical notes show Mr [A] was reviewed by the GP and reportedly presented with reduced air entry bibasally, with right basal crepitus indicating a possible lower respiratory tract infection (LRTI). According to file information, he was commenced on antibiotic therapy and an increased hydrocortisone dose. Given Mr [A]'s advance directive and family concern, it is unclear why a case conference did not occur between the GP, Clinical Manager, and Mr [A]'s EPOA at this time to discuss his goals for care and ongoing management.

The care record shows Mr [A] continued to present with signs of decline overnight. Nursing entries describe Mr [A] as unsettled, unsteady, confused, short of breath and very chesty. At 0130hrs on 29 July, Mr [A]'s vital signs were T.37.9°C, HR.107bpm, RR.26/min, O2 sats 85% on room air, BP 122/53. Progress notes indicate on-duty staff provided supportive care. The RN on the AM shift assessed Mr [A] and called an ambulance for assistance. It is an accepted practice to seek paramedic support for a medical emergency in residential aged care. I note from the file evidence, the paramedic assessment showed Mr [A] presented with symptoms of fever, respiratory distress and hypoxia — T.37.1°C, HR 170bpm, RR 40/min, O2 sats 71% on room air. He was transferred to hospital for further assessment and diagnosed with community acquired bacterial pneumonia and sepsis.

As outlined in the Frailty Care Guides, sepsis is a medical emergency (HQSC, 2019). New Zealand's Best Practice Advocacy Centre (BPAC) created clinical guidelines in partnership with the UK's National Institute for Health and Care Excellence (NICE) titled "Sepsis: Recognition, Diagnosis and Early Management"[1] as a tool for healthcare providers, consumers and care teams to refer to. The document outlines identified risk factors for developing sepsis, which includes people aged over 75 years, have an impaired immune system, take long-term steroids, or have a breach of skin integrity (BPAC, 2018). The Sepsis Screening tool provides guidance about signs of acute deterioration to inform clinical decision making. Partnered with the early warning signs STOP AND WATCH tool and ISBAR communication tool.

Clinical file documentation reflects that Mr [A]'s family were very supportive and actively involved in his care while resident at Eldon Lodge. Prior to admission, Mrs [B] was Mr [A]'s primary carer and advocate as his EPOA. Having open communication and a shared understanding of care responsibilities is particularly important for families who are acting on behalf of a resident living with a diagnosis of dementia. There are regular

[1] Overview | Sepsis: recognition, diagnosis and early management | Guidance | NICE

entries in the electronic care record by nursing staff informing the EPOA of GP visits, fall events, changes in health status such as wound care, or changes to the clinical plan of care. The submitted evidence reflects that concerns raised by family members were escalated by care staff to the registered nurse for follow up.

Change in cognition, behaviour or mental state, as reported by NOK

- Hyperthermia or hypothermia <36 or >37.5
- Tachycardia HR > 100bpm
- Tachypnoea > 24 respirations/minute
- People who are older, and frail may not develop a fever
- Unclear if Mr [A] had recent bloods taken which may have shown raised inflammatory markers and increased WBC count to indicate potential systemic infection

The ARRC Services Agreement and Health and Disability Service Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person in a timely way of any change in the resident's health condition, any identified risk or concern regarding their care and safety needs, or of any adverse event. As the EPOA for Mr [A], Mrs [B] as the consumer's decision-maker, has the right to be informed and to give informed consent to proposed changes to an agreed plan of care. Care decisions are made in partnership with the EPOA and registered nurses at the care home, and evidence of these interactions is required to be documented in the resident's family contact record, care plan, progress notes and meeting minutes.

The provider response letter has acknowledged and apologised for any miscommunication with Mrs [B] regarding Mr [A]'s weight management and related care. The provider investigation has identified opportunities for improvement with communication tools and interaction with resident's nominated representatives. There is discussion of proposed recommendations in the provider response and further evidence of a completed corrective action plan was provided.

From the evidence reviewed to respond to this question, it appears that the identification and escalation of care concerns (as stated in 4 points below) was not timely and would be viewed similarly by my peers. **Departure from accepted practice: Moderate**

1) Delay in acute treatment from 25 July 2021 of increasing signs of respiratory infection which resulted in a medical emergency and hospitalisation on 29 July 2021. The expected timeframe for notification of acute illness is the same day, the documented evidence indicated that GP was notified on 26 July 2021.
2) Non-adherence to follow resident's specific medical protocol for management of panhypopituitarism. A delay of 3 days in commencing additional hydrocortisone treatment (28 July) at the start of the acute illness on 25 July 2021.
3) Poor communication and lack of support provided to enable EPOA daughter (advocate) to meet or discuss medical concerns with the newly contracted GP.

Daughter requested a discussion with new GP during the consultation (on 28 July) which did not occur.

4) Lack of evidence of protocols for medical emergencies.

5. **Clinical advice**

I note that the events occurred during the COVID-19 pandemic period 2020–2022 and acknowledge the impacts of COVID-19 pandemic restrictions, public health measures and related challenges for residents, family/whānau, care home teams and health service providers during this time.

Communication of any change in resident care is a priority for discussion at shift handover, and sharing of any relevant information between clinical and non-clinical teams, such as a change in dietary requirements, is particularly important to ensure the resident's care and safety needs are consistently maintained. Escalation of acute changes to resident's condition can be improved with the use of the ISBAR (Introduction, Situation, Background, Assessment, Recommendation) communication tool from qualified nursing staff with GP.

In addition to the Provider's list of corrective actions, I recommend that the care home implements medical emergency protocols and a review of care planning process to ensure that the resident's individual needs are clearly documented.

I also recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely communicated to minimise the risk of a similar occurrence in the future. To support this approach, I recommend that staff complete the new online modules for further learning https://www.hdc.org.nz/education/online-learning/

Addendum: Additional dates provided for moderate departure part c) on 8 April 2025.

Dr Isabella Wright, RN, NP, Doctor of Health Science
Nurse Advisor (Aged Care)
Health and Disability Commissioner

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