HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Deterioration of care home resident while waiting for ambulance

1. On 23 March 2023, the Health and Disability Commissioner (HDC) received a complaint from Ms A on behalf of her family about the care provided to her late brother, Mr B, by The Willows Home and Hospital (Willows), an aged residential care provider, and Hato Hone St John (St John), an ambulance service provider. This investigation focuses on the care provided to Mr B following his acute deterioration on 18 November 2022 until he was transferred to hospital in the early hours of 20 November 2022. At that point, Mr B was gravely unwell. Unfortunately, his health continued to deteriorate and he later passed away.

2. I express my sincere condolences to Mr B's whānau for their loss.

Information gathered

3. Mr B, aged 59 years at the time of the events, received hospital-level care at Willows. He had significant comorbidities, including (but not limited to) obesity, type 2 insulin-dependent diabetes, diabetic nephropathy[1] and neuropathy,[2] severe muscle wasting, and functional deficits. Mr B also had an indwelling catheter (IDC) for urinary retention and required full assistance with activities of daily living. It is reasonable to assume Mr B was at increased risk of becoming seriously unwell on account of the chronic health conditions he was experiencing.

IDC management

4. Ms A raised concerns about the management of Mr B's IDC.

5. As noted in paragraph 3, Mr B had an IDC for his urinary retention. Mr B's long-term care plan (LTCP) states that his goals in relation to the IDC were to 'maintain bladder emptying without distension or residue' and 'to change IDC [on] its due date.' Documented staff interventions included encouraging Mr B to increase his fluid intake and to '[a]ssess IDC from time to time and change if necessary.' The LTCP did not specify the frequency of the monitoring, describe the assessment characteristics or criteria that would indicate a need to change the IDC, discuss resident and family education relating to proper positioning of the drainage bag, describe what signs and symptoms of infection to report, or describe the perineal cares associated with IDC management to reduce infection risk.

6. Clinical records show that, on 16 November 2022, Mr B reported pain at his IDC site, along with bloating and difficulty urinating. The IDC was irrigated, and the IDC bag was changed. Afterwards, Mr B was noted as feeling 'relieved and comfortable.' In the subsequent days, staff made regular entries in the progress notes, where the IDC was noted as 'draining well.' However, there is no reference to volume, colour, or cloudiness of the urine.

[1] A condition that occurs when high blood sugar levels damage the blood vessels in the kidneys.
[2] Nerve damage caused by diabetes.

Names have been removed (except The Willows Home and Hospital (Willows) and Hato Hone St John (St John)) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

7. The Willows Catheter Care policy (undated) states that a catheterised resident should have a high volume of fluid intake (up to 1500ml daily) and that their fluid intake should be monitored and recorded on the fluid chart. Fluid charts were not completed, but progress notes refer to Mr B as 'drinking well.' Willows told HDC that it does not use a fluid chart for residents unless there is an issue with their fluid intake and that Mr B had 'been good with his fluid intake.'

Monitoring over 18–19 November 2022

8. Ms A raised concerns about the standard of care Willows provided to Mr B on 19 November 2022.

9. As discussed above, Mr B had pain at his IDC site, with bloating and difficulty urinating on 16 November 2022. However, this was relieved by irrigating the IDC. For the remainder of 16 and 17 November 2022, he was reported as feeling well and eating and drinking well.

10. On 18 November 2022, Mr B's General Practitioner (GP), Dr C, completed a routine medical review. He recorded that Mr B was well but that his weight had increased and that he had been 'eating too much.' Dr C told HDC that Mr B was clinically well, and his only concern related to his deteriorating diabetic control and reducing renal function. Accordingly, he made changes to Mr B's diabetic medication, instructed Willows staff to monitor Mr B's carbohydrate intake and requested a urine and blood test.[3]

11. At 10pm on 18 November 2022, clinical notes recorded that Mr B was 'sweating,' 'weak,' not eating his dinner, and had opened his bowels but 'he [didn't] want to be [sent] to the hospital.' The notes recorded 'monitoring accordingly' but not what was monitored. Staff did not measure his vital signs[4] or blood sugar levels or complete a physical or verbal assessment. The notes did not record why staff had considered sending Mr B to hospital, what interventions/treatment options were discussed with him, or whether he was provided with any information regarding a transfer to hospital in accordance with standard 3.6.2 of the Ngā Paerewa Health and Disability Services Standards 2021 (HDSS).[5]

12. Over 19 November 2022, Mr B continued to be unwell, with loose and watery bowel motions, lack of appetite and not being able to eat, and a sore stomach and nausea. Internal communications show that a nurse escalated these concerns to Dr C, who instructed her to 'observe and monitor.' The escalation to and advice from Dr C was not recorded in the clinical notes. It is also not known what he intended to be observed and monitored. Morning staff also supported Mr B with electrolytes to improve his hydration.

13. Clinical notes show that Mr B's blood sugar levels and vital signs were measured. On the morning of 19 November 2022, his respiratory rate was high, at 21 breaths per minute;[6] his blood pressure was high, at 137/62mmHg;[7] his heart rate was normal, at 68 beats per

[3] The results of these tests were not available until Mr B's transfer to hospital.
[4] These include body temperature, heart rate, respiratory rate, and blood pressure.
[5] This stipulates that service providers must discuss and document the reasons for transition, transfer, or discharge between care services with the consumer and their family.
[6] The normal respiratory rate range for adults is 12–20 breaths per minute.
[7] The normal blood pressure for adults is <120/80mmHg.

minute;[8] and the documentation regarding the temperature reading and blood sugar levels is illegible.

14. At 1.47pm on 19 November 2022, Willows informed Ms A that Mr B had been unwell with a 'tummy bug' and that he was not eating. The content of this discussion was not documented in the clinical records. As Mr B was not eating, staff provided electrolyte drinks to keep him hydrated. However, there is no documentation in the afternoon and evening around maintaining Mr B's hydration. Ms A said he also 'sounded drowsy,' 'was finding it difficult to speak,' his face had swollen, his 'stomach had doubled in size,' and his IDC had 'dark urine,' which was not monitored by staff. The family visited Mr B and requested that an ambulance be contacted to transfer him to hospital.

15. St John was contacted at 4pm on 19 November 2022 (discussed further below). The family were advised that St John was very busy but would send an ambulance soon. Ms A said that staff did not check on Mr B while waiting for St John unless the family insisted.

16. At 4pm on 19 November 2022, Mr B's temperature was 37.7°C (high)[9] and his blood pressure was 100/53mmHg (low). Panadol and loperamide were administered for the fever and diarrhoea, respectively. At 7pm, Mr B's blood pressure dropped further to 91/48mmHg and his temperature increased to 38.8°C (high). Neither respiratory rate nor heart rate were measured at 4pm or 7pm. Information provided by St John indicates that Willows staff also measured Mr B's vital signs at 8.04pm and 10.12pm (discussed further below), but this was not recorded in the clinical notes. At midnight, Mr B was noted to be pale, cold, moist, responsive to touch, with a high heart rate of 124 beats per minute, low blood pressure of 91/88mmHg, and a normal oxygen saturation level of 97%.[10] Staff did not assess or document Mr B's state of mind or level of consciousness. There is also no evidence of the IDC being checked.

17. The Willows Care plans policy (undated) states that short-term care plans (STCPs) are to be developed when unpredicted or documented problems arise and that the STCP should have planned interventions for the problems documented. Likewise, Standard 3.2.5 of HDSS stipulates that, where progress is different from expected, the service provider should initiate changes to the care or support plan. However, no STCP was completed, and nor were changes made to Mr B's LTCP despite the acute changes in his condition over 19 November 2022.

18. Willows acknowledged that the assessment and documentation completed by staff over this period was not of a high standard.

Responses to provisional decision

19. St John was given a copy of the provisional decision for comment. It accepted the provisional decision and had no other comments to make.

[8] The normal heart rate range for adults is 60–100 beats per minute.
[9] The normal temperature range is 36.0–37.5°C.
[10] A normal oxygen saturation level is typically >95%.

20. Willows was given a copy of the provisional decision for comment. It did not provide any comments.

21. Ms A was given a copy of the 'information gathered' section of the provisional decision for comment. She stated that the explanations provided by Willows and St John were inadequate, inconsistent, and failed to reflect the severity of failures that occurred. Ms A emphasised that this incident was preventable and that the failures from both organisations were unacceptable.

St John – 19 November 2022

22. Willows staff contacted St John at 4pm so Mr B could be transferred to hospital for further treatment. However, an ambulance did not arrive at Willows until 12.12am (over eight hours later). Ms A raised concerns about the delays in an ambulance being dispatched.

23. St John said the workload within the Auckland region on 19 November 2022 was very high and there were no missed opportunities to dispatch an ambulance any sooner to attend to Mr B.

24. When Willows initially contacted St John, at 4pm, a nurse advised the call-handler that Mr B '[was] having diarrhoea and [was] not eating since yesterday.' No further information was provided, such as his medical background, indication of any other symptoms, vital signs, state of mind, or diagnostic reasoning. However, St John also did not request further information from Willows staff about Mr B's condition. St John then advised the nurse: '[i]f it gets worse, give us a call back.' St John said it triaged this incident as an 'ORANGE' response in accordance with its standard operating procedure (SOP), meaning the situation was urgent but not immediately life threatening. St John told HDC the incident was appropriately triaged.

25. St John apologised for the delays in dispatching the ambulance and said it is unacceptable for a patient to be left so long without clinical intervention. It also said that it is concerned about the sustained high demand for ambulance services.

26. While waiting for the ambulance to arrive, St John's call-handlers completed welfare checks on Mr B. Welfare checks are follow-up calls made by call-handlers when ambulance dispatches are delayed. St John said these calls are used to gather information to determine whether the patient's condition is stable or deteriorating and subsequently decide whether the response priority needs to be upgraded and/or reviewed.

27. St John's SOP stipulates that welfare checks are to be completed half hourly. However, the call records provided by St John indicate that welfare checks were not always completed half-hourly and were delayed at times (by up to half an hour), although welfare checks were completed at least hourly between 4pm until the ambulance's arrival at 12.12am.

28. While waiting for the ambulance, Willows staff advised St John of changes in Mr B's condition at 8.04pm and 10.12pm. At 8.04pm, Willows staff advised St John that he had an episode of diarrhoea, he did not want to eat, was getting weak, and his temperature had increased to 37.7°C (high). At 10.12pm, Willows staff advised that Mr B's temperature was

38.8°C (high), blood pressure was 91/48mmHg (low), heart rate was 120 beats per minute (high), and that he was becoming weaker. The call-handler then asked whether urgent road speed was still the appropriate response, and the nurse confirmed that was appropriate. No changes in relation to Mr B's condition were relayed to St John's call-handlers during the other welfare checks.

29. Willows acknowledged that there was poor communication with St John; however, it said this was in part due to the inconsistency and illegibility of clinical notes over this period.

30. St John said that the changes advised at 8.04pm and 10.12pm did not change the incident priority because no life-threatening symptoms were described and because a registered nurse was monitoring Mr B's condition.

31. St John's SOP stipulates that when a call-handler is advised of a change in a patient's condition, the incident must be re-triaged. However, this did not occur. St John said the call-handler should have made a request for a clinical support officer to review the incident after the 10.12pm call and that this would have enabled further clinical information to be gathered.

32. The ambulance arrived at Willows at 12.12am. Ambulance records show that Mr B was unresponsive, breathing rapidly, and desaturating[11] on room air, and the IDC bag contained dark cloudy urine. Mr B was then transferred to hospital, where sepsis[12] was suspected. Sadly, Mr B deteriorated, and he passed away later in hospital. The cause of death was deemed to be sepsis from right pyelonephritis[13] due to obstruction and suppuration[14] of the right ureter.

In-house clinical advice

33. In-house clinical advice was obtained from Aged Care Nurse Advisor, Hilda Johnson-Bogaerts (**Appendix A**). Ms Johnson-Bogaerts advised the following:

- There was a moderate departure from the accepted standard of care in relation to an absence of comprehensive assessments, critical thinking, resident-informed decision-making and ongoing monitoring on 17 and 18 November 2022.
- There was a moderate to significant departure from the accepted standard of care in relation to the standard of communication relayed by Willows staff to St John.
- There was a minor departure from the accepted standard of care in relation to Willows' monitoring and management of Mr B's IDC.

[11] Having a blood oxygen saturation level that is lower than normal, which often relates to respiratory or cardiac problems.
[12] A life-threatening condition that occurs when the body's response to an infection causes widespread inflammation, leading to tissue damage and organ failure.
[13] Infection of the kidney.
[14] Discharge of pus.

34. In addition, Ms Johnson-Bogaerts advised that she would have expected the afternoon nursing staff on 19 November 2022 to continue encouraging, monitoring, and documenting fluid intake.

Decision

Willows – breach

35. As a healthcare provider, Willows was responsible for providing services to Mr B in accordance with the Code of Health and Disability Services Consumers' Rights (the Code). Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill. As I commented at the outset of this report, Mr B had several chronic health conditions that placed him at greater risk of becoming seriously unwell if not carefully managed. This meant he was reliant on the staff caring for him to be alert to emerging symptoms and to respond accordingly, be it by seeking specialist input when needed or by initiating appropriate treatments. The events that transpired highlight deficiencies in his care.

36. I accept Ms Johnson-Bogaerts's advice that there was an absence of critical thinking, comprehensive assessment, and the necessary monitoring by Willows staff on 17 and 18 November. Having reviewed Mr B's clinical notes, it is clear that he had many early indicators of sepsis, as denoted by his low blood pressure, reduced appetite, reduced urine output, high temperature, and later his reduced level of consciousness. In my opinion, the symptoms that Mr B experienced at 10pm on 18 November should have raised suspicion and triggered a fulsome assessment. However, Willows staff did not appear to recognise the seriousness of Mr B's deterioration, which meant that he was then not monitored adequately or afforded the necessary interventions. In addition, as advised by Ms Johnson-Bogaerts, Mr B was likely not provided with sufficient information about his condition to make an informed decision, and this likely contributed to the delays in escalating his care to St John.

37. Further to the above, I am critical about the standard of communication relayed by Willows staff to St John call-handlers. St John staff relied on the verbal information from Willows staff to appropriately triage Mr B's case at a time of extreme pressures on its service. Having listened to the call recordings between St John and Willows staff, I found that Willows staff failed to fully communicate Mr B's signs and symptoms or advocate for his welfare. In my opinion, this likely contributed to the delays in Mr B being transferred to hospital.

38. Finally, I am also critical of the standard of documentation completed by Willows staff. Most clinical documentation provided to me was illegible, as is also noted by my advisor and acknowledged by Willows. Staff depend on written documentation to guide the care they provide, and I am concerned that in this instance the illegibility of the documentation hindered this. In my review of the documentation, I also found that staff failed to fully describe their observations and interventions, did not document the amount of fluid intake as required by Willows' Catheter Care policy, and omitted to document Mr B's vital signs.

39. Multiple Willows staff were involved in the provision of care over this critical period of Mr B's deterioration. For this reason, I am not holding any one individual to account for what

happened. Instead, I consider systemic failures contributed to the poor care Mr B received, and I hold Willows responsible for the standard of care he received. For the reasons outlined above, I find that Willows did not provide services to Mr B with reasonable care and skill and therefore breached Right 4(1) of the Code.

St John – adverse comment

40. As discussed above, there was a delay of around eight hours before St John could dispatch an ambulance to attend to Mr B.

41. While I consider that some of this delay is mitigated by the extreme pressures faced by St John at the time and the failure of Willows staff to adequately communicate Mr B's evolving situation to St John call-handlers, I remain concerned that St John failed to follow its SOP. The shortcomings included the failure of call-handlers to consistently undertake 30-minute welfare checks and to re-triage Mr B's case when his condition changed. As St John have acknowledged, Mr B's case should have been re-triaged and reviewed by the clinical support officer after the 10.12pm call. This would have enabled further information to be gathered. I am critical that this did not occur, and I consider that it contributed to a preventable delay in transferring Mr B to hospital.

Changes made

42. Willows has made the following changes since the events:

- completed training with its staff on documentation, observation, and reporting of changes;
- is in the process of implementing an online integrated platform for documentation and communication. Willows said this will create consistency and legibility across all staff.

43. St John has made the following changes since events:

- held a workshop for delayed patients involving senior managers, and several safety netting initiatives have been developed, including clinical support for dispatch to better prioritise waiting cases and additional capacity for remote triage;
- is actively monitoring and reviewing all incidents to determine how to ensure ambulances can be dispatched sooner.

44. Willows and St John have separately provided apologies to Mr B's family in response to my provisional decision.

Recommendations and follow-up actions

45. I acknowledge the changes Willows has made. In addition, I recommend that Willows:

a) provide training on the use of the STOP and WATCH tool[15] for recognising signs of acute deterioration and how the tool can be used to communicate with other providers, such as a GP and ambulance services. Evidence confirming the content of the presentation and delivery is to be provided to HDC within three months of the date of this report;

b) undertake further training on the importance of completing fulsome and accurate documentation. Evidence confirming the content of the presentation and delivery is to be provided to HDC within three months of the date of this report;

c) undertake training on recognising the signs of sepsis, using the home-based screening tool from Sepsis Trust New Zealand.[16] Evidence confirming the content of the presentation and delivery is to be provided to HDC within three months of the date of this report;

d) provide an update on the implementation of its online integrated platform for documentation within three months of the date of this report.

46. I acknowledge the changes St John has made. In addition, I recommend that St John:

a) undertake an audit of 15 cases where an ambulance dispatch was delayed to determine whether:

   i. 30-minute welfare checks were completed; and

   ii. the case was re-triaged when there was a change in the patient's condition.

The summary of the findings, with any corrective actions, is to be provided to HDC within three months of the date of this report.

b) provide an overview of how long red and orange triaged cases have been waiting for an ambulance in the last three months within the Auckland region, along with any measures implemented to manage or mitigate these cases. This information is to be provided to HDC within three months of the date of this report.

47. A copy of this report, with details identifying the parties removed, except Willows and St John, will be provided to HealthCERT at the Ministry of Health | Manatū Hauora and Health New Zealand | Te Whatu Ora Counties Manukau and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

Rose Wall
Deputy Health and Disability Commissioner

[15] The STOP and WATCH early warning tool helps care staff identify and report specific issues. Acute deterioration | Te tipuheke tārū (Frailty care guides 2023) issued by the Health Quality & Safety Commission | Te Tāhū Hauora.
[16] Clinical Tools | NZ Sepsis Trust

Appendix A: In-house clinical advice to the Commissioner

The following in-house clinical advice was obtained from Aged Care Nurse Advisor, Hilda Johnson-Bogaerts:

> 'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by The Willows Home and Hospital. 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.

I am asked to review the provided information and advise on the following questions:

i. Please comment on the clinical monitoring and oversight provided to [Mr B] on 17 and 18 November 2022 preceding hospital admission and whether this is consistent with accepted nursing practice.

ii. Please comment on the nursing communication with Hato Hone St John, with relevance to escalation of [Mr B]'s unwellness; and do you consider this occurred within a timely manner.

iii. Do you consider the lack of nutritional intake during the day up to and including transfer to hospital has been monitored and managed in line with accepted nursing standards.

iv. Please comment on the incident pertaining to the 'tipping of the hoist' during transfer and whether the incident form and corrective actions reflect adequate follow-up.

v. Do you consider the oversight of [Mr B]'s catheter and continence management [to be] in line with accepted nursing standards and was further referral to Urology indicated.

Documents reviewed

- File review and request for advice from Aged Care Navigator
- Provider responses dated 17 July 2023, 18 July 2023
- [Mr B]'s clinical records relating to this period
- Recordings of the communication with Hato Hone St John ambulance service
- Communication (TXT message) from Registered Nurse (RN) […] (morning duty 19 November 2022) with [Willows Management].
- Incident report and action plan relating to the hoist incident

Review documentation on file and clinical advice

At the time of the events, [Mr B] was a 59-year-old gentleman residing at The Willows Home and Hospital where he received long-term hospital-level care. He lived with multiple

comorbidities, including obesity (147kg), type 2 insulin-dependent diabetes (1992), diabetic nephropathy, diabetic neuropathy, polyneuropathy, diabetic retinopathy with macular disease, high cholesterol, peripheral vascular disease, severe muscle wasting to bilateral hands, previous falls, # R) NOF in August 2019, lumbar spondylosis, longstanding pressure injuries associated with peripheral vascular disease, along with ongoing functional deficits, primarily immobility and dysphagia. He required full assistance with all his ADL [activities of daily living] and with mobility (needing bariatric care equipment, including a full sling hoist for transfers); he was able to eat and drink independently. He had a urinary catheter (in-dwelling catheter (IDC)) in place due to enduring urinary retention. The provider described him as a very friendly man able to make decisions for himself and let his preferences [be] known to staff. At times he would need a lot of encouragement to be active, and some days he would be sleepy because he would have watched TV during the night.

On 18 November 2022, he became increasingly unwell with nausea, vomiting, and diarrhoea, which worsened the next day. In the afternoon of 19 November 2022, his family asked for a transfer to hospital, and St John ambulance was called. The ambulance service was delayed but checked in with the RN on a regular basis. The ambulance arrived after midnight, by which point [Mr B]'s health had deteriorated significantly. Unfortunately, [Mr B] died early that morning in hospital. The postmortem identified as cause of death '*Sepsis relating to acute right pyelonephritis secondary to underlying nephrolithiasis with obstruction and suppuration of right ureter*.'

i. Clinical monitoring and oversight provided to [Mr B] on the 17 and 18 November 2022

The Integrated Notes are handwritten by care staff and [in] handwriting. I note that at times the notes are very hard or impossible to read.

The documentation includes that, on 16 November 2022, [Mr B] was feeling 'bloated and wanting to wee.' The RN noted that his catheter had been irrigated before and therefore decided to replace his IDC and catheter bag. [Mr B] reportedly felt 'relieved and comfortable' after this, and his catheter was reported to drain well. 17 November 2022, the notes include 'nil concerns' and 'settled in bed.'

18 November 2022 includes further observations of the catheter to be draining well in the afternoon, with further notes relating to an episode at 22.00hrs that he had not eaten his dinner and was 'sweating … opened his bowels too' and that 'he was feeling weak but he said he is okay and he don't want to be send to hospital' and 'monitored accordingly.' I did not, however, find any notes of observations taken that would indicate he was 'monitored accordingly.'

In a residential aged care setting, when a resident is acutely unwell, sweating profusely, and has recently had an IDC replaced, I would expect the RN to conduct an initial assessment, symptom inquiry, and physical examination. This should include monitoring vital signs such as temperature, blood pressure, heart rate, respiration rate, and oxygen saturation. Profuse sweating may indicate fever or autonomic dysregulation, warranting prompt action. The RN should engage with the resident to ask about symptoms such as pain, nausea, and chills and check for redness, swelling, or discharge around the catheter area. Assessing the catheter

function, the amount of urine draining over time, and noting its colour and clarity are also crucial. These observations and critical thinking should be documented, along with a follow-up conversation with the resident about the seriousness of the situation and proposed actions such as escalation as appropriate to a GP or hospital, about symptom management in the meantime (e.g., pain management and comfort), and continued monitoring.

Conclusion: Overall, I found that there was an absence of comprehensive assessments, critical thinking, resident-informed decision-making, and ongoing monitoring, constituting a moderate deviation from accepted practice for that reason.

ii. Nursing communication with Hato Hone St John, with relevance to escalation of [Mr B]'s unwellness; and do you consider this occurred within a timely manner.

The Integrated Notes indicate that, on 19 November 2022, [Mr B] continued to be very unwell, with symptoms described as an "upset tummy" and "refusing to eat anything." His blood sugar levels were checked in the morning and recorded, along with his vital signs in the Integrated Notes (T illegible, BP 131/63, RR 21, HR 68) by the morning RN. Panadol was administered as an action. The TXT message from the morning RN to [Willows Management] included that the GP was contacted '*he ordered to observe and monitor*'.

[Mr B]'s sister was called, had a video conversation with [Mr B], and arrived at the care home around 3:30 PM, requesting that he be sent to the hospital. There were no notes documenting the content of the conversation with his sister or with [Mr B] about his situation or considerations taken into account. The notes also lacked observations or comments on his state of mind or responsiveness. This may be because there were no changes or concerns observed at the time. It is good practice, however, to note this in the clinical documentation. At 4pm, his temperature was recorded as 37.7°C, but his blood pressure results were illegible in the documentation. At 7pm, it was noted that he had a loose bowel motion. At 9pm, his blood pressure was recorded as 91/48, and his temperature was 38.8°C. No other vital signs, such as respiration rate, heart rate, or further blood sugar levels, were documented. This indicates that the RN on afternoon duty did not critically assess the situation or look for potential symptoms of sepsis while UTI [urinary tract infection] was a possibility. The notes mention that the ambulance was informed and stated, "they will come once available."

Listening to the recordings of the phone conversation between the ambulance service and the afternoon RN, I noted the following:

Initial call at 4pm: At this call, the RN was asked about the provisional diagnosis; the RN said, 'He is having diarrhoea and is not eating since yesterday.' The ambulance service responded, 'If it gets worse, give us a call back.' I consider the information provided by the RN to the ambulance service to have been lacking and not providing a comprehensive picture of the situation. For example, it did not include a medical background, current full clinical presentation, vital signs, state of mind, or diagnostic reasoning. Instead, the RN answered the questions asked by the ambulance service only and briefly. I also noted that the questions asked by the ambulance service were general and did not request additional details such as "What are the vital signs?" I recommend that the care home develop a

communication tool for such calls to the ambulance service or uses the commonly used SBAR [Situation, Background, Assessment, and Recommendation] tool.

At 7pm: The RN reported only an increased temperature.

At 8pm: The RN reported another liquid bowel motion and noted they had been waiting for four hours already. The ambulance service apologised and asked the RN to ring as soon as anything changed.

At 9pm: The RN reported no change. There was a weak attempt from the RN to advocate for the resident by saying that the family was getting restless and wanted to accompany the resident to the hospital with the ambulance.

At 10pm: The RN reported that [Mr B] was still not eating. There was an attempt to advocate for the resident by asking how long it would take for an ambulance to arrive.

At 10:15pm: The RN called 111 and, when asked what had changed, provided the low blood pressure results and high temperature, noting that [Mr B] was getting weaker. The RN was then firmly asked by the service if in 'his medical opinion' the triaging status of 'urgent road speed' was still appropriate, to which the RN responded, "Yes, it is." The service asked the RN to call back if the situation became immediately life-threatening. *I have questions about the appropriateness of asking the RN for his 'medical opinion' and the appropriateness of the emergency status, as I would not consider the ambulance emergency status to be common knowledge to registered nurses working in long-term care.*

At 11pm: The ambulance service checked in, and the RN said, "He needs to go to the hospital now." The ambulance service apologised and responded that, if it got worse, to call back.

The Integrated Notes include the entry of the RN on night duty, who documented a full set of vital signs and observations. The ambulance arrived shortly after this at 12:12am, and care was handed over, with the ambulance reported to have left at 12:30am.

Conclusion: The afternoon RN's actions and documentation indicate a lack of critical assessment and comprehensive communication with both the resident and the ambulance service. There was insufficient documentation of vital signs and symptoms, and the communication with the ambulance service did not provide a complete picture of the resident's evolving condition. This highlights the need for improved assessment protocols, better documentation practices, and the development of a communication tool for emergency calls to ensure timely and appropriate care. **I consider the nursing oversight in the afternoon and communication with the ambulance service to have been a moderate to significant deviation from accepted practice.**

Noting that the adequacy of "emergency services response and protocols for triaging" by the emergency service response team are out of my scope of practice, I recommend that appropriate advice is sought to assess the adequacy of the telephone triaging and telephone support provided by the call centre.

iii. Do you consider the lack of nutritional intake during the day up to and including transfer to hospital has been monitored and managed in line with accepted nursing standards.

Reviewing [Mr B]'s care plan relating to eating and drinking, I note that he was independent with meeting his dietary requirements. His care plan goal was to maintain a normal body weight and sugar levels. The interventions include to give him plenty of time to finish his meals and to check his weight monthly and his blood sugar levels regularly to titrate insulin dose. It would appear that, generally, he was eating and drinking well. The progress notes of 18 November 2022 include that he didn't have his dinner … 'but he said he was okay.' The next day, the notes from the HCA [healthcare assistant] include that he had an 'upset tummy' followed by notes made by the RN on morning duty, who gave him electrolytes to keep him hydrated and monitored his blood sugar levels, checked his vital signs, and contacted the GP. In the afternoon he increasingly became unwell and other more acute issues took centre stage.

I consider the response by the morning RN to monitor his blood sugar levels and provide fluids with electrolytes to have been an appropriate response to the situation. The notes from the RN in the afternoon do not include a focus on maintaining hydration. Blood sugar levels were taken and seemed to have stayed within normal range.

In conclusion, I did not find a deviation from accepted practice relating to the monitoring of nutritional intake, however, would have expected for the afternoon RN to continue encouraging, monitoring, and documenting fluid intake.

iv. Please comment on the incident pertaining to the 'tipping of the hoist' during transfer and whether the incident form and corrective actions reflect adequate follow-up.

Reviewing the provider response of 18 July 2023 and the incident report, [Mr B] was to be transferred using the usual full sling hoist, which has a weight capacity of 250kg to transfer him from bed to wheelchair. Unfortunately, the staff member turned the hoist too fast, making it tip and resulting in [Mr B] slowly being lowered to the floor while the second care staff was holding on to the sling from the back. He was then assessed for injury and hoisted safely back to bed.

The incident form includes that this was a preventable incident, and it was recommended that the floor be kept free from obstacles and for staff to keep the hoist stable when operating. A corrective action plan was created, including staff education. The corrective action plan was reviewed and signed off on 28 February 2022 as completed with no further follow-up needed.

Reviewing the documentation, I consider this incident to have been an unfortunate accident. The incident seemed to have been well investigated and followed up with an action plan. The actions taken, however, all seemed to be staff and incident centric. I recommend that the management of such incidents should also consider the impact of such an incident on resident and family trust. It is recommended that the action plan also includes a restoration of resident trust in staff and equipment. I did not find documentation that included that the staffer extended an apology for the incident to [Mr B]. Further I identified

some minor documentation completion issues, including missing dates and times, as well as limited details on the assessment for injury.

In conclusion, I consider the follow-up on this incident and the documentation to have been a mild to moderate deviation from accepted practice, specifically because of the lack of consideration of the impact on [Mr B] and his family and lack of thorough completion of documentation.

vi. Do you consider the oversight of [Mr B]'s catheter and continence management in line with accepted nursing standards, and was further referral to Urology indicated.

Reviewing [Mr B]'s long-term care plan relating to continence and catheter care, I consider this care plan to be too brief to guide staff. Specifically, the care goals could be "I" statements of what the resident experiences or would like to experience. And the interventions could be more specific to guide staff. For example, the statement 'assess IDC from time to time and change if needed' could be improved to: Assess catheter and drainage system at least every shift and as needed (e.g. decreased urine flow or discomfort is to be reported) to ensure patency, check for kinks, and observe urine characteristics (colour, odour, clarity). I recommend for the care plan to include individualised guidelines for changing the catheter, clarifying the criteria that would prompt an earlier change than the due date. Additional interventions not considered in the care plan include the resident and family education relating to proper positioning of the drainage bag, signs and symptoms of infection to report, and the regular perineal care to reduce infection risk.

I note that the progress notes include regular reporting on the drainage of the catheter, and a record is kept of when the IDC was changed. I did not find comments in the notes relating to the aspect of the urine and assessment of hydration.

In conclusion: I consider the care plan and oversight of [Mr B]'s catheter and continence management to have been a minor deviation from accepted practice because the care plan, care focus, and care documentation omits several key details that most care homes would include.

Further referral to urology is typically indicated when standard management fails to resolve or adequately address urinary issues – such as recurrent urinary retention, frequent catheter-associated infections that do not respond to usual treatment, unexplained blood in urine, or suspected strictures. In such cases, a urological evaluation can help identify causes and determine if specialised interventions – like imaging studies, cystoscopes, or surgical procedures – are necessary. The provided albeit limited clinical documentation did not include any of these indications for further urology referral.

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Nurse Advisor (Aged Care)

Health and Disability Commissioner'.