8 May 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to adequately manage continence, hydration and diabetes in a vulnerable resident

(Case 22HDC02657/CAS-13974-S4Q8D1)

Introduction

1. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner.

2. On 24 October 2022, this Office received a complaint from Ms A about the care provided to her grandmother, Mrs B (aged 82 years at the time of events) while she was a resident at Annie Brydon Lifecare (a Heritage Lifecare facility) in March 2022.

3. The following issues were identified for investigation:

- *Whether Heritage Lifecare Limited (operating as Annie Brydon Village) provided Mrs B with an appropriate standard of care in March 2022.*
- *Whether Registered Nurse (RN) C provided Mrs B with an appropriate standard of care in March 2022.*

Background

4. Mrs B had previously been a resident of Annie Brydon in 2017 and then was transferred to another care home for dementia-level care. After a decline in her functional and cognitive capacity, Mrs B was assessed as needing hospital-level care and was transferred back to Annie Brydon on 1 March 2022.

5. Mrs B's medical history included type 1 diabetes, for which she required long-term insulin; advanced dementia; high blood pressure; and chronic kidney disease. She required a wheelchair to mobilise and needed a sling hoist to move her from the wheelchair to her bed.

6. Annie Brydon told the Health and Disability Commissioner (HDC) that the hospital wing has a staff-to-resident ratio of 1:5 for the morning and 1:10 for the afternoon, as well as the support of a registered nurse 24/7. The Clinical Service Manager (CSM) is also on duty during the morning shift.

7. RN C held the role of CSM for hospital-level care at Annie Brydon. She told HDC that this role included supervising a small team of RNs and healthcare assistants, as well as planning, coordinating, and ensuring that appropriate care was delivered to the residents. The primary staff involved in Mrs B's care were RN C, RN D, RN E, and RN F. Mrs B was also assisted by several healthcare assistants, as named below.

Admission

8. On Mrs B's admission to Annie Brydon, no nursing handover from the previous care home to Annie Brydon was completed. A response from Heritage Lifecare noted that it was unable to locate any handover nursing information relating to when Mrs B arrived at Annie Brydon in March 2022.

9. Usually, a nursing handover occurs when a resident is transferred from one care home to another to share information about that resident, including their needs, risks, etc, so that the new care home can begin the resident's initial care plan on admission. This is important to ensure continuity of care for the resident and address any concerns.

10. On Mrs B's admission, a registered nurse developed a brief interim care plan. It noted that Mrs B had dementia, was incontinent and required incontinence products, needed full assistance with meals and showering, and required a diabetic diet and insulin injections.

11. In relation to falls management, Heritage Lifecare provided HDC with Mrs B's care plan from her 2020 admission, which included a Falls Risk Assessment Tool (FRAT) completed on 9 May 2020. This document had been restored for Mrs B's 2022 admission. It identified that Mrs B was a low falls risk. However, the interim care plan noted that she was now a high falls risk, having had previous falls in the last 12 months, and that she required a wheelchair and lifting/transferring equipment such as a sling hoist with two people assisting her.

12. The requirements to manage Mrs B's diabetes were identified in Mrs B's interim care plan. This included her progress notes, which documented that Mrs B required her blood glucose levels to be tested three times a day before her meals. However, Heritage Lifecare told HDC that it could not locate any short-term care plans developed for Mrs B to address her diabetes management.

13. Heritage Lifecare told HDC that there was no record of any general practitioner (GP) request form, email, or text communication to the GP on the day of Mrs B's admission to Annie Brydon to alert the GP of her arrival so that he could assess her. Mrs B had last been reviewed by a GP on 6 January 2022, when the GP had noted that she had very 'labile[1] blood sugars [and] having highs more before lunch'.

14. Progress notes indicate that, on 15 March 2022, a GP reviewed Mrs B. He noted that her dementia was 'stable' and that she remained 'pleasantly confused'. However, there were no instructions from the GP regarding ongoing clinical care for Mrs B, such as how to manage her diabetes.

15. There is no documentation to indicate that the family was contacted to establish Mrs B's care needs or to be involved in the development of her interim care plan. In the 'family/rep feedback' area of the care plan, the corresponding questions to family were all marked as 'NA'.

Urinary continence management

[1] Unstable, and something that can change quickly and spontaneously.

16. From 25 March 2022 through to 27 March 2022, Mrs B's progress notes contain four entries using the words 'smelly', 'foul' or 'putrid' regarding vaginal secretions.

17. On 25 March 2022, caregiver1 documented that Mrs B had a 'smelly secretion from [her] vagina' and that the RN had been informed.

18. On 26 March 2022, RN F recorded that Mrs B had 'smelly' secretions from her vagina and was experiencing 'vaginal discharge … coming out of pads very foul odour and putrid'. Mrs B's family were notified, but there is no indication that the GP was informed about these secretions.

19. On 27 March 2022, RN D recorded that Mrs B's blood-glucose level was high and that her vaginal secretions were 'putrid in smell and dark in colour? UTI [urinary tract infection].'

20. RN D stated that, even though she noted a 'foul' odour from Mrs B's vagina, she did not obtain a midstream urine sample to test for a UTI as the previous nurse had done a urine dipstick test. However, Heritage Lifecare told HDC that it could find no documentation regarding the outcome of a dipstick test.

21. Heritage Lifecare told HDC that this situation should have been escalated to the GP but '[u]nfortunately' the GP was not contacted in this instance. Eventually, Mrs B was diagnosed with a UTI when she was subsequently admitted to hospital.

Hydration management

22. Mrs B's progress notes document that, in her initial days at Annie Brydon in 2022, she was tolerating a small diet and adequate fluids.

23. However, from 22 to 27 March 2022, there are documented instances in which Mrs B was unable to tolerate food or fluid.

24. On 22 March 2022, caregiver3 recorded: '[Mrs B] has not [had] a lot to eat or drink this shift as she was always asleep …' It is not documented whether this was escalated to an RN.

25. On 25 March 2022, caregiver1 recorded that Mrs B had vomited and that the RN had been informed. On the same day, RN E notified Mrs B's family that Mrs B was 'unresponsive' and unable to eat or drink and that medications were being withheld. RN E told the family that she would continue to monitor Mrs B and keep them updated.

26. On 26 March 2022, caregiver2 documented that Mrs B was not eating or drinking. RN F recorded: '[Mrs B's] condition is declining gradually [and she is] not responding well.' It is documented that Mrs B was unable to swallow and that her medications and insulin were withheld. Mrs B's family were notified, and it is documented that, at that time, they did not want a hospital transfer. There is no indication that the GP was informed of Mrs B's change in health status.

27. On 27 March 2022, caregiver2 recorded that Mrs B was not eating or drinking. RN E recorded that Mrs B was 'still unresponsive' and had not been able to eat or drink and that her

medications had been withheld and her blood-glucose level was high. There is no evidence that the GP was informed.

28. Despite the change in Mrs B's health status and her apparent deterioration, there is no evidence that any short-term care plans were developed to address Mrs B's poor fluid intake, such as commencing a fluid balance chart or food chart to measure her intake and output. HDC requested fluid balance and food charts from Heritage Lifecare, but it responded that these are not available for the time Mrs B was in Annie Brydon.

29. Ms A requested an explanation as to why Mrs B was not placed on intravenous fluids when she was exhibiting signs of extreme dehydration (such as a very dry mouth and lips and extreme thirst). Heritage Lifecare told Ms A:

> We have a clear pathway in our Nutrition and Hydration policy, which has an assessment tool to follow … It appears that this assessment tool was not adopted in the case of [Mrs B]. We are extremely disappointed and concerned about this.

Diabetes management

30. Mrs B had type 1 diabetes, which is a chronic long-term condition in which the pancreas does not make insulin. People with this condition require insulin injections.

31. Mrs B's medication chart indicates that she had been prescribed Lantus insulin as a long-term medication and was to be given 32 units subcutaneously (ie, just under the skin) at bedtime (between 7 and 9pm, according to her medication chart).

32. Mrs B's interim care plan noted that she had diabetes and required insulin injections, but no further instructions were provided to guide staff on the management of her diabetes, such as when to check her blood glucose and the rationale, or how to manage her insulin injections as they related to her type 1 status. There is also no evidence that her nutrition and hydration needs were assessed on admission and a short-term care plan developed, despite her type 1 diabetes having been identified.

Management of Mrs B's elevated blood-glucose levels and insulin administration

33. According to Diabetes New Zealand, normal blood-glucose levels are between 4mmol/L and 8mmol/L.[2] If the blood-glucose reading above 8mmol/L is considered high (hyperglycaemia), and, if sustained, can damage nerves, blood vessels (such as in the eyes, affecting eyesight), tissues, and organs (such as the kidneys). Severe hyperglycaemia can lead to life-threatening complications, such as diabetic ketoacidosis (DKA), or a hyperosmolar hyperglycaemia state (HHS), especially in people with diabetes who take insulin.[3]

34. From 22 to 27 March 2022, there are six instances in which Mrs B was noted to be 'sleepy', 'unresponsive', and unable to eat or drink; three instances in which her Lantus insulin was

[2] https://www.diabetes.org.nz.

[3] Diabetic ketoacidosis is a serious, life-threatening complication of diabetes that occurs when the body does not have enough insulin and so produces excess blood acids called ketones. A hyperosmolar hyperglycaemia state is another life-threatening complication of diabetes; it is characterised by very high blood glucose, extreme dehydration, and altered consciousness.

withheld; and one incident in which she experienced a sudden drop in her blood pressure and was very unwell. There is no evidence that Mrs B's care was escalated to the GP for any of these 10 instances.

35. In addition, Mrs B's average blood-glucose readings increased during this time. On 22 March 2022, they were recorded as 14.3mmol/L (high). By 27 March 2022, they were recorded as 31.4mmol/L. The clinical notes show that Mrs B's blood-glucose levels increased between 2mmol/L and 5mmol/L per day, with the exception of 24 March 2022, where they decreased from 21.9mmol/L the previous day to 20.2mmol/L.

36. Various staff, including caregiver3, RN C, and caregiver1, noted in the clinical records that Mrs B appeared to be sleepy, with minimal eating and drinking on these days.

37. There is no record that Mrs B's elevated blood-glucose levels or the concerns about her presentation were escalated to an RN or the GP.

38. On 25 March 2022, RN E recorded that Mrs B had had a sudden drop in her blood pressure, was 'drooling', and was very unwell and nearly unresponsive. RN E helped Mrs B back to bed and elevated her feet to raise her blood pressure, and Mrs B appeared to recover. It is not documented whether this incident was escalated to the GP. RN E notified Mrs B's family regarding the incident and told them that Mrs B was unable to eat or drink and that her medications were being withheld. RN E told the family that she would continue to monitor Mrs B and keep them updated.

39. The clinical records show that Mrs B's Lantus insulin was withheld multiple times during this period. RN C first withheld the insulin on 23 March 2022, but no rationale was recorded, and there is no record that the GP was informed of this.

40. Mrs B's insulin was next withheld by RN D on 25 May 2022. The clinical records note: '[Mrs B's insulin was] withheld as she is unresponsive no food intake BGL: 16.5.' RN D stated that she withheld Mrs B's insulin as she was not eating. RN D said she felt that Mrs B would be at risk of hypoglycaemia if given her insulin. RN D acknowledged that she 'failed' to notify the GP that Mrs B's blood-glucose levels were higher than 10mmol/L.

41. Mrs B's insulin was next recorded as having been withheld by RN D on 26 March 2022. RN D documented: '[R]isk for hypoglycaemia BGL: 18.9.' Caregiver2 noted that Mrs B was not eating or drinking, and RN F recorded that Mrs B's condition was 'declining gradually'. There is no indication that the GP was informed of Mrs B's change in health status.

42. On 27 March 2022, RN D recorded that Mrs B's blood-glucose level was high and that she might have a UTI. RN E documented that Mrs B was 'still unresponsive', had not been able to eat or drink, her medications had been withheld, and her blood-glucose level was high. RN E informed Mrs B's family, who asked that she be transferred to hospital for further care and treatment.

Transfer to hospital (Health NZ) on 27 March 2022

43. Mrs B's hospital notes document that she was unresponsive on arrival and had had a gradual decline over the previous month, 'with rapid decline in the last 2 days'. It was noted that Mrs B had been slowly getting 'less mobile, less interactive, and lethargic'.

44. Sadly, a few days later, Mrs B passed away in hospital. Her death certificate noted the cause of death as:

- hyperosmolar hyperglycaemic state
- severe hyperglycaemia, 4 days' duration
- extreme dehydration
- urinary tract infection, 4 days' duration.

Policies and guidelines

Age-Related Residential Care Agreement

45. Health New Zealand | Te Whatu Ora (Health NZ) contracts with aged residential care providers for delivery of services to older people. A key agreement is the Age-Related Residential Care Agreement (ARRC Agreement).

46. Section D16.1 of the ARRC Agreement outlines that 'each potential resident who may be admitted to [the] facility … has been assessed using the most clinically appropriate interRAI assessment tool' prior to admission.

47. Section D16.2(a)(c) of the ARRC Agreement outlines that 'each resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 21 days [and] the assessment utilises information gained from the resident [and] their nominated representative (where applicable)'.

48. Section D16.4(a) of the ARRC Agreement outlines that an RN 'must ensure that each Resident's Care Plan is evaluated, reviewed and amended … either when clinically indicated by a change in the resident's condition or at least every 6 months, whichever is the earlier'.

49. Section D.16.5(e)(ii)(1) of the ARRC Agreement outlines that 'each resident is examined by a General Practitioner … within 2 to 5 working days of admission … except where the resident has been examined by a medical practitioner … not more than 2 working days prior to admission, and you have a summary of the medical practitioner's … examination notes'.

50. Section D16.3(f) of the ARRC Agreement outlines that 'each resident and if applicable … [the] family/whānau … have the opportunity to have input in the resident's care planning process'.

51. Section D17.5(d) of the ARRC Agreement provides that '[a]ny staff member carrying out tasks, procedures, or treatment must have demonstrated that they are competent at performing [these tasks] and follow documented policies, and protocols developed by [the organisation] to ensure safe practice'.

Frailty Care Guides

52. The Frailty Care Guides were designed by healthcare professionals to support clinical judgement in the aged residential care environment.

53. For people with type 1 diabetes, the Frailty Care Guides state that basal insulin[4] should not be withheld because that can result in diabetic ketoacidosis.

54. Hyperglycaemia can be caused by blood glucose-lowering medication such as insulin being missed or administered late. The Frailty Care Guides state that symptoms of hyperglycaemia can include tiredness, fatigue, feeling weak or lethargic, and, at a late stage, loss of consciousness.[5]

55. The Heritage Lifecare policies described in the following paragraphs relate to Mrs B's care at Annie Brydon.

Medical Practitioners' Policy

56. The purpose of the Medical Practitioners' Policy is to 'support collaborative relationships between residents, clinical employees and general practitioners to ensure residents receive care that is continuous, safe, timely and effective and delivered in the most appropriate care setting'.

57. The GP's responsibilities include reviewing the resident 'when a change in their medical status is reported', organising diagnostic tests, prescribing medications, and ensuring that their interactions with staff and residents are noted in the resident's medical progress notes.

58. The responsibilities of the CSM and RNs include ensuring that the resident is assessed by the GP within two working days of the resident's admission (unless they have been seen by another GP 'not more than 2 days prior to admission' and those medical notes are available), ensuring that the GP is contacted if there is a significant change in the resident's condition, recording the reason why a review is necessary, and completing a GP request form before the GP visit.

Deterioration In Health Status Procedure

59. The purpose of the Deterioration in Health Status Procedure is '[t]o ensure timely and appropriate assessment of an identified change in a resident's health status whether due to injury or illness'.

60. This policy provides that it is the responsibility of the RN to escalate any concerns or changes to a resident's condition to the GP and notes a pathway for seeking GP advice or transfer to hospital (after gathering further information such as blood-sugar levels, hydration, vital observations, and level of consciousness).

[4] Long-acting insulin that gives a small but constant stream of insulin to help keep blood glucose steady.
[5] https://www.hqsc.govt.nz/resources/resource-library/diabetes-mate-huka-frailty-care-guides-2023/. (page 5).

Nutrition and Hydration Policy

61. The purpose of this policy is to '[provide] guidance to staff to ensure the nutritional and hydration needs of residents are consistently met'. It relates to the nutrition and expected assessment and documentation required for those with diabetes.

62. The policy states that where residents have specific dietary or nutritional requirements (such as a diabetic diet), this must be documented in the resident's long-term care plan, and food and fluid monitoring charts should be used.

63. It is the CSM's responsibility to ensure that a nutritional assessment is completed for a resident on admission to the care home and to ensure that short-term care plans are developed by RNs to support the resident's nutritional requirements.

64. RNs are responsible for ensuring that nutritional charts are maintained accurately on each shift, and, alongside care staff, that the resident's food and fluid intake are monitored.

65. In terms of hydration, the policy notes that it is the responsibility of all staff who interact with the residents to recognise and respond to dehydration and that staff must ensure that regular drinks are provided to residents with reduced mobility who rely on staff for their hydration needs.

66. The policy documents signs of dehydration such as confusion, weakness, decreased urine output, and the consequences of dehydration in the elderly, such as increased risk of acute kidney injury, weakness, fatigue, impaired cognition, and increased risk of falls.

67. The policy outlines the steps in the assessment, management, and prevention of dehydration. If dehydration is suspected, the first line of treatment is to commence a fluid input/output chart for three days, to ensure that the resident is offered drinks regularly, and to aim for at least 1600ml input per day. Following this, the resident should be reassessed over a 24-hour period and the GP contacted to review the resident.

Medication Management Policy and Procedure

68. The purpose of the Medication Management Policy and Procedure is '[t]o ensure medications are managed and administered safely and in line with legislation, standards and guidelines'. This applies to the administration of insulin, which is noted as a high-risk medication as it can be 'lifesaving and life threatening'.

69. The policy documents that residents with type 1 diabetes are insulin dependent and that 'if their insulin injections are missed or stopped it can be life threatening'.

70. The policy states that only RNs can withhold medications 'if they consider it is clinically indicated or would compromise resident safety'. If insulin is withheld, it is to be noted in MediMap (the electronic medication chart) and the resident's progress notes with a rationale.

Further information

Heritage Lifecare response

71. Heritage Lifecare told HDC:

> '[W]e wish to make it clear that Heritage Lifecare accepts that the standard of care that was delivered to Mrs B was below its expectations. It is relevant that when we started to investigate our concerns over those matters, the principal people involved, being RN C (who was the CSM), and another RN D, both tendered their immediate resignations.'

72. The internal investigation noted that Mrs B had not been seen by a GP on admission (1 March 2022) and was not seen until 15 March 2022, which 'did not meet the ARC contract which requires a resident to be assessed within five days of admission'. The investigation also noted that, when Mrs B's condition deteriorated, she was not assessed by a GP.

73. The investigation notes document:

> Mrs B [had] insulin-dependent [diabetes]. Mrs B's insulin was withheld, despite her [having] longstanding [diabetes] and without any consultation or discussion with Mrs B's General Practitioner.
>
> …
>
> Mrs C did not ensure that the admission assessment or appropriate referral occurred.

74. Heritage Lifecare told HDC that the internal investigation could not be continued because the key individuals (RN C and RN D) both tendered their resignations.

75. Ms A asked Heritage Lifecare why Mrs B's insulin had been withheld when she had been using insulin for a long time. Heritage Lifecare told Ms A that it was within the RN's scope to withhold Mrs B's insulin but noted: '[I]n this instance, the GP was not informed to review [Mrs B] and considering she was deteriorating … we would certainly expect medical advice would be sought.'

76. Heritage Lifecare told HDC that 'the standard of care being delivered by the [CSM] … sets a model for the entire facility', and RN C was the senior person who had primary responsibility for the services provided**.**

77. Heritage Lifecare told HDC:

> If there were staff shortages in the care home, the Clinical Services Manager (RN C) would cover as required and staff would be sourced from other homes in the region. Or staff would do 12-hour shifts.

78. The process in place for escalating concerns to the GP involved an acute referral form being completed by the RN on shift and scanned to the GP practice. This would result in a virtual consultation being provided that day. Any new admission would be seen by the GP within three days of admission. It is Heritage Lifecare's understanding that at the time, the CSM was the only staff member who was liaising with the GP practice, which meant that the other nurses were not familiar with the process.

79. Heritage Lifecare told HDC that it could not locate any records of training provided to staff regarding managing residents with diabetes prior to April 2022.

RN C's response

80. In a statement to Annie Brydon Heritage Lifecare, RN C acknowledged that there was poor documentation and communication with the multi-disciplinary team, and that there needed to be better communication with the GP.

81. RN C initially told HDC that, during the entire period in which Mrs B was a resident at Annie Brydon, she was working night shifts as an RN, at the request of the Facility Manager, to cover staff shortages for several weeks. In a later response, she said that she was working night shifts for 'most of the period, including all the period Mrs B's health deteriorated'. She noted that the staff shortages were 'significant' and 'very challenging'. RN C said that no other RNs were available or willing to work night shifts and that being assigned to the night shift 'was not ideal, but in the circumstances, there was no option'.

82. RN C told HDC that, because she was on night duty, she was not involved in Mrs B's admission or planning or coordinating her care. She stated:

> To the best of my recall, nothing at all was ever mentioned to me in relation to Mrs B … [B]ecause I was on night shifts, I was not aware that Mrs B's insulin had been discontinued for one or more doses.

83. RN C told HDC that, in her role as CSM, she would have conducted ward rounds first thing in the morning to check on the residents and to talk to staff about any concerns regarding the residents. She would then have checked residents' charts and reports. She noted:

> These checks and balances were missed during the time Mrs B was at Annie Brydon Village while I was covering night shifts … Looking back, I should have ensured that someone was properly covering this vital work in my absence. I unreservedly apologise for failing to do this.

Response to provisional decision

Heritage Lifecare

84. Heritage Lifecare was given a copy of the provisional report and the opportunity to respond. Its responses have been incorporated where relevant in the report and addressed in separate correspondence.

85. Heritage Lifecare told HDC that RN C was not working night shifts in the period that Mrs B was a resident and that it could not locate the staff roster for the week of 21 March 2022.

RN C

86. RN C was given a copy of the provisional report and an opportunity to respond. Her response has been incorporated where relevant in the report.

87. In addition, RN C acknowledged that in her role as Clinical Manager, during the period Mrs B was a resident, she held overall accountability for the shortcomings identified in the care

provided. She expressed her sincere regret that Mrs B did not receive care to the expected standard and that communication with her family was inadequate.

Ms A

88. Ms A was given a copy of the provisional report and the opportunity to respond.

89. Ms A told HDC that she was brought up by Mrs B, who treated her 'like her daughter' and that to have been seen as someone not involved in her 'mother's' care was 'hurtful' as she was always 'attentive' to Mrs B's needs.

90. Ms A told HDC that she was present on admission on 1 March 2022 to assist her grandmother with moving to Annie Brydon Village and visited Mrs B. She added that 'at no time did she refuse for her mother to be transferred to hospital, [and] she strongly refutes this.'

91. Ms A told HDC that it was 'most concerning for the whānau … that the GP was not informed of Mrs B's admission to Annie Brydon given her complex diabetes management.' She also questioned 'why no handover was undertaken when her mother was transferred [from her previous care home] to Annie Brydon and if effective communication was undertaken to … escalate this.'

Opinion: Heritage Lifecare Limited — breach

92. I acknowledge the distress that these events have caused Mrs B's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered regarding the concerns raised. I should emphasise that this has been a particularly challenging exercise because of the differing accounts submitted by RN C and Heritage Lifecare and the omission of certain information. To determine whether the care provided by Heritage Lifecare was appropriate, I considered in-house clinical advice from RN Jane Ferreira (Appendix A).

Mrs B's admission into Annie Brydon on 1 March 2022

93. Mrs B had been a resident of Annie Brydon previously in 2020. She then moved to another care home, returning to Annie Brydon in 2022. RN Ferreira advised:

> File information reflects that electronic nursing assessments and care plan records from Mrs B's previous admission in 2020 were restored; however, this raises concern regarding the currency of resident assessment and care information. A Falls Risk Assessment Tool (FRAT) dated 9 May 2020 was included in the submitted evidence, which stated that Mrs B was a low falls risk (7/20), with no falls reported in the last 12 months. However, the interim care plan stated that Mrs B had experienced weekly falls and was at high risk … the falls risk status and checklist was not reviewed to reflect an accurate falls risk score, in line with Mrs B's revised level of care … It would be considered accepted nursing practice to complete new risk assessments for all resident admissions, in line with contractual responsibilities and professional standards.

94. When a resident is transferred from one care facility to another, a nursing handover is usually conducted so that essential information about the resident can be shared and the receiving facility can start to form the resident's initial care plan.

95. RN Ferreira advised:

> [T]here is no evidence that the Clinical Manager (CM) or RN sought or received a nursing handover from the previous provider as part of the transfer of care responsibilities, which would be considered accepted practice to ensure continuity of resident care.

96. In addition, when a resident is admitted, an RN is required to complete assessments such as mobility, falls risk, nutrition, and pressure injury risk. This is to ensure that a comprehensive care plan is developed for the resident that addresses any issues via the creation of short-term care plans. Short-term care plans focus on an area of concern. For example, it was recorded on admission that, in a previous GP review, Mrs B had unstable blood-glucose readings and required long-term insulin to manage her diabetes.

97. RN Ferreira advised:

> [I]t does not appear that additional nursing assessments, such as pain or pressure injury risk, were completed. Records show that baseline observations (vital signs) were taken on admission, a BSL monitoring record and bowel chart commenced; however, there is no indication that a continence assessment occurred or fluid balance chart was implemented given Mrs B's history of recurrent UTIs.

98. RN Ferreria noted:

> Checks of blood sugar levels (BSL) were requested four-times daily due to type 1 diabetes; however, nursing documentation provides no specific guidance about the management of Mrs B's diabetic care.

99. When a resident is admitted, there should be an opportunity for family to participate in the admission and assessment process. However, RN Ferreira advised:

> The ARRC service agreement (D16.3f) states … that each resident and if applicable, his or her family/whānau or nominated representative will have the opportunity to have input into the resident's care planning process … Viewed family communication and progress note records provide no evidence of day of admission interactions with Mrs B's whānau. Records show the first documented contact was 25 March 2022 … The Culturally Safe Policy and Procedure discusses responsibilities to the assessment, planning and delivery of culturally safe care. Reviewed nursing information provides no evidence that Mrs B's whānau were involved in the admission and initial care planning process … It does not appear that care home leaders met with Mrs B and her nominated representative, whānau/family to review the preadmission information such as an advance care plan, to participate in admission assessment and care processes, and to establish goals for care, ensuring any cultural beliefs were upheld.

100. Mrs B was admitted into Annie Brydon on 1 March 2022; however, it was not until 15 March 2022 that she was assessed by a GP. RN Ferreira advised:

> The Medical Practitioner's policy states that the CM or RN is responsible for facilitating GP visits. Records show that Mrs B was admitted on 1 March 2022 but first seen by her GP on 15 March 2022, which would be considered outside of contractual requirements … [Heritage Lifecare] has stated that the organisation expects residents to be medically assessed within three days of admission but, based on their investigation, are unable to explain why Mrs B was not reviewed prior to 15 March 2022.

101. RN Ferreira advised:

> While the care home had systems and processes in place to guide nursing actions, there appears to be a lack of clinical leadership and oversight, communication, care and documentation responsibilities. Given Mrs B was living with multiple long-term health conditions, it would be considered accepted practice to ensure that comprehensive nursing assessments were completed on admission with an appropriate plan of care in place to safely support her needs during the settling-in phase.

102. Taking the above into account, RN Ferreira advised that the incomplete admission assessments, missing information, and lack of GP review on admission, which contributed to a lack of comprehensive care planning and short-term care plans, along with the lack of nursing handover, amounted to a moderate to serious departure from the accepted standard of care.

103. I accept RN Ferreira's advice. In my view, accurate comprehensive health assessments are the cornerstone of good nursing practice and clinical decision-making. A robust assessment that includes input from the family, a GP, and/or multidisciplinary teams such as physiotherapists and dietitians (given that Mrs B was on long-term insulin for diabetes) can identify issues and health risks and guide the formation of a comprehensive care plan. These care plans will then guide the actions of staff. In my opinion, in this case, the cumulative effects of missed or incomplete nursing assessments on admission were detrimental to Mrs B's wellbeing, given that she was a vulnerable resident with a complex medical background.

104. I acknowledge RN Ferreira's comments about Mrs B's 2020 FRAT and her concern that this was relied on to manage Mrs B's care in 2022 despite no longer being accurate about her level of risk. Having reviewed the evidence, I am unable to make a factual finding that this was the case. Although I recognise that the 2020 document was included in Mrs B's clinical record, I note that the interim care plan developed at her admission in 2022 stated that she was a high falls risk. In the absence of any evidence that Heritage Lifecare viewed Mrs B as a low falls risk, rather than a high falls risk, I am unable to make a determination on this matter.

105. I have also considered the relevant policies in place at the time Mrs B was a resident at Annie Brydon. The Medical Practitioner's Policy documents that it is the responsibility of the CSM and RNs to ensure that a resident is assessed by the GP within two working days of admission (unless the resident was assessed by a GP not more than two days before the

admission). Mrs B was not assessed by the GP until 14 days after she was admitted. Her last assessment by a GP had been two months before her admission on 1 March 2022. In my opinion, this delay in GP review is unacceptable. I am concerned that staff did not follow this policy; based on the training records provided, it is unclear whether staff received training on the policy.

Urinary continence management

Management of Mrs B's UTI

106. Mrs B's notes from 25 to 27 March 2022 contain entries that describe 'smelly', 'putrid', and 'foul' vaginal secretions. Mrs B's progress notes indicate that the RN was advised of concerns that Mrs B was sleepy and had minimal oral intake and elimination. However, there is limited evidence of expected actions by the RN, including, but not limited to, assessment of vital signs, pain, and oral intake status. Further, there is no documentation of communication with the GP or whether a urine sample was indicated for analysis.

107. RN Ferreira advised that accepted practice is for an RN to commence a short-term care plan for a suspected UTI. This would entail increased monitoring and GP involvement. However, no short-term care plan is documented. The Deterioration in Health Status Procedure provides guidance for nurses and carers in the event that a resident is unwell, but it appears that this was not followed.

108. RN D told Annie Brydon that she had noted the strong foul odour, but she did not obtain a urine sample to test for a UTI, because a nurse on the previous shift had done a urine dipstick test. Heritage Lifecare told HDC that, unfortunately, it could not locate the result of this test.

109. RN Ferreira advised:

> The submitted information appears to show a lack of critical thinking by the CM and RN team to inform appropriate actions, care responsibilities and timely escalation. From the information reviewed, it appears that appropriate interventions were not in place, interactions with Mrs B's GP were not completed in a timely manner, and guidance provided in the submitted organisational policies was not followed.

110. Taking the above into account, RN Ferreira advised that the lack of escalation to the GP, the lack of a short-term care plan created to address management of a suspected UTI, and the lack of nursing action such as a obtaining a urine sample and managing hydration, amounted to a moderate to serious departure from the accepted standard of care.

111. I accept RN Ferreira's advice. Progress notes over three days indicate that Mrs B's urine was dark in colour and that secretions from her vagina were very offensive. In my opinion, the nurses were negligent in their failure to escalate this to the GP and to obtain a urine sample so the GP could consider appropriate antibiotics to treat the infection. Considering that Mrs B was a very vulnerable resident with multiple comorbidities and was unwell with a UTI, I find the nurses' lack of action and escalation very concerning.

112. I have also considered the relevant policy in place at the time Mrs B was a resident of Annie Brydon. Heritage Lifecare's Deterioration in Health Status Procedure contained a pathway

for nurses to follow if a resident was deteriorating. I am concerned that, even if staff were aware of and identified the deterioration, the procedure was not followed, to the detriment of a very vulnerable resident.

Hydration management

113. From 22 to 27 March 2022, there are documented instances in which Mrs B was unable to tolerate food or fluid.

114. RN Ferreira advised that Mrs B's progress notes report that she was unwell, but there is no evidence that an RN commenced a short-term care plan, monitored her oral intake, or sought advice from the GP and whānau. Heritage Lifecare told HDC that there are no nutritional or fluid intake records for the relevant period.

115. RN Ferreira noted that the Nutrition and Hydration Policy states that the CSM is responsible for ensuring that nutritional assessments are completed on admission. RNs are responsible for monitoring resident food and fluid intake and taking action when concerns are identified.

116. RN Ferreira said that it is unclear why the nursing team did not seek medical guidance to inform Mrs B's plan of care. She advised that the management of Mrs B's hydration needs was below accepted standards. RN Ferreira is also concerned that there is limited evidence of nursing assessments, care planning, and RN oversight and that there were delays in escalation.

117. RN Ferreira advised that the lack of recognition that Mrs B was deteriorating resulted in an absence of short-term care plans being created, along with an absence of fluid monitoring charts, and no escalation to the GP, which amounted to a moderate to serious departure from the accepted standard of care.

118. I accept RN Ferreira's advice. It is concerning that there appears to be a wider competence issue in staff recognising the impact of dehydration on a vulnerable older resident who had diabetes and could not feed herself because of severe dementia.

119. Although I accept that, as registered health professionals, the nursing staff working with Mrs B were accountable for their individual nursing practice, in my opinion, Heritage Lifecare was also responsible for ensuring it had appropriate policies in place for its nursing and support staff to follow and that staff were educated and trained in their application. I acknowledge that, at the time of events, a Nutrition and Hydration Policy was in place, which noted the signs of and risks from dehydration. However, multiple staff members failed to abide by the policy, which indicates a systemic lack of knowledge or training in this area, which was the responsibility of Heritage Lifecare.

Diabetes management

120. In a GP review before Mrs B's admission to Annie Brydon, it is noted that Mrs B's blood-glucose levels were unstable and high before lunch. On admission, it was noted that Mrs B had diabetes and was on long-term insulin to manage this.

121. RN Ferreira advised:

> Given Mrs B was a new admission with a history of unstable diabetes, it would be considered clinically relevant to commence food and fluid monitoring to support [blood glucose] records and inform nursing judgement. I note there is no evidence monitoring was commenced per policy guidelines when Mrs B's health status changed.

122. RN Ferreira said that, although Mrs B's interim care plan noted that she required insulin injections, no rationale or further instruction was provided. RN Ferreira advised:

> It would be considered accepted nursing practice to implement a specific, personalised diabetic management plan from the day of admission that included GP instructions, medication, dietary and care requirements, advance care wishes and goals for care.
>
> …
>
> Records show that Mrs B's [blood glucose] readings were elevated for several days, with signs of unwellness reported on 25 March 2022. It would be considered accepted practice for an RN to regularly review BSL readings and escalate clinical concerns to the CM, or the delegated senior RN, for nursing guidance, with actions reflected in the care record, as outlined in the Deterioration in Health Status Procedure.

123. RN Ferreira noted:

> Although reviewed policies indicate that systems and processes were in place, it appears there were gaps in clinical leadership and delays in recognising and prioritising Mrs B's specific care requirements by the nursing team.

124. RN Ferreira said that, on admission, there was a lack of documentation completed regarding how to manage Mrs B's type 1 diabetes, such as with a short-term care plan, and when her blood-glucose levels were high there was a lack of escalation to senior staff for guidance. RN Ferreira advised that these failures amounted to a moderate to serious departure from the accepted standard of care.

125. I accept RN Ferreira's advice. In my opinion, for a resident such as Mrs B, who had several comorbidities and a need for diabetes management, it would have been prudent to ensure that she was assessed properly and that comprehensive care plans were developed. I am critical that this did not occur and that staff were not guided to provide the appropriate diabetes care and complete the appropriate assessments/documentation for Mrs B. This created missed opportunities to recognise when Mrs B was deteriorating or when her blood-glucose levels required escalation to the GP.

126. I have also considered the relevant policies in place at the time Mrs B was a resident at Annie Brydon. The Nutrition and Hydration Policy specified that residents with diabetes should be on a diabetic diet and that food and fluid monitoring charts should have been commenced.

Management of Mrs B's elevated blood-glucose levels

127. Mrs B had type 1 diabetes. Her blood-glucose levels were considered over a six-day period from 22 to 27 March 2022 because of documented changes in her health status, such as being unable to eat or drink and being sleepy and unresponsive, alongside her high blood-

glucose readings over this time. Over this period, on 23, 25, and 26 March, Mrs B's long-term Lantus insulin was withheld by RN D and RN C.

128. RN Ferreira advised that the Diabetes and Medication Management Policies state that residents with type 1 diabetes are insulin dependent and that missing an injection can be life threatening. The policy recommends that medical assistance is sought rather than insulin withheld. RN Ferreira stated that, given this, it is unclear why the nurses did not contact the GP, particularly when Mrs B's blood glucose levels were elevated. RN Ferreira noted that the policy states that only RNs can withhold medication if they consider that it is clinically indicated or would compromise resident safety.

129. RN Ferreira advised:

> The Medical Practitioner's policy states that the [Clinical Manager] or RN is responsible for contacting the GP and requesting a visit whenever there is a "significant change in the resident's condition, or inappropriate response to treatment" … however, there is no record of GP consultation or involvement in Mrs B's care.
>
> …
>
> [T]here appears to be a lack of understanding from the nursing team about the management of type 1 diabetes and responsibilities to assessment, clinical care, medication safety and care escalation … there appears to be concern surrounding nursing assessment, informed care planning, critical thinking and related actions. It appears that guidance provided in the submitted organisational policies was not followed, and this would be viewed as a serious deviation from accepted practice by my peers.

130. RN Ferreira advised that the above issues amount to a serious departure from the accepted standard of care because of concerns about whether the nursing staff understood how to manage residents with type 1 diabetes and whether they were aware of organisational policies that were in place at this time.

131. I accept RN Ferreira's advice. I am concerned about the competence of the nursing staff in managing a resident with type 1 diabetes appropriately. It is clear that, over the six-day period, Mrs B's blood glucose was consistently high and rising every day, from 14.3mmol/L to 31.4mmol/L. Mrs B was reliant on Lantus insulin, and I am critical that this was withheld when her blood glucose was still rising. I am concerned that the nursing staff did not recognise or understand that Mrs B was deteriorating and that Mrs B's rising blood glucose did not trigger staff to escalate her care to the GP.

132. In my opinion, the cumulative effects of missed nursing assessments by various individuals regarding diabetic care, the lack of a short-term care plan, and the lack of understanding regarding type 1 diabetes, and therefore the lack of escalation of care to the GP, were detrimental to Mrs B's wellbeing. I note the apparent lack of support from Heritage Lifecare in ensuring that its nursing staff were trained in managing residents with diabetes, as indicated by the lack of staff training records. In my opinion, Heritage carried some

responsibility for ensuring its staff were familiar with the organisational policies for managing residents with unstable blood sugar levels and, more importantly, were following them.

Conclusion

133. There were shortcomings in the care Mrs B received over the relatively brief time she was resident at Annie Brydon Lifecare in March 2022. A focus of this investigation has been differentiating between the responsibilities Heritage Lifecare carried as the contracted provider of ARRC services and the duties RN C held in her capacity as the facility's CSM. I acknowledge that, as the CSM, RN C was the senior person with primary responsibility for the services provided to residents. However, the failings that occurred were not solely her responsibility, and I also consider Heritage Lifecare had a responsibility for ensuring its staff were equipped to perform their roles and that appropriate systems and processes were in place to guide their actions and the provision of care.

134. With reference to the advice from my in-house aged care clinical expert, I find that Heritage Lifecare Limited did not provide Mrs B with an appropriate standard of care in March 2022, for the following reasons:

a) The admission assessments were incomplete or missing, which contributed to a lack of comprehensive care planning, along with the lack of short-term care plans and GP review on or around the day of her admission.

b) Regarding Mrs B's UTI, there was a lack of nursing action such as informing the GP, taking a urine sample and ensuring that a result was received and acted on, and ensuring that Mrs B was getting enough fluids.

c) There was a lack of recognition that Mrs B was deteriorating and unable to eat or drink, an absence of fluid monitoring charts, and no escalation to the GP.

d) There was a lack of documentation completed on admission regarding how to manage Mrs B's type 1 diabetes, such as a short-term care plan, and there was a lack of escalation to senior staff for guidance when her blood glucose levels were high.

e) There are competence concerns about whether nursing staff understood how to manage Mrs B's type 1 diabetes and a lack of awareness of organisational policies in place at the time.

135. Taking the above into account, I consider that Heritage Lifecare Limited (trading as Annie Brydon Village) breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[6]

RN C — breach

136. As I have stated, RN C was the CSM at Annie Brydon and, in her role, had overall responsibility for resident care. I have considered the reasonableness of her actions as the clinical lead in the context of the systemic issues I have outlined above.

137. Heritage Lifecare stated that RN C was primarily responsible for the services provided to Mrs B, including the completion of admission documentation. As noted, there was limited admission documentation for Mrs B.

[6] Right 4(1) stipulates that '[e]very consumer has the right to have services provided with reasonable care and skill'.

138. Heritage Lifecare also stated that the CSM is the only staff member able to escalate a resident's care to the GP. In response to the provisional decision, RN C told HDC that:

> It was never my understanding or experience during my tenure at the Annie Brydon Village that I was the only registered nurse who could contact a general practitioner, nurse practitioner or any other health service provider if a resident's health deteriorated … As far as I was aware all the registered nurses at Annie Brydon Village could contact medical staff based on their professional judgement as necessary at any time.

139. I am concerned that there is conflicting information about whether or not RN C was the only staff member who could escalate Mrs B's care to the GP. However, notwithstanding the differing views, I accept RN C was in charge at critical times over the period in question and therefore had a responsibility for ensuring Mrs B's care was escalated.

140. On 23 March 2022, it was recorded that RN C withheld Mrs B's Lantus insulin and did not record a rationale for why this decision was made. Mrs B's average blood glucose on this day was high, at 19.6mmol/L. RN C also recorded that Mrs B was unusually sleepy. The changes in Mrs B's presentation were not escalated to the GP, nor were they escalated on the other occasions when staff withheld Mrs B's insulin.

141. I am critical that no rationale for why Mrs B's Lantus insulin was withheld was recorded, given that Mrs B's blood glucose was very high. I am also critical that the GP was not contacted about Mrs B's subsequent change in presentation or informed that her insulin had been withheld.

142. I acknowledge Heritage Lifecare's responses, which indicate where individual staff failed to take appropriate action in Mrs B's care. I agree that there were instances where RNs should have recognised Mrs B's deterioration and escalated it to the appropriate person. RN C, as the CSM, also should have recognised the pattern of Mrs B's care and escalated it to the GP when she herself withheld insulin on 23 March 2022.

Conclusion

143. In summary, I find that RN C did not provide Mrs B with an appropriate standard of care in March 2022, for the following reasons:

a) No rationale was recorded as to why RN C withheld Mrs B's Lantus insulin, even though Mrs B had a high blood glucose.

b) Mrs B's care was not escalated to the GP when she had high blood glucose readings, her insulin was withheld, and a change in her presentation was noticed.

c) As CSM, RN C had overall responsibility for resident care, including that of Mrs B.

144. Taking the above into account, I consider that RN C breached Right 4(1) of the Code.

Other comment – shifts worked

145. In its response to the provisional opinion, Heritage Lifecare told HDC that RN C was **not** working night shifts during the time Mrs B was a resident [emphasis added]. RN C, in her 7 July 2023 statement, stated that '[d]uring the **entire** period in which Mrs B was a resident at Annie Brydon Village, I was working night shifts as a registered nurse [emphasis added]. She noted that this was because of 'significant' staff shortages and staff sickness. RN C also noted that, because she was on night duty, she was 'not involved in Mrs B's admission or in planning or coordinating [Mrs B's] care.'

146. HDC has since received further information in the form of timesheets from Heritage that record that, in contrast to RN C's previous statement, she was in fact working for the majority of March 2022 in her substantive role as CSM during the day.

On review of the timesheets and Mrs B's progress notes, the following information was noted:

- From 1 to 4 March, 7 to 11 March, and 14 to 18 March 2022, RN C worked as CSM during the day.
- From 21 to 26 March 2022, inclusive, other RNs worked the night shift.
- On 28 March, 30 March, and 1 April 2022, RN C worked the night shift.

147. From the above information, it appears RN C worked night shift on three occasions during the month of March.

148. RN C was given the opportunity to respond to the evidence provided by Heritage. She believed that the roster was 'somewhat misleading' in terms of the hours she worked and noted she 'frequently worked on the floor' to cover staff shortages, working afternoons and nights as necessary. She maintained that she worked nights on 8–9, 11–13, 16, 19, and 21–31 March 2022. However, she also added that she wanted to amend her 2023 statement from 'the entire period Mrs B was a resident' to 'most of the period, including all the period Mrs B's health deteriorated.'

149. While it is not my role to determine the veracity of RN C's statements, the evidence provided, including documentation, is persuasive and indicates that – contrary to RN C's submission – she did not work on night shifts for the majority of March and was more involved in Mrs B's care than she initially told HDC.

Changes made since events

150. Heritage Lifecare has created a detailed induction programme for CSMs to assist them to meet the standards of a senior RN.

151. Heritage Lifecare has put in place further education sessions for staff on diabetes and identification of deteriorating residents.

Recommendations

152. I recommend that Heritage Lifecare provide a written apology to Mrs B's family for the issues identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

153. I recommend that Heritage Lifecare provide HDC with a report on how staff shortages are currently managed, and the contingency plan created to ensure continuity of care for its vulnerable residents when there is a staffing issue; this is to be sent to HDC within three months of the date of this report.

154. Annie Brydon was audited by a designated auditing agency and certified for four years in September 2025. The audit did not identify any areas requiring improvement. Notwithstanding this result, I recommend that Heritage Lifecare undertake the following and report back to HDC within six months of the date of this report:

Use an anonymised case study of this decision as the basis for staff training sessions on the following topics:

a) How to manage a resident with type 1 diabetes, the importance of any long-term/long-acting insulin such as Lantus, an understanding of the usual blood glucose ranges, and when a resident is experiencing hyperglycaemia, when to escalate the care to a GP, and the follow-up actions required.

b) The Medication Management Policy and Procedure (and evidence of compliance with this policy).

c) The Frailty Care Guides regarding managing older adults with diabetes.

d) The importance of completing widely used comprehensive resident assessments on admission, including falls assessments, and the details required to be noted in the individualised care plans; and evidence of staff compliance with the Medical Practitioners' policy.

e) The importance of creating comprehensive care plans (including initial, short-term, and long-term care plans).

f) The importance of managing UTIs in older adults, how to identify a UTI and the follow-up actions required, and evidence of staff compliance with the Deterioration in Health Status Procedure.

g) The importance of hydration management in older adults, how to identify that a resident may be at risk of dehydration, how to identify when a resident is becoming dehydrated and the follow-up actions required, and evidence of staff compliance with the Nutrition and Hydration Policy.

155. These recommendations should be directed to Annie Brydon.

156. I recommend that RN C provide a written apology to Mrs B's family for the issues identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

157. I recommend that RN C, within six months of the date of this report:

a) Undertake education/training on diabetes management in older adults, including topics such as managing and understanding insulin. Evidence of attendance, such as a certificate, and a written reflection on the learnings and how these are going to be applied in practice is to be provided to HDC.

b) Reflect on the deficiencies in care identified in this case and provide a written report to HDC on her reflections and the changes to practice she has instigated as a result of this case.

Follow-up actions

158. A copy of the sections of this report that relate to RN C will be sent to the Nursing Council of New Zealand.

159. A copy of this report with details identifying the parties removed, except the advisor on this case and Heritage Lifecare Limited (operating as Annie Brydon Village), will be sent to HealthCERT, Health New Zealand | Te Whatu Ora, and the Nursing Council of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Ferreira:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Annie Brydon Care 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**

- Letter of complaint received 25 October 2022
- Provider responses and supporting information received between 10 August 2023 and 25 June 2024
- Clinical records, including nursing assessments, interim care plan, progress notes, monitoring forms, communication records, allied health and medical records, medication records, and historical care records 2019–2020
- Organisational policies, including Care Plan, Clinical Handover, Culturally Safe Care, Deterioration in Health Status Procedure and Escalation Process, Diabetes Management, Insulin Administration and Medication Management, Medical Practitioner's policy, Māori Health Plan, Nutrition and Hydration
- Clinical and operational role information.

3. Complaint

Mrs [B]'s whānau have expressed concern about the clinical care provided to Mrs [B] during her admission to the care home in March 2022. Concerns relate to diabetic management, recognition of decline, clinical care, and communication.

<u>Background</u>
Mrs [B] was admitted to the care home on 1 March 2022 at hospital-level care.

Her medical history included type 1 diabetes (30 years), chronic kidney failure, depression, hypertension, osteoarthritis, advanced Alzheimer's dementia and recurrent urinary tract infections (UTIs). File information reported that Mrs [B] required a high level of carer assistance to reposition and meet all activities of daily living. Following admission, Mrs [B]'s health and wellbeing began to decline and on 27 March 2022 she was transferred to hospital for further assessment. Mrs [B] was diagnosed with hyperosmolar hyperglycaemic syndrome and acute kidney injury with possible sepsis; she passed away [in late] March 2022. I extend my condolences to Mrs [B]'s whānau/family at this time.

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:

a) The nursing admission process undertaken for Mrs [B] and whether this aligns with Heritage Lifecare policy

Clinical and operational responsibilities for care home resident admissions are outlined in the Age-Related Residential Care (ARRC) Agreement and Ngā Paerewa Health and Disability Service Standards. The ARRC contract (D16.1) states that each potential resident will be assessed using the most clinically appropriate interRAI assessment tool prior to admission. The resident's health and personal care needs are assessed on admission to inform an interim care plan, with an interRAI assessment and holistic nursing care plan completed within 21 days of admission per contractual requirements. Further nursing assessment and care plan review is required to be repeated every six months, or more frequently as clinically indicated. Partnered with this is a provider responsibility to ensure that a newly admitted resident is seen by a General Practitioner (GP) or Nurse Practitioner (NP) within two to five working days from admission (D16.5e) to develop the clinical plan of care.

Preadmission information reported that Mrs [B] had resided at dementia-level care with another provider. Due to assessed cognitive and functional decline, a request for a change in care level was submitted to Health New Zealand | Te Whatu Ora […] (InterRAI LTCF: "Significant change in status" 18 February 2022) and approved by a case manager on 22 March 2022. Mrs [B] was reassessed to hospital-level care and transferred to Annie Brydon Care Home on 1 March 2022. The preadmission interRAI clinical assessment provided relevant information about Mrs [B]'s needs and abilities at the time of discharge. File documentation indicated that Mrs [B] was known to the care home from a previous admission; however, there is no evidence that the Clinical Manager (CM) or Registered Nurse (RN) sought or received a nursing handover from the previous provider as part of the transfer of care responsibilities, which would be considered accepted practice to ensure continuity of resident care.

Progress notes from 1 March 2022 introduced Mrs [B] and discussed day of admission activities and essential care requirements, noting completion of an interim care plan. The entry stated that Mrs [B] was at high risk of falls, outlined a mobility plan and safety measures. Checks of BSLs were requested four-times daily due to type 1 diabetes; however, nursing documentation provides no specific guidance about the management of Mrs [B]'s diabetic care. File information reflects that electronic nursing assessments and care plan records from Mrs [B]'s previous admission in 2020 were restored; however, this raises concern regarding the currency of resident assessment and care information. A Falls Risk Assessment Tool (FRAT) dated 9 May 2020 was included in the submitted evidence, which stated that Mrs [B] was a low falls risk (7/20) with no falls reported in the last 12 months. However, the interim care plan stated that Mrs [B] had experienced weekly falls and was at high risk. The document's falls history was updated 8 March 2022 to record a hazard event; however, the falls risk status and checklist was not reviewed to reflect an accurate falls risk score, in line with Mrs [B]'s revised level of

care. I note that the reviewed nutritional and dietary assessments also reflect inaccurate information, which potentially raises a risk to resident safety and wellbeing. It would be considered accepted nursing practice to complete new risk assessments for all resident admissions, in line with contractual responsibilities and professional standards.

Nursing information stated Mrs [B] had a history of severe dermatitis, which impacted skin integrity, exacerbated by reduced mobility and continence concerns. Progress notes state that a skin assessment was completed; however, it does not appear that additional nursing assessments, such as pain or pressure injury risk, were completed. Records show that baseline observations (vital signs) were taken on admission and a BSL monitoring record and bowel chart commenced; however, there is no indication that a continence assessment occurred or fluid balance chart was implemented given Mrs [B]'s history of recurrent UTIs. The preadmission interRAI assessment provided rich information to inform nursing assessments and the initial care plan, but this does not appear to have been applied.

As outlined above, new residents are required to be clinically assessed by a GP/NP within contractual timeframes, though the ARRC service agreement (D16.5eii) states "*… except where the resident has been examined by a GP/NP not more than 2 working days prior to admission, and you have a summary of the GP/NP examination notes".* Medical records reflect that Mrs [B] was last seen by her GP on 6 January 2022 for a three-monthly review. There is no evidence provided of a handover process between the medical centre and the admitting care home regarding Mrs [B]'s health needs or medical plan of care. Progress notes from 1 March 2022 state "*GP aware"* of Mrs [B]'s admission; however, there is no evidence of communication with the GP on the day of admission regarding a visit nor follow-up by any qualified nurses reported in the care record.

The Medical Practitioner's policy states that the CM or RN is responsible for facilitating GP visits. Records show that Mrs [B] was admitted on 1 March 2022 but first seen by her GP on 15 March 2022, which would be considered outside of contractual requirements. The CM documented the admission visit in the care record, describing Mrs [B]'s presentation, but there is no discussion provided in nursing notes about GP instructions for an ongoing plan of clinical care. The provider has stated that the organisation expects residents to be medically assessed within three days of admission but, based on their investigation, are unable to explain why Mrs [B] was not reviewed prior to 15 March 2022.

Records show that Mrs [B] was assessed twice by a physiotherapist during her admission. An initial assessment was completed on 3 March 2022, which identified mobility and transfer requirements. Mrs [B] was seen again on 10 March 2022 regarding the risk of falling from bed. Assessment notes report concern with safe equipment use, referring to bariatric bed use, and inappropriate mattress size. Guidance was provided by the physiotherapist; however, specific care, mobility and safety requirements were not reflected in the nursing care plan to inform and guide the care team.

The ARRC service agreement (D16.3f) states "… *that each resident and if applicable, his or her family/whānau or nominated representative will have the opportunity to have input into the resident's care planning process …*" While the Resident Admission policy was not included in the submitted evidence, reviewed clinical and operational information outlines responsibilities to resident admission processes and documentation standards. As outlined in organisational policies, providers have a responsibility to maintain effective communication with residents, nominated representatives, and whānau/family and to document any interactions as communication records in the clinical file. Viewed family communication and progress note records provide no evidence of day of admission interactions with Mrs [B]'s whānau. Records show the first documented contact was 25 March 2022. The Culturally Safe Policy and Procedure discusses responsibilities to the assessment, planning and delivery of culturally safe care. Reviewed nursing information provides no evidence that Mrs [B]'s whānau were involved in the admission and initial care planning process, which would be considered a departure from accepted practice in the circumstances. It does not appear that care home leaders met with Mrs [B] and her nominated representative, whānau/family to review the preadmission information such as an advance care plan, participate in admission assessment and care processes, and establish goals for care, ensuring any cultural beliefs were upheld.

Summary:

While the care home had systems and processes in place to guide nursing actions, there appears to be a lack of clinical leadership and oversight, communication, care and documentation responsibilities. Given Mrs [B] was living with multiple long-term health conditions, it would be considered accepted practice to ensure that comprehensive nursing assessments were completed on admission with an appropriate plan of care in place to safely support her needs during the settling-in phase. From the evidence reviewed to respond to this question, it appears that admission processes were below the accepted standard in the circumstances, and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

b) Please comment on the nursing oversight of Mrs [B]'s diabetes, specifically in relation to assessment and intervention; does this provide an accurate guide to ensure the safe delivery of care for Mrs [B]?

As outlined in the Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Frailty Care Guides, diabetes affects multiple body systems. Routine monitoring of BSL is recommended to ensure target ranges are maintained, with appropriate care interventions in place to support quality of life (HQSC, 2019; HQSC, 2023).

The Nutrition policy states that residents will be nutritionally assessed on admission, six monthly and as clinically indicated, using the care home's electronic care platform. The policy refers to the use of assessment tools, care plans, and monitoring forms to support clinical oversight and care management, with input from a range of health professionals. The policy recommends the use of a Food and Fluid chart for residents

with diabetes, and implementation where intake is causing concern. Given Mrs [B] was a new admission with a history of unstable diabetes, it would be considered clinically relevant to commence food and fluid monitoring to support BSL records and inform nursing judgement. I note that no evidence monitoring was commenced per policy guidelines when Mrs [B]'s health status changed.

The interim care plan completed on 1 March 2022 reported under "Complex healthcare procedures" that Mrs [B] required insulin injections although no rationale or further instruction was provided. Preadmission health information indicated that Mrs [B] had been experiencing unstable BSLs. GP notes on 6 January 2022 reported "*very labile blood sugars, having highs more before lunch".* The interRAI assessment indicated that Mrs [B] was experiencing signs of increasing frailty related to her medical background, requiring a higher level of care. It would be considered accepted nursing practice to implement a specific, personalised diabetic management plan from the day of admission that included GP instructions, medication, dietary and care requirements, advance care wishes and goals for care.

Despite the lack of a specific diabetic care plan, file information showed that BSL records were maintained during Mrs [B]'s admission, with medications administered as prescribed until 25 March 2022. Reviewed progress notes discuss care occurring, with entries referring to mobility needs, eating, drinking and personal care delivery. While medication administration records reflect BSL checks and insulin administration, the progress note entries provide minimal discussion of diabetic management or evaluation until 25 March 2022.

It is concerning that there is no evidence of CM oversight of a new resident with diabetes until the GP visit on 15 March, with no further CM entries observed in the care record. It is unclear if the CM and RN team held regular review meetings to discuss residents of concern and ensure appropriate plans of care were in place. Records show that Mrs [B]'s BSL readings were elevated for several days, with signs of unwellness reported on 25 March 2022. It would be considered accepted practice for an RN to regularly review BSL readings and escalate clinical concerns to the CM, or the delegated senior RN, for nursing guidance, with actions reflected in the care record, as outlined in the Deterioration in Health Status Procedure.

As outlined in the Frailty Care Guides, care of older people living with diabetes requires an agreed plan with established goals for care (HQSC, 2019; HQSC, 2023).

From the evidence reviewed to respond to this question, it appears that the management of Mrs [B]'s diabetes was of the minimum standard of accepted practice in the circumstances. Although reviewed policies indicate that systems and processes were in place, it appears there were gaps in clinical leadership and delays in recognising and prioritising Mrs [B]'s specific care requirements by the nursing team. This would be viewed by my peers as a moderate to serious deviation from accepted practice.

- <u>Departure from accepted practice</u>: Moderate to serious.

c) Please comment on the administration of insulin between 25 and 27 March 2022, specifically whether withholding of insulin was in line with policy guidance.

Mrs [B] had been insulin dependent for many years, and her whānau have expressed concern regarding the clinical decision-making process to withdraw planned care.

The ARRC service agreement (D17.5d) states that "*any staff member carrying out tasks, procedures, or treatment must have demonstrated they are competent … and follow documented policies and protocols developed by* (the organisation) *to ensure safe practice".*

File documentation reported that Mrs [B] did not receive prescribed insulin on 25, 26 and 27 March 2022 due to reduced oral intake and changes in level of consciousness. The organisation's Medication Management policy states, "ONLY *RN's have the ability to withhold medication if they consider it is clinically indicated or would compromise resident safety …"* noting actions with rationale are required to be recorded in MediMap and resident progress notes.

Progress notes on 25 March 2022 describe care provided to Mrs [B] following a suspected medical event. Health information stated that Mrs [B] was prone to orthostatic hypotension and "*experienced small TIAs quite frequently"*. Entries in the care record state that Mrs [B] was unresponsive, therefore food, fluid and all medications were withheld due to aspiration risk. File information stated that the rationale for withholding prescribed insulin was due to a lack of nutrition with potential risk of hypoglycaemia. BSL records report that Mrs [B]'s readings were elevated in previous days: 23 March (17.4mmol), 24 March (18.6mmol), 25 March (16.5mmol). It is unclear if the RN team were familiar with symptoms of hyperglycaemia, such as lethargy, changes in motor function and altered level of consciousness, or considered additional risk factors such as signs of infection in their primary nursing assessment (HQSC, 2019; HQSC, 2023). It is unclear whether the RN sought guidance from a senior RN regarding the decision to withhold insulin, to ensure actions were in line with policy guidelines, with no evidence of GP consultation, which would be considered accepted practice.

The Medical Practitioner's policy states that the CM or RN is responsible for contacting the GP and requesting a visit whenever there is a "*significant change in the resident's condition, or inappropriate response to treatment"* and to record this request with rationale in the resident's progress notes. The care record reflects that whānau were informed of the suspected medical event; however, there is no record of GP consultation or involvement in Mrs [B]'s care.

The Frailty Care Guides state "*do not withhold basal insulin from people with T1DM, as this can result in diabetic ketoacidosis. Liaise with GP, NP or diabetes services for advice"* (HQSC, 2019; HQSC, 2023). The Diabetes and Medication Management policies state that "*Residents with type 1 diabetes are 'insulin dependent'. If their insulin injections are missed or stopped it can be life threatening*". The policy does not state to withhold insulin, rather "*seek medical assistance"*. Given policy guidance, it is unclear why

qualified nurses rostered across this timeframe did not contact the primary GP or on-call GP services about Mrs [B]'s insulin administration and care requirements, particularly when BSL records remained elevated; 25 March (18.9mmol), 26 March (26.8mmol), 27 March (31.4mmol). I note there was no STCP [short-term care plan] developed by the RN team to direct Mrs [B]'s care at this time.

Medical notes and the interim nursing care plan do not discuss a diabetic management plan or provide specific guidance about quality-of-life wishes. Consistently elevated BSLs, termed a hyperosmolar hyperglycaemic state, is considered a medical emergency that requires prompt recognition and management (HQSC, 2019; HQSC, 2023). Submitted BSL records show that Mrs [B] had been experiencing elevated BSL recordings during her admission; however, there is no evidence of senior RN review, escalation to the GP or guidance sought from a Diabetic Nurse Specialist. Of concern is the lack of consultation with Mrs [B]'s nominated representative/whānau in the care planning process.

Insulin is considered a high-risk medication, and organisational polices refer to the double-checking process as part of medication rights and administration responsibilities. Table A in the Medication Management policy states that insulin is one of the top six highest risk medications. As outlined in health guidelines, over/under dosing of this prescribed medication may be considered a significant adverse event, requiring service providers to complete an investigation and implement corrective actions. Table B in the Medication Management policy outlines criteria for Medication Incidents. It does not appear that an incident report was completed in response to this event; however, the Adverse Event policy was not included in the evidence to inform further comment at this time.

From the information reviewed, there appears to be a lack of understanding from the nursing team about the management of type 1 diabetes and responsibilities for assessment, clinical care, medication safety and care escalation. The provider has advised their investigation identified concerns with internal processes regarding communication with GP services. Clinical and operational information clearly outlines role expectations regarding medication management, recognition of resident decline and how to seek clinical guidance. The provider has advised that education and training records about diabetic management are unavailable, and corrective actions implemented in response to this event are unclear.

From the evidence reviewed to respond to this question, there appears to be concern surrounding nursing assessment, informed care planning, critical thinking and related actions. It appears that guidance provided in the submitted organisational policies was not followed, and this would be viewed as a serious deviation from accepted practice by my peers.

- Departure from practice: Serious

d) Please comment on the nursing oversight of Mrs [B]'s decline in relation to reports of a suspected urinary tract infection; and whether escalation to hospital occurred within a timely manner.

File information reported that Mrs [B] required regular carer assistance to meet her toileting needs. She was prone to UTIs, which affected her health and wellbeing. It does not appear that a continence assessment occurred on admission or that a prevention plan was developed by nurses to reduce infection risk.

The Deterioration in Health Status Procedure outlines the organisation's process and expectations for seeking clinical support. Carers use the Stop and Watch tool to report changes in a resident's condition, then inform the RN who will clinically assess the resident. Progress notes describe Mrs [B] as sleepy, with minimal oral intake, and elimination concerns. Carers report informing the RN; however, there is limited evidence of RN actions, such as assessment of vital signs, pain, BSL monitoring, oral intake and hydration status, skin integrity or review of elimination records. There is no record of communication with the GP for medical advice about medication and care requirements, such as whether a urine sample was indicated for analysis. It would be considered accepted practice for an RN to commence a STCP to guide Mrs [B]'s care for a suspected UTI, with increased monitoring of vital signs, nutrition, hydration and elimination needs, and GP involvement; however, there is no evidence of this nursing action in the care record.

The Deterioration in Health Status Procedure provides guidance for nurses and carers in the event a resident is unwell or injured. Assessment, intervention, escalation and reporting responsibilities are supported by a flow chart to inform nursing actions. The document discusses the pathway for seeking GP advice or "transfer to hospital" process, and use of the ISBAR communication tool to guide essential conversation content.

The submitted information appears to show a lack of critical thinking by the CM and RN team to inform appropriate actions, care responsibilities and timely escalation. From the information reviewed, it appears that appropriate interventions were not in place, interaction with Mrs [B]' s GP was not completed in a timely manner, and guidance provided in the submitted organisational policies was not followed. This would be viewed by my peers as a moderate to serious deviation from accepted practice.

- Departure from accepted practice: Moderate to serious.

e) **Please comment on the management of Mrs [B]'s fluid intake prior to hospital admission and whether this aligns with facility policy.**

The Nutrition and Hydration Policy states that the CSM is responsible for ensuring that nutritional assessments are completed on admission and use of STCPs. The RNs are responsible for monitoring resident food and fluid intake, in partnership with the care team, and taking appropriate actions when concerns are identified. The policy states that food and fluid charts are "*used to monitor residents of concern, such as residents with diabetes"* and includes a flow chart to guide the care team about signs of

dehydration, assessment, management, and prevention strategies. Signs and consequences of dehydration are discussed (which included falls, weakness and fatigue, impaired cognition, pressure injuries, infections and acute kidney injury), with nursing interventions; monitoring of fluid intake and output, 24-hour reassessment and GP/NP involvement.

Mrs [B]'s interim care plan stated that she required carer assistance to meet her mobility and care requirements and demonstrated minimal verbal interactions. The reviewed policy states "*Residents with mobility or communication difficulties rely on staff for their hydration needs … Recognising and responding to dehydration is essential and is the responsibility of all staff who interact with residents".*

Progress notes report that Mrs [B] was unwell; however, there is no evidence that an RN commenced an STCP, implemented monitoring of oral intake, or sought advice from the GP and whānau regarding alternative therapies or an agreed care pathway. The provider has advised there are no nutritional and fluid intake records available for the timeframe in question. The interim care plan section Palliative Care Requirements stated that Mrs [B]'s goal for care was comfort and dignity; "*no non-invasive interventions … no IV* (intravenous) *or SC* (subcutaneous) *fluids*"; however, there is no specific evidence that Mrs [B] had been medically assessed as requiring palliative care. It is unclear why the nursing team did not seek medical guidance to inform Mrs [B]'s plan of care in the circumstances.

From the evidence reviewed to respond to this question, it appears the management of Mrs [B]'s hydration needs was below the accepted standard of practice in the circumstances. There is limited evidence of nursing assessment, care planning and RN oversight of a vulnerable older person, with delays in recognition of decline and appropriate escalation, which is concerning. I consider there to be moderate to serious departures in nursing practice, and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

References

Health Quality and Safety Commission. (2019). Frailty Care Guides. http://www.hqsc.govt.nz/

Health Quality and Safety Commission. (2023). Frailty Care Guides. http://www.hqsc.govt.nz/

Request for additional information: 27 September 2024

I have been asked to provide further advice/comment on the following question:

Can you please comment on RN [C]'s practice as it related to the care provided to Mrs [B] in March 2022.

I note that this event occurred during the COVID-19 pandemic period 2020–2022, and I would firstly like to acknowledge the challenges and distress caused to residents, family/whānau, care teams and health service providers during this time.

As identified in the case review, there are a range of practice concerns relating to clinical leadership, care oversight and delivery of safe and appropriate resident care.

The provider has advised that the care home was experiencing workforce issues at the time of Mrs [B]'s admission, with RN [C] covering different shifts. The provider has shared clinical and operational information which discusses the CM role and related senior nurse responsibilities, but it is unclear how delegation of such responsibilities was managed in the absence of the CM at the time. It is also unclear what support was provided from the organisation's clinical and quality leaders given the identified issues and associated risks to resident care.

While RN [C] held the role of CM and as clinical lead had overall responsibility for resident care, I note there were other RNs involved in Mrs [B]'s care at the time. RNs working in this health setting have the clinical knowledge, education and training to enable them to provide quality care to older people. They are required to question, seek clarification and act as outlined in organisational policies. While this case review has identified concern with the clinical leadership and oversight of Mrs [B]'s care, there remain concerns with critical thinking and appropriate decision-making by the wider nursing team, which would be viewed similarly by my peers.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner'