Rest Home

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC02271)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a rest-home resident who deteriorated overnight. The Deputy Commissioner emphasises the importance of nurses practising safely within their scope of practice, and the need for nursing staff to recognise when a resident is deteriorating and escalate care appropriately, and to communicate with the resident's family to enable them to provide comfort and support.

2. The elderly woman became unwell one evening, with vomiting and shortness of breath. The nurse who provided care to the woman overnight, twice administered Asthalin and two litres of oxygen via a nebuliser (with neither medication prescribed). The nurse did not contact the woman's general practitioner (GP) or family, or call an ambulance. The woman was seen by her GP in the morning and admitted to hospital, but she continued to deteriorate and, sadly, died the following day.

Findings

Nurse

3. The Deputy Commissioner found the nurse in breach of Right 4(1) and Right 4(2) of the Code. The Deputy Commissioner was critical that the nurse acted outside her scope of practice by administering medications that had not been prescribed for the woman; failed to escalate the woman's care overnight; did not communicate with the family in a timely or appropriate manner; and did not document the care she provided adequately.

Rest-home owner

4. The Deputy Commissioner was critical that staff did not document their 30-minute observations of the woman overnight, and considered that this contributed to the failure to recognise the woman's deterioration.

Recommendations

5. The Deputy Commissioner recommended that the nurse review her practice in light of HQSC's NZ Frailty Care Guides and report back to HDC; report back to HDC on her learnings from the further training she has attended; and provide a written apology to the woman's family. The Deputy Commissioner also recommended that the Nursing Council consider whether a review of the nurse's competency is warranted.

6. The Deputy Commissioner recommended that the rest-home owner provide training to staff on documentation; consider amending its Emergency Policy; and provide a written apology to the family.

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Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her late mother, Mrs A, at a rest home. The following issues were identified for investigation:

- *Whether the rest-home owner provided Mrs A with an appropriate standard of care in Month5[1] 2018.*
- *Whether RN C provided Mrs A with an appropriate standard of care in Month5 2018.*

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

9. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Rest-home owner	Provider
RN C	Provider/registered nurse

10. Further information was received from:

Ms D	Nurse Manager
RN E	Registered nurse
Ms F	Caregiver
Dr G	General practitioner (GP)
District Health Board (DHB)	
Ministry of Health (HealthCERT)	

11. Independent expert advice was obtained from RN Kaye Milligan (Appendix A).

Information gathered during investigation

Background

Rest home

12. The rest home is owned and operated by a rest-home company that is contracted by the DHB to provide rest-home and hospital-level care.

Mrs A

13. At the time of events, Mrs A was in her eighties, and her medical history included chronic kidney disease, a renal mass,[2] hepatitis B, paroxysmal atrial fibrillation,[3] and severe osteoarthritis.

[1] Relevant months are referred to as Months 1–5 to protect privacy.

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14. On 23 Month1, Mrs A was admitted to hospital after experiencing sudden right-sided facial droop and right-sided weakness. Mrs A was diagnosed with a left middle cerebral artery stroke, and she received thrombolysis[4] with a good outcome. However, because of her pre-existing frailty, poor mobility, and urinary incontinence, Mrs A was assessed as requiring hospital-level care in a residential facility. Previously, she had been living with her daughter.

15. On 31 Month1, Mrs A was discharged to the rest home as a permanent resident for hospital-level care. The discharge summary recommended that she receive warfarin,[5] with a target INR[6] level of 2.0–3.0.

Assessments at the rest home

16. On 12 Month3, an interRAI assessment was completed for Mrs A. The assessment recorded that she did not have shortness of breath (SOB) at rest, but would experience SOB when undertaking moderate activities. In addition to warfarin, her regular medications were noted as paracetamol, isosorbide mononitrate,[7] aspirin, Norvasc,[8] and furosemide.[9]

17. On 13 Month3, a long-term care plan was completed for Mrs A. The plan noted that Mrs A spoke limited English, and that her daughter, Ms B, was to interpret for her. The care plan also recorded in several places that Ms B had asked to be informed immediately if Mrs A's health status changed, to enable Ms B to attend the rest home and provide support and interpretation for her mother. In addition, the "Consent from resident's contact person to establish level of notification required" form (the Contact Consent Form) recorded that Ms B wished to be notified after every incident that involved her mother, and that Ms B could be contacted at any time, day or night.

23 Month5

18. On the evening of 23 Month5, the progress notes record that Mrs A had eaten her supper and had been "eating and drinking well". She received visitors following supper. After the visitors left, Mrs A vomited at approximately 9.43pm.

19. RN E was informed of Mrs A's vomit and attended to assess Mrs A. RN E told HDC that she sighted approximately 40ml of vomit that consisted mainly of frothy sputum and undigested food.

20. RN E documented at 9.50pm that Mrs A's abdomen was soft and non-tender, and that she appeared comfortable lying in her bed and was not showing any signs of distress. RN E told

[2] A tumour on a kidney.
[3] Episodes of rapid, irregular contractions of the heart that resolve spontaneously.
[4] Treatment to break down blood clots.
[5] Medication used to prevent blood clots.
[6] International normalised ratio — a blood test to determine how well blood clots.
[7] Medication used to prevent chest pain.
[8] Medication used to treat chest pain and high blood pressure.
[9] Medication used to treat fluid build-up.

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HDC that she used the principles of the Abbey Pain Scale[10] to assess Mrs A's level of comfort, and did not detect any discomfort. RN E recorded Mrs A's vital signs, all of which were in the normal range.[11] RN E told HDC that she compared these with the vital sign recordings taken on Mrs A's admission to the rest home, and noted that the recordings were very similar.[12]

21. RN E said that after her assessment she remained with Mrs A for approximately 10 minutes and held her hand and offered her a drink of water, and Mrs A drank several sips. RN E stated that she considered ringing Ms B once she had completed her assessment, but decided not to because Mrs A's condition had stabilised and she had had no further vomiting or signs of distress, and her vital sign recordings were all within the normal range.

Handover to overnight staff

22. At approximately 10.15pm, RN E handed over to RN C, the incoming night nurse and Duty Leader for the overnight shift. RN E stated that she told RN C about Mrs A's vomiting episode and initial vital sign observations, and mentioned that Mrs A had been settled in bed with no further vomiting, but that she would need to be monitored overnight.

23. RN C confirmed that RN E handed over to her that Mrs A had had a vomiting episode but that her vital signs were stable and she was not distressed or short of breath. RN C told HDC that she checked on Mrs A immediately after handover, and Mrs A was asleep. RN C further stated that she and the evening staff undertook the usual physical round of all residents at 10.45pm, and that Mrs A was still settled and asleep at this time. RN C said that following the round she checked on Mrs A regularly at 30-minute intervals, but did not document the checks.

24. Caregiver Ms F was working on the overnight shift with RN C. Ms F told HDC that at the start of her shift, RN C informed her about Mrs A's vomiting episode and instructed her to monitor Mrs A closely during the shift. Ms F said that when she is asked to monitor a resident closely, normally she would document the times she checked the resident and note any relevant information, and then provide the information to the registered nurse. However, no observations were documented between 9.50pm and 1.30am (on 24 Month5).

25. Ms F stated that she was aware that the rest home had monitoring forms for residents, and, on reflection, realises that she should have used the form and documented in the progress notes when she checked Mrs A.

[10] The Abbey Pain Scale is used to assess pain in people who are unable to articulate their needs clearly.

[11] Mrs A's temperature was 36.3°C, pulse 68 beats per minute (bpm), respiratory rate 18 breaths per minute, blood pressure (BP) 140/75mmHg, and oxygen saturation 95%.

[12] Mrs A's admission recordings were pulse 64bpm, respiratory rate 18, BP 140/70mmHg, and oxygen saturation 91%.

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24 Month5

1.15am — SOB noted and first nebuliser administered

26. The rest-home owner told HDC that at approximately 1.15am on 24 Month5, Ms F and a caregiver assisted Mrs A to the commode. The caregivers noticed that Mrs A was short of breath and notified RN C, who attended immediately. Ms F told HDC that when they helped Mrs A to the commode she was very weak, and she "had a small vomit (approximately half a teaspoon), which looked like frothy saliva".

27. RN C told HDC that when she attended to review Mrs A, she noted an audible wheeze. RN C said that she communicated with Mrs A using the communication sheet[13] on the wall, and used the Abbey Pain Scale to assess Mrs A's level of pain. RN C stated: "[Mrs A] had no pain. There was no obvious weakness in her limbs, no 'drooling' of the mouth." RN C said that she then administered a nebuliser of Asthalin[14] and two litres of oxygen. In response to the provisional opinion, Ms B noted that Mrs A was not asthmatic and had no history of chronic obstructive pulmonary disease or bronchitis.

28. At 1.30am, RN C documented the following in the progress notes:

> "Caregiver noted SOB. Another vomit x1 (undigested food & sputum). Temp 35.4, O_2 sats 89%, irregular pulse 64–90. Nebulizer (Asthalin) x1 + O_2 2 litres.
>
> Post [nebuliser] O_2 90%, pulse 99, BP 130/70, [respiratory rate] 24. GP review [morning]. No PRN [prescription]. Main concerns: wheeze, vomiting & cough. General weakness and fatigue. Please notify family [morning] regards GP visit and outcome."

29. The rest-home owner told HDC that RN C also recalled taking Mrs A's respiratory rate at this time as part of her usual routine of assessing a resident with SOB and low oxygen saturations, but did not record this. The rest-home owner stated that Mrs A was not charted Asthalin or oxygen, and acknowledged that RN C acted outside her scope of practice in administering these. The rest-home owner said that RN C had wanted to provide some relief to Mrs A.

30. RN C told HDC:

> "I have asked myself many times why I did not look at the medication chart. This is not how I practice and this was out of my scope of practice. I acted out of instinct which I realise is not safe practice."

31. RN C stated that she did not call Ms B at this stage because Mrs A then settled and went to sleep, but added that she would have called Ms B if Mrs A had not settled.

[13] The rest-home owner told HDC that a language board was used to communicate with Mrs A owing to her limited English.

[14] Asthalin is a medication used to treat symptoms of asthma and chronic obstructive pulmonary disease such as coughing, wheezing, and breathlessness.

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32. The rest-home owner told HDC that on reflection RN C also accepted that she should have called an ambulance.

33. RN C told HDC that following her review at 1.30am, she and the caregivers monitored Mrs A closely, with checks of her breathing pattern, peripheral circulation, and radial pulse every 30 minutes. However, the checks were not documented in the progress notes. The rest-home owner told HDC:

> "[RN C] recalls that the SOB was no longer present. [RN C] accepts that it is inappropriate that she did not record the regular monitoring of [Mrs A] in the progress notes."

34. The rest-home owner further stated that RN C did not re-check Mrs A's temperature between 1.30am and 5am.

5am — second nebuliser administered

35. At 5am, RN C documented in Mrs A's progress notes: "Wet pad. Generally weak & lethargic. 2nd [nebuliser] given. O_2 sats 88%–91% (post). HR 90–64. [Respiratory rate] 22."

36. The rest-home owner told HDC that RN C and a caregiver changed Mrs A's continence pad and nightwear, and that RN C noted that Mrs A was lethargic and short of breath following these cares. RN C told HDC that at this time Mrs A also had a wheeze. RN C said that she administered a second nebuliser of Asthalin and two litres of oxygen, and that following this, Mrs A settled again and went back to sleep.

6am — family contacted

37. RN C contacted Ms B at approximately 6am to update her on Mrs A's condition. RN C documented that she told Ms B that the GP would be visiting, and noted that Ms B told her that the family would want Mrs A to go to hospital if the GP deemed this to be necessary. RN C also noted that Ms B would come in to visit.

38. Ms B told HDC that she arrived at the rest home within five minutes of receiving RN C's telephone call. Ms B stated:

> "[My mother] was uncomfortable, irritable, pale and weak. I requested that the GP see her as soon as possible as I realised within minutes my mother was in a serious, urgent condition and required critical management."

7.30am — GP review

39. Mrs A was reviewed by her GP, Dr G, at approximately 7.30am during her routine round at the rest home. Dr G told HDC that Mrs A presented as unwell and lethargic but able to answer questions, which were translated by Ms B.

40. Dr G noted Mrs A's vomit and shortness of breath overnight, and also that Mrs A had had good fluid intake that morning and was not complaining of pain. Dr G recorded Mrs A's vital signs as oxygen saturation 89%, BP 130/70mmHg, respiratory rate 24 breaths per

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minute, and pulse 99bpm, and documented a provisional diagnosis of a lower respiratory tract infection. Dr G told HDC:

> "I felt [Mrs A] was significantly unwell so I had a discussion with her daughter about how to proceed with her care. We discussed whether she wanted her to be sent to hospital for management or whether given her extensive comorbidities, she would prefer her to be managed at [the rest home] with the understanding that she may die if she remained at [the rest home] due to the severity of her condition."

41. Ms B decided to transfer her mother to hospital, and an ambulance was called. Mrs A arrived at the hospital at 10.02am. Mrs A was diagnosed with an intracerebral haemorrhage[15] and, sadly, she continued to deteriorate and died in hospital the following morning.

Further information

Ms B

42. Ms B told HDC:

> "[M]y mother received inconsistent very poor nursing care. There are some basic, fundamental principles missing here least of which was communication. I and my family are absolutely devastated to be kept out of the loop. … Our mother, grandmother and great-grandmother was a humble, kind and extremely giving person who did not want to bother people with her needs."

RN C

43. RN C told HDC:

> "I am deeply sorry for the distress that I have caused [Mrs A's] family. My intent was never to cause her any harm. … I cannot change any of the events that happened that night but I have learned a valuable lesson. I will participate fully in the training plan set out for me at [the rest home] [to] improve upon scope of practice, assessment, documentation, safe administration of medication, be more astute when working with residents who do not speak English, care plans and timely communication with relatives. … I do understand the significance of this complaint. I would like to continue my work at [the rest home] as I get a great deal of satisfaction in working with the elderly."

44. RN C provided HDC with a copy of her ongoing professional development plan, which included attending a Respiratory Course, and Close Observation and Cardiac Study Days in 2020.

Rest-home owner

45. The rest-home owner told HDC that RN C accepts that she should have contacted Mrs A's GP or called an ambulance earlier, and also that she should have contacted Ms B when she recognised that Mrs A's health status had changed. The rest-home owner stated:

[15] Her INR, tested at 12.10pm on 24 Month5, was 2.5 (i.e., within the target range).

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"[The rest home] acknowledges that by not contacting [Ms B], [Mrs A] did not have the opportunity for her daughter to act as an advocate for her health and wellbeing … Further to this, [Ms B] was not able to provide support to her mother meaning [Mrs A] was unsupported by whānau during this time."

46. The Nurse Manager, Ms D, told HDC:

"In my absence, during afterhours service, my expectations of Registered Nurses/Duty Leader are that they will work within their scope of practice and abide by the Registered Nurses' legislation that include the Registered Nurses code of conduct and competencies, as outlined by [the] New Zealand Nursing Council …"

47. Ms D stated that she would have expected RN C to recognise Mrs A's deterioration overnight, which "would have indicated an earlier response from [RN C] including the need to seek further advice/support i.e. Ambulance or to call [Ms D]".

Policies and procedures in place at time of events

48. The rest-home owner provided HDC with a copy of the registered nurses' Care Guide for Residential Aged Care policy document (the Care Guide) that is provided to staff. The respiratory section of the Care Guide provides that where shortness of breath is present, the registered nurse is to undertake and record a number of assessments, including vital sign observations, oxygen saturations, assessment of lung sounds, mental status, and cough and/or sputum production. If two or more symptoms including fever or hypothermia,[16] dyspnoea,[17] or oxygen saturations of less than 90% are present, then the registered nurse is to contact the resident's GP.

49. The rest-home owner also provided HDC with a copy of its Communication with Residents and Relatives policy (the Communication Policy), which states that staff must inform a resident's nominated relative when a resident's condition changes.

Changes to policies and procedures

50. The rest-home owner provided HDC with copies of its updated policies and procedures, which include:

- The introduction of the Health Quality & Safety Commission's (HQSC's) "Frailty care guides"[18] into its Registered Nurses Care Guides.
- A new process for recording and highlighting in long-term care plans special instructions for notification of relatives, including where interpretation is required for residents.
- Additional orientation requirements for registered nurses, including assessment of deteriorating residents and appropriate action after hours, and communication with a resident's whānau, including in emergency situations.

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[16] An abnormally low body temperature.
[17] Difficult or laboured breathing.
[18] Wellington, 2019.

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- A new Emergency Policy specifically to require staff to call 111 where a resident's health condition deteriorates and medical review is required but the GP is not available.

Responses to provisional opinion

51. Ms B, RN C, and the rest-home owner were all given the opportunity to respond to the relevant sections of my provisional opinion. Where appropriate, their responses have been incorporated into this report.

52. Ms B emphasised that her mother had a language barrier with limited English, and reiterated one of her key concerns: "I was not given the opportunity to advocate/interpret for my mother and felt devastated for not supporting my mother during the time of her need." Ms B also stated:

> "It is good to see there are strategies and policies that are put in place and I hope that these strategies and policies are actually carried out and are continuously monitored by the external body during audits and reviews of the services provided by the nurses and caregivers at [the rest home]."

53. The rest-home owner told HDC that it accepted the provisional opinion and the proposed recommendations.

54. RN C did not wish to comment further.

Relevant standards

55. The Nursing Council of New Zealand's (NCNZ's) Code of Conduct (the NCNZ Code) outlines the following standards expected of registered nurses:

> "4.1 Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.
>
> …
>
> 4.9 Administer medicines and health care interventions in accordance with legislation, your scope of practice and established standards or guidelines."

Opinion: RN C — breach

56. RN C was the registered nurse and Duty Leader for the overnight shift on 23–24 Month5. At approximately 10.15pm, RN E handed over to RN C that Mrs A had vomited. RN E also informed RN C of Mrs A's vital sign observations, and that Mrs A had been settled in bed with no further vomiting, but that she would need to be monitored overnight.

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57. RN C told HDC that she checked Mrs A every 30 minutes but did not document these checks. RN C was called to review Mrs A at approximately 1.15am, when caregivers noted that she was short of breath. RN C noted that Mrs A had vomited a small amount, and documented her vital signs, including an oxygen saturation of 89% and an irregular pulse of between 64 and 90bpm. RN C administered Mrs A Asthalin and two litres of oxygen via a nebuliser, but did not contact Mrs A's GP or Ms B, or call for an ambulance.

58. RN C said that she and the caregivers continued to observe Mrs A every 30 minutes, but did not document these checks. RN C's next documented assessment of Mrs A was at 5am, when it was noted that she was generally weak and lethargic and had oxygen saturations of 88%. RN C administered a second nebuliser of Asthalin and two litres of oxygen, but did not contact Mrs A's GP or Ms B, or call for an ambulance.

59. RN C contacted Mrs A's family at approximately 6am. Ms B arrived at the rest home promptly and requested a GP review. Dr G reviewed Mrs A at approximately 7.30am, and following the review an ambulance was called to transfer Mrs A to hospital.

Administration of oxygen and Asthalin

60. Mrs A had not been prescribed either oxygen or Asthalin. My expert advisor, RN Kaye Milligan, advised:

> "Registered nurses (who are not authorised to prescribe) administer medication which is prescribed by an authorised prescriber (medical practitioner or nurse practitioner) only. They are not authorised to prescribe. In this situation the registered nurse prescribed and administered both oxygen and Asthalin which is not within the registered nurse scope of practice."

61. RN Milligan considered this to be a major departure from accepted practice. I acknowledge that RN C wanted to provide relief to Mrs A, and did not intend to cause harm. Nonetheless, I accept RN Milligan's advice and am critical that RN C acted outside her scope of practice when twice she administered medication that had not been prescribed for Mrs A. Plainly this is unsafe and inappropriate, and placed Mrs A's well-being at risk. In addition, I note that this was inconsistent with standard 4.9 of the NCNZ Code.

Failure to escalate care

62. The respiratory section of the Care Guide provided that if a resident had shortness of breath, the registered nurse was to undertake and record a number of assessments. If two or more symptoms including fever or hypothermia, dyspnoea, or oxygen saturations of less than 90% were found to be present, the registered nurse was required to contact the resident's GP.

63. RN Milligan considered that a GP review was indicated prior to the morning of 24 Month5. RN Milligan commented:

> "As [Mrs A's] vital signs had altered from normal range to abnormal range between 2150hrs (23 Month5) and 0130hrs (24 Month5) and she exhibited more than two of

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the stated symptoms in the RN care guidelines for Residential Aged Care, respiratory care guide, the recommended action was to contact the GP. This did not happen."

64. RN Milligan advised that the failure to escalate Mrs A's care was a major departure from accepted practice. I accept this advice. I am very concerned that by not escalating Mrs A's care and seeking medical review, RN C apparently failed to recognise the clinical signs of Mrs A's deterioration, and failed to comply with the Registered Nurses Care Guide. In addition, I note that this was inconsistent with standard 4.1 of the NCNZ Code. Ultimately, the failure to escalate when first warranted delayed the provision of appropriate medical intervention.

Communication with family

65. It was documented in several places in Mrs A's care plan and in the Contact Consent Form that Ms B was to be contacted immediately if Mrs A's health status changed, to enable Ms B to provide support and interpretation for her mother. However, Ms B was not contacted by RN C until 6am, approximately four and a half hours after RN C documented her first assessment of Mrs A. I note RN Milligan's comment that the level of communication overnight on 24 Month5 was not appropriate, as it did not follow the express wishes of Mrs A's daughter. RN Milligan considered that this did not meet professional standards, and was a major omission.

66. I accept RN Milligan's advice and I am critical that RN C did not contact Ms B when Mrs A's health status changed overnight. As a result, Mrs A's family were not able to provide comfort and support to Mrs A for some time in the period leading towards her death. It is understandable that this was upsetting for the family.

Documentation

67. RN C stated that following her review of Mrs A at 1.30am, she and the caregivers checked Mrs A every 30 minutes. RN C said that the checks involved observation of Mrs A's breathing pattern, peripheral circulation, and radial pulse. However, the checks were not documented in the progress notes.

68. I note RN Milligan's comment that "the monitoring (as retrospectively stated) meets professional standards however the monitoring (as documented) was below professional standards and is a moderate omission in documentation". I accept RN Milligan's advice, and I am critical that RN C did not document any of her checks of Mrs A between 1.30am and 5am.

Conclusion

69. I have a number of concerns about the care provided to Mrs A by RN C. Specifically, RN C:

- Acted outside her scope of practice by administering oxygen and Asthalin to Mrs A on two occasions, when neither medication had been prescribed for Mrs A.
- Failed to escalate Mrs A's care and seek a medical review when Mrs A deteriorated overnight.

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- Did not communicate with Mrs A's family in a timely or appropriate manner when Mrs A's health status changed overnight.
- Did not document any checks of Mrs A between 1.30am and 5am.

70. I acknowledge that when administering the oxygen and Asthalin, RN C was trying to alleviate Mrs A's symptoms. However, this does not mitigate the seriousness of her acting outside her scope of practice, or of the other issues identified. In my view, the above concerns amount to a failure to provide services to Mrs A with reasonable care and skill. Accordingly, I find that RN C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[19] Furthermore, these failures meant that RN C did not comply with the NCNZ Code and, consequently, I find that she also breached Right 4(2) of the Code.[20]

71. In reaching this conclusion, I also note RN Milligan's comment: "[RN C's statement] shows a registered nurse open to making improvements to her practice and open to the support that is being offered."

Opinion: Rest-home owner — adverse comment

Introduction

72. As a healthcare provider, the rest-home owner is responsible for ensuring that services are provided at the rest home in accordance with the Code. In this case, I consider that the errors that occurred did not indicate broader systems or organisational issues at the rest home. Therefore, I consider that the rest-home owner did not breach the Code directly.

73. In addition to any direct liability for a breach of the Code, under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for acts or omissions by an employee. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code. Previously, this Office has found a provider not liable for the act or omission of its staff when the act or omission clearly relates to an individual clinical failure made by the staff member.

74. RN C was an employee of the rest-home owner at the time of events. I note the comments of my expert advisor, RN Kaye Milligan, about the policies in place at the time of events:

> "Regarding the reference to the RN Care Guides for Residential Aged Care … — while these guides provided excellent reference material, they contained a caution that they did not replace sound clinical judgements. Nor did they over-ride the NCNZ scope of practice for the registered nurse."

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

[20] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

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75. I consider it reasonable for the rest-home owner to rely on RN C to administer medications in accordance with her scope of practice, and to exercise her clinical judgement to escalate clinical issues for medical review appropriately. In my view, the issues identified above were individual clinical errors. I therefore do not find the rest-home owner vicariously liable for RN C's breaches of the Code.

76. However, as discussed below, I am concerned at the standard of the documentation by staff.

Observations not documented by staff — adverse comment

77. Handover to night staff on 23 Month5 occurred at approximately 10.15pm. RN E told RN C that Mrs A had vomited, and noted Mrs A's vital sign recordings and mentioned that Mrs A had been settled in bed with no further vomiting but would need to be monitored overnight.

78. Caregiver Ms F told HDC that RN C asked her to monitor Mrs A closely. RN C said that she and the caregivers checked on Mrs A every 30 minutes overnight. However, these checks were not documented, aside from RN C's assessments at 1.30am and 5am on 24 Month5.

79. I note RN Milligan's comment that "the monitoring (as retrospectively stated) meets professional standards however the monitoring (as documented) was below professional standards and is a moderate omission in documentation". I agree, and I am critical that the rest-home owner's staff did not document their 30-minute observations. These inadequacies in the clinical record are concerning and, in my view, contributed to the failure to recognise Mrs A's deterioration. They also demonstrate a need for the rest-home owner to deliver further training to its staff on the importance of documentation.

Recommendations

80. I recommend that RN C:

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

b) Review her practice in light of the Health Quality & Safety Commission's NZ Frailty Care Guides, and report back to HDC on her learnings, within four months of the date of this report.

c) Report back to HDC on her learnings from the further training she has attended as part of her professional development plan, particularly in relation to respiratory nursing, deterioration, and close observation. The report is to be provided within four months of the date of this report.

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81. I recommend that the Nursing Council consider whether a review of RN C's competency is warranted, based on the information contained in this report.

82. I recommend that the rest-home owner:

a) Provide a written apology to Mrs A's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to Mrs A's family, within three weeks of the date of this report.

b) Provide training to its staff on documentation and the use of its monitoring forms, particularly in the context of a deteriorating resident. Evidence of the training is to be provided within four months of the date of this report.

c) Consider amending its Emergency Policy to replace the wording "A correct diagnosis of the condition is made" in the initial actions with "Red flags are identified and a sound clinical judgement is made", in accordance with the recommendation made by RN Milligan. The rest-home owner is to report back on the results of its consideration, including the updated Emergency Policy if applicable, within four months of the date of this report.

Follow-up actions

83. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, which has been advised of RN C's name.

84. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Ministry of Health (HealthCERT) and the DHB, and they will be advised of the name of the rest home.

85. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Kaye Milligan:

"[**Rest home**]

I have been asked to provide advice to the Commissioner on case number C18HDC02271.

I have read and agree to follow the guidelines 'Guidelines for Independent Advisors'.

My qualifications are Registered Nurse, Doctor of Philosophy (PhD), Master of Arts (Hons), Bachelor of Arts (Nursing), and Diploma of Teaching (Tertiary). I have worked as a registered nurse for approximately 40 years in clinical practice and in nursing education. My teaching experiences include undergraduate nursing students (including teaching in older persons' health), registered nurses and postgraduate students. My clinical practice as a registered nurse includes surgical services and also Assessment, Treatment and Rehabilitation of Older Adults. My PhD thesis was a case study of the clinical decisions that Registered Nurses in Residential Aged Care in NZ make.

The aim of this report is to provide the Commissioner with advice about the care provided by [the rest home] to [Mrs A] in [Month5]. I will provide advice as requested on:

1. The adequacy of the monitoring and assessments by nursing staff on 23/24 [Month5]
2. The appropriateness of the registered nurse administering oxygen and Asthalin given the consumer's clinical history and the fact these were not charted by the GP
3. Whether there was any indication for a GP review prior to the morning of 24 [Month5]
4. The appropriateness of the level of communication with [Mrs A's] family
5. The appropriateness of the actions taken by [the rest home] as a result of this complaint
6. Any other comments.

List of documents and records reviewed:

- Letter of complaint from [Ms B] to HDC dated …
- Letter of complaint from [Ms B] to [the] General Manager of [the rest home] dated [2018]
- [The rest home's responses]
- Clinical records.

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List of resources referred to:

Health and Disability Commissioner (1996). Code of Health and Disability Services Consumers' Rights. Retrieved from http://www.hdc.org.nz/the-act--code/the-code-of-rights

Nursing Council of New Zealand (2007, amended 2016). Competencies for Registered Nurses. Retrieved from: http://www.nursingcouncil.org.nz/Nurses

Nursing Council of New Zealand. (2019). Registered Nurse Prescribing [Website]. Retrieved October 18, 2019, from:

https://www.nursingcouncil.org.nz/Public/Nursing/Nurse_prescribing/NCNZ/nursing-section/Nurse_Prescribing.aspx?hkey=091ed930-56ca-4f25-ae9e-52b33decb227

1: The adequacy of the monitoring and assessments by nursing staff on 23/24 [Month5]

Appropriate assessments were completed at 2150hrs (23 [Month5]) and 0130hrs (24 [Month5]). Monitoring is retrospectively identified to have occurred at 30 minute intervals. Documentation omitted reference to all of these intervening assessments. Actions were taken — see 2: below.

Summary: *In my professional opinion, the monitoring (as retrospectively stated) meets professional standards however the monitoring (as documented) was below professional standards and is a moderate omission in documentation.*

2: The appropriateness of the registered nurse administering oxygen and Asthalin given the consumer's clinical history and the fact these were not charted by the GP

Registered nurses (who are not authorised to prescribe) administer medication which is prescribed by an authorised prescriber (medical practitioner or nurse practitioner) only. They are not authorised to prescribe. In this situation the registered nurse prescribed and administered both oxygen and Asthalin which is not within the registered nurse scope of practice.

Summary: *In my professional opinion it is inappropriate that the registered nurse administered oxygen and Asthalin given the fact these were not charted by the GP.*

I consider this to be a major departure from professional standards.

3: Whether there was any indication for a GP review prior to the morning of 24 [Month5]

As [Mrs A's] vital signs had altered from normal range to abnormal range between 2150hrs (23 [Month5]) and 0130hrs (24 [Month5]) and she exhibited more than two of the stated symptoms in the RN care guidelines for Residential Aged Care, respiratory care guide, the recommended action was to contact the GP. This did not happen.

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Summary: *In my professional opinion, a GP review prior to the morning of 24 [Month5] was indicated.*

I consider this does not meet professional standards and is a major omission.

4: The appropriateness of the level of communication with [Mrs A's] family

The documentation clearly states that [Mrs A's] daughter requested that she was to be notified if there were any changes in her mother's health status and that she would then provide support to, and interpret for, her mother. This is documented on the:

'Consent from resident's contact person to establish level of notification required' form which stated after 'each incident' 'at any time of day or night'.

Nursing care plan, pages 12 and 14, under the headings 'Cultural' and 'Communication/hearing and sight' which were dated 13 Month3.

Comment: the level of communication appears to be satisfactory except for the overnight deterioration in [Mrs A's] condition.

Summary: *In my professional opinion, the level of communication overnight on 24 [Month5] was not appropriate as it did not follow the expressed wishes of [Mrs A's] daughter.*

I consider this does meet not meet professional standards and is a major omission.

5: The appropriateness of the actions taken by [the rest home] as a result of this complaint

The four key areas of concern (communication, documentation, clinical assessment and decision making skills, and scope of practice for RNs ENs and caregivers) are appropriate areas to focus on and the actions undertaken by [the rest home] related to these issues are appropriate.

Ongoing education and professional development for the registered nurse who did not contact the GP and acted out of scope, at registered nurse level, would also be appropriate. It is imperative this registered nurse knows the scope of his/her practice.

Summary: *In my professional opinion, the responses are appropriate.*

I recommend a review of, and plan for, paid/supported ongoing education/ professional development, at registered nurse level, about pathophysiological processes underlying medical conditions and changes in condition, as well as their relationships to physical assessments, in order to assist the registered nurse to improve both assessment and clinical decision making.

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6: Any other comments

The documentation in the progress notes completed by the registered nurses on the evening of 23 [Month5] and overnight 24 [Month5] provides sufficient information for the sequence of events to be followed.

The response by [the rest home] has been very thorough. A key concern for [Mrs A's] daughter is that her mother was not able to express herself adequately when her health was deteriorating and this aspect has been acknowledged by [the rest home]. The other concern raised is that her daughter was not able to provide support at this time (different to interpreting her needs) meaning [Mrs A] was unsupported during the time leading towards her death. I consider that this issue could have been acknowledged further as this would be a distressing ongoing concern for her daughter and family."

The following further advice was obtained from RN Milligan:

"Addendum to advice provided to the Commissioner on case number C18HDC02271: [the rest home].

I have read all additional information provided:

- response and enclosures from [the rest home owner] dated 18 December 2019
- response from [RN C] dated 2 February 2020.

I do not wish to amend the conclusions drawn in my initial advice. I do wish to make additional comments.

I will also provide advice about the adequacy of service improvements and policy updates outlined by [the rest-home owner].

Point 2: Response to issues raised:

2.1 response is appropriate

2.2 response is appropriate. Regarding the reference to the RN Care Guides for Residential Aged Care … — while these guides provided excellent reference material, they contained a caution that they did not replace sound clinical judgements. Nor did they over-ride the NCNZ scope of practice for the registered nurse.

2.3 response is appropriate

2.4 response is appropriate

The actions put in place to ensure [RN C] provides competent care should provide sufficient support for her development within her scope of practice as a registered nurse. The external clinical supervision should also provide support and some assessment of her practice.

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Point 3: this action is appropriate to ensure competent medication administration. As well as competent administration [RN C] acknowledges that the administration of medication that was not prescribed is outside her scope of practice and should not have occurred.

Point 4: whilst the facility can encourage and request advanced care directives, some family members may not consider this to be a propriety or financially manageable.

In this situation it is important that resident and family wishes are documented (as happened in this situation) and applied (which did not happen in this situation).

Point 6 and 7: the registered nurse and caregivers' written responses are consistent and effectively illustrate the chain of events that occurred with sufficient details to follow the progression of [Mrs A's] condition.

Point 8: Nurse Manager [Ms D's] response is appropriate, and she refers to acceptable levels of professional nursing care.

Point 10: Regarding ongoing professional development: [RN C's] record lists ongoing professional development. While some of this appears to be focused at Registered Nurse level the study days that are now to be provided [in 2020] (Respiratory Course, Close Observation Study Day and Cardiac Study Day provided by [a] DHB) are very relevant and targeted at apparent deficits in [RN C's] knowledge and will provide excellent support for her.

There is no evidence of the Health Quality and Safety Commission NZ Frailty Care Guides being introduced and discussed with [RN C] on her professional development plan and I would expect this to have occurred.

In addition to the documents regarding [RN C's] 'orientation, staff training and professional development plan' [RN C] has also submitted a statement. I consider this shows a registered nurse open to making improvements to her practice and open to the support that is being offered. Ongoing external supervision is a suitable way for her to move forward, along with ongoing professional development to support registered nurse practice.

Point 12: Reference to the Health Quality and Safety Commission NZ Frailty Care Guides as a reference for RNs is appropriately included. Quality activities should support registered nurse practices and the use of external clinical supervision is an excellent initiative.

Document 9 includes:

- the 'registered nurse care guides for aged care'. [RN C] should be familiar with these guidelines. These guidelines also contain a statement that they should not replace sound clinical judgement and/or individualised resident goals of care. This is a relevant resource.

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- the 'nursing care plan cover page summary' and the 'nursing care plan — long term' contain a specific section for 'relative notification' which should ensure this information is easy to access. This is appropriate.
- The 'Consent From Resident's Contact Person to Establish Level of Notification Required' now includes a question related to acting as an interpreter. Time frames for notification are also included. This document is appropriate.
- The additional orientation checklist for registered nurses has appropriate competencies to achieve. I recommend also including the use of relatives or trained interpreters to ensure this aspect is included.
- The 'emergency policy' includes phoning doctor/ambulance. I suggest altering 'a correct diagnosis of the condition is made' in the initial actions to 'red flags are identified and a sound clinical judgement is made' as medical staff would usually diagnose the medical condition.

Kaye Milligan"

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