Residential Management Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01468)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman at a rest home owned and operated by Residential Management Limited (RML) in 2018. This report highlights the importance of detailed catheter care planning and the management of recurrent urinary tract infections (UTIs) in consumers with continence issues.

2. The woman was hospitalised for a UTI. When she returned to the rest home, she had a permanent indwelling catheter and frequent bowel incontinence. In the subsequent months, the woman developed further UTIs on several occasions. The woman died after being hospitalised for another UTI.

Findings

3. RML was found in breach of Right 4(1) of the Code for the sub-optimal management of the woman's recurrent UTIs and her catheter care, which, in the Deputy Commissioner's opinion, demonstrated a pattern of poor care and poor compliance with policy. The Deputy Commissioner was also critical of the deficiencies in the rest home's call bell policy, that its call bell escalation system was not working correctly at the time of events, and that a meeting with the family was not documented.

Recommendations

4. The Deputy Commissioner recommended that RML provide a written apology to the family, develop and present training to its staff on management of UTIs and catheter cares, update its UTI and catheter care policies, and consider developing a form for recording discussions with families and the resulting decisions about a resident's care.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mrs B (the consumer's daughter) on behalf of the family about the services provided to their late mother, Mrs A, at the rest home. The following issue was identified for investigation:

- *Whether Residential Management Limited provided Mrs A with an appropriate standard of care between Month1[1] and Month5 (inclusive).*

6. 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.

7. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's daughter
Residential Management Limited	Provider

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

8. Further information was received from:

RN C	Clinical Manager
Dr D	General practitioner (GP)
Ministry of Health (HealthCERT)	
District Health Board	

Also mentioned in this report:

RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
Ms J	Hospital manager

9. Independent expert advice was obtained from Registered Nurse (RN) Julia Russell and is included as Appendix A.

Information gathered during investigation

Introduction

10. This report discusses the care provided to Mrs A at the rest home between Month1 and Month5 (inclusive). In her complaint, Mrs B told HDC that she was concerned that there were delays in Mrs A being treated for her recurrent urinary tract infections (UTIs). Mrs B was also concerned that Mrs A's catheter bag was often overfilled and leaking, and about the timeliness of responses to Mrs A's call bell.

Background

Rest home

11. The rest home is owned and operated by Residential Management Limited (RML). RML is contracted by the DHB to provide rest-home and hospital-level care at the rest home.

Mrs A

12. Mrs A, aged in her nineties at the time, became a permanent resident of the rest home for hospital-level care in 2017. On admission, Mrs A had a number of complex health issues, including congestive heart failure (CHF),[2] chronic atrial fibrillation,[3] chronic pulmonary

[2] Heart failure in which the heart is unable to maintain an adequate circulation of blood in the bodily tissues or to pump out the venous blood returned to it by the veins. Symptoms of CHF include shortness of breath (dyspnoea), fatigue and weakness, and swelling (oedema) in the legs, ankles, and feet.
[3] Very rapid uncoordinated contractions of the atria of the heart resulting in a lack of synchronism between heartbeat and pulse.

embolism,[4] chronic vertigo, hypertension,[5] Ménière's disease,[6] osteoporosis,[7] trigeminal and focal neuralgia,[8] and short-term memory impairment. She took a number of regular medications, including atorvastatin,[9] furosemide,[10] gabapentin,[11] and warfarin.[12] Her admission weight was 80.2kg.

13. The first interRAI assessment for Mrs A at the rest home was completed three months after her admission. The assessment recorded that Mrs A was independent with toileting at the time, and was bowel and bladder continent. She was also able to mobilise with a walker, with supervision, and required assistance with her cares.

First admission to hospital

14. On 12 Month1, Mrs A was reviewed by GP Dr D.[13] The progress notes record that Mrs A's weight was stable. As such, Dr D noted that Mrs A was to be weighed three times a week (previously she was being weighed daily).

15. Dr D reviewed Mrs A again on 15 Month1, in response to concerns from Mrs A's family that she was short of breath (which was a symptom of her CHF). Dr D documented that Mrs A had her usual mild shortness of breath but appeared comfortable. He charted extra furosemide for a week.

16. On 22 Month1, Dr D reviewed Mrs A again owing to her shortness of breath, and noted that her weight had not changed on the increased furosemide. He discussed with Mrs A's daughter the importance of monitoring Mrs A's weight as an indicator of her CHF.

17. A fluid balance chart was commenced for Mrs A on 25 Month1.

18. Dr D reviewed Mrs A again on 1 Month2. He noted that Mrs A's weight had increased two kilograms over the preceding four to five days, and that she was experiencing shortness of breath at rest. Dr D spoke to a medical registrar at the public hospital, and it was decided that Mrs A would be admitted to hospital.

19. Mrs A was admitted to the public hospital at 1.30pm, and received intravenous (IV) furosemide and was placed on fluid restriction.

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[4] An obstruction of a pulmonary artery or one of its branches that is usually produced by a blood clot that has originated in a vein of the leg or pelvis and travelled to the lungs.
[5] Abnormally high blood pressure.
[6] A disorder of the inner ear that is marked by recurrent attacks of dizziness, tinnitus, and hearing loss.
[7] A condition that is characterised by a decrease in bone mass with decreased density and enlargement of bone spaces, producing porosity and fragility.
[8] A chronic pain disorder that can cause severe facial pain.
[9] A medication used to lower lipid levels in the blood.
[10] A medication used to promote urine production and expel excess fluid from the body.
[11] A medication used to treat pain.
[12] An anticoagulant (blood thinner) medication commonly used to treat blood clots and help to prevent stroke in people who have atrial fibrillation, valvular heart disease, or artificial heart valves.
[13] A vocationally registered GP. Dr D told HDC that he was contracted to provide GP services at the rest home and was the sole GP at the rest home for 15 years. He terminated his contract at the rest home on 30 Month3.

Return to the rest home

20. Mrs A was discharged back to the rest home on 7 Month2 with a primary diagnosis of CHF exacerbation with fluid overload, and a secondary diagnosis of supratherapeutic INR.[14] While in hospital, her furosemide dose was increased to 160mg twice daily.

21. Dr D reviewed Mrs A on 8 Month2, and noted and prescribed the increased furosemide dose, and recorded her weight as 80kg. Dr D's plan was to restrict Mrs A's fluids to 1.5 litres a day and weigh her three times a week. He noted that he would review Mrs A if her weight increased by more than a kilogram or decreased by more than seven kilograms.

22. Between 7 and 11 Month2, the progress notes show that Mrs A was tired and frail, occasionally short of breath, and complaining of back pain.

23. On 10 Month2, Mrs A's family requested a GP review owing to her distended abdomen. RN E added Mrs A to the GP's list for review on Monday, 12 Month2. At 10pm that night, RN E recorded in the progress notes that Mrs A appeared very frail and mildly confused at times, and requested that a urine sample be taken to rule out a possible UTI.

Month2 — second admission to the public hospital

24. Overnight on 10–11 Month2, Mrs A was unsettled. At 3.30am on 11 Month2, RN F recorded in the progress notes that Mrs A had passed urine twice and was short of breath. RN F also noted that Mrs A reported a sore back and asked to go to the hospital. RN F recorded Mrs A's vital signs, including oxygen saturations of 91%, and gave her codeine and a Ventolin inhaler.

25. At 4am, Mrs A rang her call bell because she wanted to go to the toilet. However, she could not stand or be touched, saying that her "whole body [was] broken". RN F noted that Mrs A's respiratory rate was 27 breaths per minute[15] and her oxygen saturations were 85%. RN F administered two litres of oxygen.

26. At 4.30am, RN F noted that Mrs A's oxygen saturations were 91–92% on oxygen. RN F spoke to Mrs A's daughter, who requested a GP review.

27. Later that morning, RN E spoke to Dr D, who advised that Mrs A should be admitted to hospital. Mrs A was admitted to the public hospital at 10.37am.

Return to the rest home

28. While in hospital, Mrs A was treated with IV antibiotics. She was discharged back to the rest home on 19 Month2 with a primary diagnosis of an *E. coli*[16] UTI and secondary diagnoses of supratherapeutic INR, hyponatraemia,[17] acute kidney injury, and CHF exacerbation. Mrs A also had a new permanent indwelling catheter (IDC) and was

[14] A supratherapeutic INR (Internalised Normalised Ratio) indicates that the blood is clotting too slowly, increasing the risk of bleeding.
[15] A normal adult respiratory rate is roughly 12–20 breaths per minute.
[16] *Escherichia coli* — bacteria commonly responsible for UTIs.
[17] Low sodium concentration in the blood.

prescribed a further five days of oral antibiotics. Her progress notes record that she was now "in bed full time" and fully dependent on staff for all cares.

29. A catheter output chart was commenced that day. A copy of the chart for the period 19 Month2 to 19 Month5 was provided to HDC. Aside from the period 26 to 29 Month4, the chart shows that staff regularly recorded the volume of urine output. The chart includes a "Comments" column for other observations about the urine, and the rest home staff often recorded that the urine was clear, although approximately 25 entries in the chart contain no notes in this column.

30. On 22 Month2, a routine interRAI assessment was completed for Mrs A. The updated assessment recorded that Mrs A now had an IDC and had frequent bowel incontinence. The assessment also reflected Mrs A's dependence on staff for her cares, and that since the hospital admission she had declined cognitively.

31. Mrs A completed the course of antibiotics for the UTI on 24 Month2.

32. On 25 Month2, the care plan for Mrs A was updated by RN G. RN G noted Mrs A's IDC and bowel incontinence. New interventions recorded in the care plan included that Mrs A used bowel incontinence products and was to be toileted every morning. There were no interventions specified for the IDC. In response to the provisional opinion, Mrs B questioned how often rest home staff checked whether her mother's incontinence product needed changing.

33. RN G also recorded in the care plan that Mrs A was on fluid restrictions of 1.2 litres a day and was to be weighed on alternate days, with medical review if her weight changed by two kilograms. RN G noted that Mrs A no longer mobilised with her walker, required a full body hoist for all transfers, and required full assistance from two people for all cares.

34. On 25 Month2, the progress notes record that Mrs A complained of lower back pain and was short of breath at rest.

35. Dr D reviewed Mrs A on 26 Month2. He noted her weight (69.8kg) and that she was reporting back pain. His plan included weighing her on alternate days, and a review if her weight changed by two kilograms. He also noted that Mrs A's family was to consider whether they wanted morphine prescribed for her pain.

36. Between 26 and 29 Month2, the progress notes record that Mrs A was at times short of breath and reported pain in her lower ribs and stomach.

37. On 29 Month2, a family meeting was held with the rest home's Clinical Manager at the time, RN H, and RN F. The rest home told HDC that the purpose of the meeting was to discuss morphine for Mrs A. Mrs B told HDC that at this meeting they requested that a urine test be undertaken owing to their concerns that Mrs A had a UTI. There is no documented record of what was discussed at the meeting.

38. Dr D reviewed Mrs A that day. He documented that Mrs A remained "settled", and had been experiencing back pain but it was not an issue at the time of his review. Dr D also noted her weight (70.1kg), and that she had bilateral crackles in her chest and minimal oedema. Dr D prescribed morphine as required for pain. He noted that Mrs A was to be weighed three times a week.

Month3 — UTI

39. On the morning of 4 Month3, the progress notes record that Mrs A was showing signs of confusion.

40. At 2.30pm, RN I requested in the progress notes that staff obtain a urine sample from Mrs A. A sample was obtained at 10.30pm, and on 5 Month3, the progress notes record a request for a new urine sample to be obtained. The rest home told HDC that the medical laboratory[18] collects urine samples from the rest home on Monday, Wednesday, and Friday each week. The sample collected on Wednesday, 4 Month3 was obtained after the medical laboratory's courier had been to collect urine samples. As such, the second sample was obtained for the courier to collect on Friday, 6 Month3, as the previous sample would have been too old.

41. On 6 Month3, the medical laboratory collected and tested the urine sample, which showed increased leucocytes and *E. coli*. On 9 Month3, RN G rang the medical laboratory and was told that the urine test results would be in the following day. The progress notes do not refer to the results of the urine test. However, the rest home told HDC that the urine test was received by Dr D on 12 Month3, and he reviewed Mrs A that day. Dr D started Mrs A on a seven-day course of antibiotics. In response to the provisional opinion, Mrs B pointed out that this was 14 days after the family first requested a urine sample. She also questioned why the rest home did not ensure that Mrs A received antibiotics sooner, given Mrs A's previous UTIs.

Month3 — suspected UTI

42. Mrs A completed the course of antibiotics on 18 Month3. The progress notes show that Mrs A's fluid balance chart was discontinued by RN H because "[Mrs A was] drinking well".

43. On 19 Month3, the progress notes record: "[Mrs A's daughter] concerned that mum [Mrs A] has UTI still. MSU collected for lab, form faxed. Mrs A has finished course of ABs, due for MSU check." On 20 Month3, the medical laboratory collected and tested the urine sample, which showed increased leucocytes and mixed culture growth. On 21 Month3, RN E documented in the progress notes that the result would be relayed to Dr D on Monday, 23 Month3. RN E also discussed the result with one of Mrs A's daughters.

44. Dr D reviewed Mrs A on 23 Month3. He recorded in the notes:

> "Family wants to know if prophylactic [antibiotics] indicated. In view of infrequency of UTIs to date as well as limited clinical evidence of effectiveness of prophylactic

[18] An external laboratory that provides testing services.

antibiotics → not indicated. Monitor for signs and symptoms of UTIs and treat as appropriate."

45. Dr D told HDC:

> "At this stage it was more difficult to be certain of a diagnosis of [UTI] as the patient now had an indwelling catheter. Her complaint of dysuria may well have been caused by physical irritation of the catheter in the urethra. It is well known that once a catheter had been in place for a month or longer, there will be a 100% positive urine culture rate in all patients, and the significance of this finding has to be interpreted with symptoms and physical examination findings."

Month4 — catheter bag overfilled

46. Mrs B told HDC that during the month of Month4, she or one of her sisters found Mrs A wet five times[19] after her urine bag overfilled. Mrs B said that the overfilled catheter bags would coincide with Mrs A reporting pains in her abdomen. On 9 Month4, Mrs B raised concerns with RN H about the catheter bag overflowing into Mrs A's slippers. RN H told Mrs B that the catheter bag would be emptied earlier in the morning to prevent overflow.

47. The rest home told HDC:

> "We fully understand why [Mrs A's] family were upset at [Mrs A's] catheter urine bag being overfilled at times which may have caused [Mrs A] to experience pain. There are incidences noted in [Mrs A's] progress notes for [Month4] of the catheter urine bag having leaked onto [Mrs A] herself, or onto her bed or into her slippers. We fully accept the fact we should have been more proactive to ensure this did not occur as regularly as it did. Accordingly, we have improved our processes around the care of catheter urine bags."

Month4 — further UTI

48. Mrs A was reviewed by a nurse practitioner[20] on 24 Month4. The nurse practitioner noted the family's concern that Mrs A had lower abdominal pain. The nurse practitioner also noted that at the time of her review, Mrs A denied pain and had no clinical symptoms of CHF. The nurse practitioner wrote that Mrs A was to be weighed weekly.

49. Mrs B told HDC that on 25 Month4, her mother "looked terrible" and she suspected another UTI because her mother's urine appeared cloudy, concentrated, and smelly. RN E undertook a urine dipstick test and noted that it showed leucocytes. RN E requested that on Sunday night (27 Month4) staff obtain a urine sample for lab testing.

50. On 28 Month4, the progress notes record that Mrs A complained of burning pain while passing urine. A urine sample was collected that day and sent to the medical laboratory.

[19] Specifically, Mrs B stated that Mrs A was found wet on 3 Month4, 9 Month4, 10 Month4, 16 Month4, and 26 Month4.
[20] Contracted to provide nurse practitioner services at the rest home in 2018.

51. At 11pm on 30 Month4, RN G wrote in the progress notes a request for staff to follow up with the medical laboratory as to the result of Mrs A's urine test, as her daughters were concerned. The medical laboratory's records show that it collected and tested the urine sample on 30 Month4. The results showed increased leucocytes and *E. coli*.

52. On 1 Month5, Mrs A was given Ural[21] sachets for a burning sensation while passing urine. On 4 Month5, Mrs A reported pain in her shoulder and abdomen.

53. The progress notes record that the medical laboratory result was received by the rest home on 6 Month5. A second nurse practitioner[22] reviewed Mrs A that day. The nurse practitioner recorded her diagnosis of *E. coli* UTI and that Mrs A had ongoing confusion from time to time, but did not have any pain at that time. The nurse practitioner prescribed a five-day course of antibiotics.

54. On 9 Month5, Mrs A's catheter was changed by RN I. RN I noted that the tip of the catheter was black in appearance but Mrs A's urine was clear and did not have an offensive smell. Mrs A reported feeling nauseous and did not want to eat.

Month5 — first admission to hospital

55. On 10 Month5, one of Mrs A's daughters approached the Hospital Manager at the time, Ms J, to report her concerns that her mother had a painful and distended abdomen, had not eaten for the previous four days, and was very sleepy. RN I recorded Mrs A's vital signs, which were within normal range, and requested in the progress notes that staff continue to record fluid intake on the fluid balance chart.

56. On the morning of 11 Month5, Mrs A reported deep pain in her abdomen. She said that she felt shaky and had been hallucinating. RN C noted that Mrs A's urine was dark in colour. An ambulance was called and Mrs A was admitted to the public hospital at 3.48pm. While in hospital, she was diagnosed with a UTI and treated with IV cefuroxime.[23] Mrs A was noted to be disoriented during her admission.

Return to the rest home

57. Mrs A was discharged back to the rest home on 15 Month5. The discharge summary requested that Mrs A be given 48-hour antibiotic cover when her catheter was changed, and suggested that her urine be tested on a monthly basis.

58. The new Clinical Manager, RN C, met with Mrs A's family on 15 Month5. RN C documented:

> [T]hey were tearful and disappointed in how long it took [Mrs A] to get her antibiotics from when family thought she had her UTI. [Mrs A] returned from hospital quite delirious."

[21] A product that alkalises urine.
[22] Contracted to provide nurse practitioner services at the rest home in 2018.
[23] An antibiotic.

59. The progress notes for 15 to 18 Month5 show that Mrs A was at times drowsy, pale and exhausted, and nauseous. She received oxygen via nasal prongs for the majority of this period.

Month5 — second admission to hospital

60. On 19 Month5, RN C noted that Mrs A was complaining of a painful and bloated abdomen. RN C undertook a urine dipstick test, which she noted was positive for UTI. After a discussion with Mrs A's family, it was decided that Mrs A would be taken to the public hospital. An ambulance was called and Mrs A was admitted to hospital at 8.11pm.

61. While in hospital, Mrs A was treated with IV antibiotics but continued to deteriorate. A decision was made that she would be for comfort cares only, and she died a few days later. The cause of her death was recorded as sepsis due to UTI and lower respiratory tract infection.

Further information

Mrs B

62. Mrs B told HDC:

> "[T]hose 'overfilled' urine bags and blackened catheter tube 'end' certainly did not help Mum in anyway to overcome her countless infections. Such neglect & procrastination of proactive urine testing had caused Mum to suffer unduly as she was continually in pain and discomfort and as a consequence Mum became very anxious and depressed.
>
> … Whilst the family does have intense issues with some aspects of the medical treatment at [the rest home], we would like to add that the caregivers are absolutely wonderful and the new Clinical Manager [RN C] and some of her medical staff are absolutely amazing too."

Rest home

Call bell report

63. The rest home provided HDC with a call bell report for Mrs A, which showed the calls Mrs A made between 1 Month2 and 19 Month5 that lasted longer than one minute. A total of 737 calls were made, approximately 38% (283 calls) of which took four minutes or longer to answer. Approximately 14% (102 calls) took eight minutes or longer to answer.

64. In response to the provisional opinion, Mrs B stated that sometimes she had waited up to 20 minutes or more for a response to her mother's call bell. She said that sometimes she had to go look for a nurse to attend.

Medical laboratory results

65. At the time of events, the medical laboratory results were sent to the rest home by post in an envelope addressed to the rest home's GP. The rest home advised that the typical length of time between a urine sample being collected by the medical laboratory and the results being received at the rest home was about six days, although this could vary if, for

example, there was an intervening public holiday or weekend. However, the rest home stated: "When [the medical laboratory] were testing Warfarin levels or a 'serious matter' requiring immediate attention, they telephoned through the results to [the rest home]."

Relevant policies

66. The Catheter Care Policy (the CC Policy) in place at the time provided guidance to staff on catheterisation, changing catheter bags, and general catheter care. Specifically, catheter bags were to be emptied at the end of each shift with the volume, odour, and presence of material to be recorded. The CC Policy further required catheter bags to be changed weekly, and the catheter itself to be changed at least every three months.

67. The UTI Identification and Prevention Policy (the UTI Policy) in place at the time provided guidance to staff on early detection of UTIs and preventative measures. The UTI Policy stated that if a resident had a positive result for a UTI test, once the doctor had prescribed antibiotics, the following steps were to be followed:

- Instigate a short-term care plan.
- Instigate a fluid balance chart.
- Keep relatives informed.
- If the resident fails to improve within 48 hours, notify the doctor.
- Re-test if required 48 hours after the antibiotics course is finished.

68. The Call Bell System & Sensor Mat Policy (the Call Bell Policy) in place at the time stated that call bells were to be answered in a timely manner, and that a delay of up to four minutes was acceptable. The rest home told HDC that if a bell is unanswered after eight minutes, the call is then escalated to the Hospital Manager's mobile phone. If the bell remains unanswered for a further four minutes, it is then escalated to the General Manager's mobile phone. The rest home said that call bell reports are reviewed monthly. However, the Call Bell Policy at the time did not include these details.

69. The rest home also told HDC that its review revealed that the escalation system had not been working for Mrs A's calls from Month1 to Month5. It has since involved an external nurse call specialist provider to rectify the fault and to ensure that the escalation system is working.

Changes made

70. The rest home told HDC that its internal investigation revealed that no Short Term Care Plans (STCPs) were put in place for Mrs A. The rest home stated:

> "[We] have reiterated to our Registered Nurses the requirement for these documents for short term health matters. We have raised a corrective action plan, held an education session with our Registered Nurses and since October 2018 have completed monthly audits to ensure compliance."

71. The rest home told HDC that it has also made the following further changes:

- It has introduced a catheter care chart, which provides space for staff to record details about urine output volumes, whether catheter bags were emptied or changed, and whether catheters were flushed or changed.
- A corrective action plan was created to improve response times to call bells.
- It has introduced a new electronic system with the medical laboratory, which allows the rest home staff immediate access to the medical laboratory results.
- Rest home staff attended training on the management of bowel incontinence.

Responses to provisional opinion

72. Mrs B and RML were given the opportunity to respond to the relevant sections of my provisional opinion. Where relevant, these responses have been incorporated into this report.

73. In addition, Mrs B stated: "I am pleased to know that changes have been made for the residents of [the rest home]."

74. RML advised that it accepted the findings in the provisional opinion. It further advised that it has scheduled the training and implemented the changes in accordance with the Deputy Commissioner's recommendations (as set out in paragraph 106 of this report).

75. RML also gave its staff the opportunity to comment on the provisional opinion. RN C commented: "The outcome of the complaint is that everyone learns from this and is overall safer in terms of care."

Opinion: Residential Management Limited — breach

Introduction

76. RML is responsible for the operation of the clinical services it provides, and for any service failures. RML is required to operate the rest home in a manner that provides its residents with services of an appropriate standard.

77. As noted by my expert advisor, RN Julia Russell, management of Mrs A's health was complex, and rest home staff demonstrated considerable effort in caring for her, and GP and Nurse Practitioner reviews were undertaken regularly. Rest home staff were particularly focussed on managing Mrs A's CHF, as evidenced by the attention to regular weighing and to her shortness of breath. RN Russell also advised that the CC and UTI Policies were both comprehensive. Nonetheless, multiple staff members failed to adhere to policy and therefore provide timely interventions for Mrs A.

78. As this Office has stated previously, inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not support and assist staff sufficiently to do what is required of them and ensure that its residents receive optimal support, and RML must bear overall responsibility for this.

Management and treatment of Mrs A's UTIs

79. On 19 Month2, after being admitted to the public hospital with an *E. coli* UTI, Mrs A returned to the rest home with a permanent IDC in place and reduced mobility. She completed her course of antibiotics on 24 Month2. Her care plan and interRAI were updated in Month2, to record the IDC and bowel incontinence, and her full dependency on staff for all cares. The updated care plan included new interventions relating to incontinence products and toileting, but no interventions were specified for the IDC.

80. On 6 Month3, another urine sample was collected and tested by the medical laboratory. This sample showed increased leucocytes and *E. coli*, and on 12 Month3 Mrs A was prescribed a seven-day course of antibiotics. Mrs A completed the antibiotics on 18 Month3. The next day, the progress notes record the family's concern that Mrs A still had a UTI. On 20 Month3, a urine sample was tested and showed increased leucocytes and mixed culture growth. Three days later, Dr D reviewed Mrs A. He discussed with the family the use of prophylactic antibiotics, but ultimately decided that it was not clinically indicated.

81. On 25 Month4, Mrs A's daughter expressed concern that her mother had another UTI. A urine sample was collected and tested by the medical laboratory on 28 Month4. The progress notes show that the test result, which showed increased leucocytes and *E. coli*, was received by the rest home on 6 Month5. The nurse practitioner prescribed a five-day course of antibiotics that day.

82. On 11 Month5, Mrs A was admitted to the public hospital, where she was diagnosed with a UTI. She was discharged on 15 Month5. Unfortunately, she was again admitted to hospital on 19 Month5 after developing another UTI.

83. The UTI Policy sets out the following steps after a resident has been prescribed antibiotics:

- Instigate an STCP.
- Instigate a fluid balance chart.
- Keep relatives informed.
- If the resident fails to improve within 48 hours, notify the doctor.
- Re-test if required 48 hours following completion of antibiotics course.

84. No STCP was put in place for Mrs A at any time.

85. RN Russell advised:

> "[UTIs] were a recurrent problem for [Mrs A] and along with her congestive heart failure were serious health issues which needed to be considered in conjunction with each other not in isolation. The fluid restriction that was part of the treatment for the congestive heart failure limited the normal treatment from a urinary tract infection which would be to encourage fluids.
>
> … Unfortunately, the urinary tract infections continued and along with the catheter bag problems that the family noted became recurrent issues that more proactive management may have been able to minimise. Nowhere in the notes/careplan does it appear that there was a possible link made between her bowel incontinence and urinary tract infections."

86. Overall, RN Russell considered that the management of Mrs A's UTIs by the rest home represented a serious departure from accepted practice.

87. I accept RN Russell's advice, and I am critical of the management of Mrs A's recurrent UTIs by the rest home staff. Specifically:

- Mrs A was not re-tested within 48 hours of completing antibiotics on 24 Month2, which is inconsistent with the UTI Policy.
- No STCPs were instigated after any of Mrs A's UTI diagnoses, which is also inconsistent with the UTI Policy.
- There was no apparent consideration of the relationship between Mrs A's faecal incontinence and recurrent UTIs, which was a missed opportunity to consider different interventions that may have prevented Mrs A from developing further UTIs.

88. It is also concerning that there was a delay of nine days between Mrs A's urine sample being collected and tested by the medical laboratory (on 28 Month4) and Mrs A being prescribed antibiotics for the UTI (on 6 Month5). In the intervening period, Mrs A reported burning urination and pain, and it is possible that these symptoms could have been avoided with more prompt treatment. However, it is pleasing that the rest home staff now have immediate electronic access to the medical laboratory results.

Catheter care

89. Mrs A returned to the rest home on 19 Month2 with a permanent IDC in place and reduced mobility. A catheter output chart was commenced that day. The chart shows that the rest home regularly recorded the volume of urine output and regularly described the urine as "clear". However, a number of entries in the chart did not record any observations about the urine except for the volume, and there are no chart entries for 26 to 29 Month4.

90. The CC Policy requires catheter bags to be emptied at the end of each shift, and for the volume, odour, and presence of material in the urine to be recorded. The CC Policy further requires catheter bags to be changed weekly, and the catheter itself to be changed at least every three months. RN I documented having changed Mrs A's catheter on 9 Month5,

nearly three months after it was first put in place. However, the progress notes do not record any catheter bag changes.

91. Shortly after Mrs A's return to the rest home, both her interRAI assessment and care plan were updated to record the IDC and her change in mobility. However, the care plan did not outline any specific interventions for the IDC.

92. Mrs B was concerned that on a number of occasions in Month4, Mrs A's catheter bag was left to overfill, and that often this coincided with Mrs A reporting pain. On 9 Month4, Mrs B raised concerns with RN H about the catheter bag overflowing into Mrs A's socks and slippers. RN H told Mrs B that the catheter bag would be emptied earlier in the morning to prevent overflow.

93. The rest home acknowledged that at times Mrs A's catheter bag was overfilled, which may have caused her pain. The rest home stated that it should have been more proactive in ensuring that this did not happen.

94. RN Russell advised:

> "[T]he careplan update on the 25 [Month2] did not have enough detail regarding bag changing and dates for the catheter to be changed. Charts are an integral part of monitoring a resident's health and it is essential that they are completed consistently — there are gaps in the comments areas of the catheter output form. Clinical documentation is the recording of a resident's life in a facility and there are areas of the care plan around catheter management that do not meet the standards."

95. RN Russell noted that the CC and UTI Policies were comprehensive. However, she added:

> "[The rest home] acknowledges that staff did not meet the expected standards of care for the management of the catheter bag with regards to emptying it and that it leaked on several occasions. … Given the impact the overfull catheter bags had on [Mrs A] regarding pain and infection potential this is a serious departure from the expected standards."

96. I accept RN Russell's advice. In my view, Mrs A's catheter care was poorly managed by the rest home staff. Specifically:

- The catheter output chart was frequently not completed fully and was not completed at all for the period 26 to 29 Month4. This meant that changes in urine appearance, which can indicate a UTI, could have been missed.
- The care plan did not detail any interventions about the management of the catheter, such as the timing of emptying the catheter bags or changing the catheter bag or catheter tube.
- Catheter bags were not emptied in a timely manner, which resulted in urine leaking on Mrs A on a number of occasions.

- There is no evidence that catheter bags were changed, which may have resulted in Mrs A being exposed to an increased risk of infection.

Conclusion

97. Mrs A was an elderly woman with a significant number of comorbidities, most notably her CHF. Despite considerable effort in providing care to Mrs A in some areas, a number of failures by staff led to sub-optimal management of Mrs A's recurrent UTIs and her catheter care. These failures (discussed above) demonstrate a pattern of poor care and poor compliance with policy, for which RML bears overall responsibility. In my view, RML failed to provide services to Mrs A with reasonable care and skill and, accordingly, I find that RML breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[24]

Adverse comment — call bell and documentation of family meeting

Call bell

98. The call bell report for Mrs A between 1 Month2 and 19 Month5 showed that a total of 737 calls were made. Approximately 38% of the calls took four minutes or longer to answer, while approximately 14% took eight minutes or longer to answer. The Call Bell Policy at the time stated that calls were to be responded to in a timely manner, and that a delay of up to four minutes was acceptable.

99. The rest home told HDC that its review of Mrs A's calls revealed that the escalation system had not been working for her unanswered calls between Month1 and Month5.

100. RN Russell advised that the Call Bell Policy did not provide guidance to staff on the specific timeframe in which calls must be answered. I also note that the Call Bell Policy did not set out the escalation system for unanswered calls. In RN Russell's view, the deficiencies in the Call Bell Policy represented a mild departure from the expected standard.

101. I accept RN Russell's advice. It is important that policies provide clear guidance to staff as to the expected timeframe for responding to calls and the escalation system. It is disappointing that the Call Bell Policy at the time was lacking these details.

102. It is also concerning that the escalation system was not working for Mrs A's calls in Month1 to Month 5. As a result, approximately 14% of Mrs A's calls were not escalated to the Hospital Manager as they should have been, and Mrs A may have been kept waiting longer than necessary for a response to these calls. As RN Russell noted, "the call bell system is the only way that the frail and dependent residents can communicate with staff". However, it is appropriate that the rest home has since engaged its external provider to ensure that the escalation system is working across the facility.

Documentation of family meeting

103. On 29 Month2, RN H and RN F met with Mrs A's family. The rest home told HDC that the purpose of the meeting was to discuss morphine for Mrs A. Mrs B told HDC that at this

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

meeting they requested that a urine test be undertaken owing to their concerns that Mrs A had a UTI. There is no documented record of what was discussed at this meeting, or of any decisions made about Mrs A's care.

104. RN Russell noted: "The use of short-term care plans following [family meetings] with action lists are opportunities to ensure that residents' needs are met, and the family's requests are followed up." I agree. Maintaining an accurate record of family discussions about a resident's care is important to ensure that the resident receives the appropriate and necessary interventions. It is disappointing that the rest home did not ensure that the outcomes from this meeting were recorded.

Recommendations

105. In response to the recommendation in my provisional opinion, RML provided a written letter of apology to Mrs A's family for the breach of the Code identified in this report. The apology has been forwarded to the family.

106. I recommend that RML:

a) Develop and present training to all nursing and caregiver staff based on BPAC's "A pragmatic guide to asymptomatic bacteriuria and testing for urinary tract infections (UTIs) in people aged over 65 years".[25] RML is to provide evidence to HDC of this training within three months of the date of this report.

b) Update the UTI Policy to require that catheters be changed after catheterised residents have been started on antibiotics for a UTI. RML is to provide HDC with a copy of the updated policy within three months of the date of this report.

c) Update the CC Policy to require staff to update care plans with timeframes for emptying and changing bags, and changing the catheter, and any other specific IDC interventions, where a resident has been catheterised. RML is also to present training to all nursing and caregiver staff on the updated policy, and provide HDC with a copy of the updated policy, and evidence of the training, within three months of the date of this report.

d) Present training to all nursing and caregiver staff on IDC cares and management, using the facts of this case as a case study. RML is to provide evidence to HDC of this training within three months of the date of this report.

e) Consider developing a specific form for recording discussions from family meetings and the resulting decisions about a resident's care. RML is to report back to HDC on the result of its consideration within three months of the date of this report.

[25] Best Tests. July 2015.

Follow-up actions

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

108. A copy of this report with details identifying the parties removed, except Residential Management Limited and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Julia Russell:

"13 March 2019

Re: [Mrs A], [the rest home] C18HDC01468

The purpose of this report is to consider whether the care provided to [Mrs A] by [the rest home] was reasonable. The areas to be commented on include:

1. The timeliness of responding to [Mrs A's] call bells
2. Adequacy of relevant policies and procedures in place for managing and treating urinary tract infections
   a. The management of [Mrs A's] urinary tract infections
3. Whether the catheter bags were changed in a timely manner
4. The quality of the clinical documentation

For each of these points, consideration is given to the following:

- what is the standard of care/accepted practice;
- If there has been a departure from the standard of care or accepted practice, how significant is this;
- How would it be viewed by our peers; and
- Any recommendations for the future.

Background

This report has been prepared by reviewing: daily progress notes, interRAI reports from 2017 and 2018, policies regarding catheter management and urinary tract management, medical notes, nursing notes and the care plan were reviewed. The family's complaint acknowledges [Mrs A] was a frail and elderly woman with multiple health issues. The concerns they raise are about the timeliness of bell responses but most particularly about the lack of attention to emptying of catheter bags and actions not taken despite family input regarding the state of [Mrs A's] health in relation to recurrent urinary tract infections.

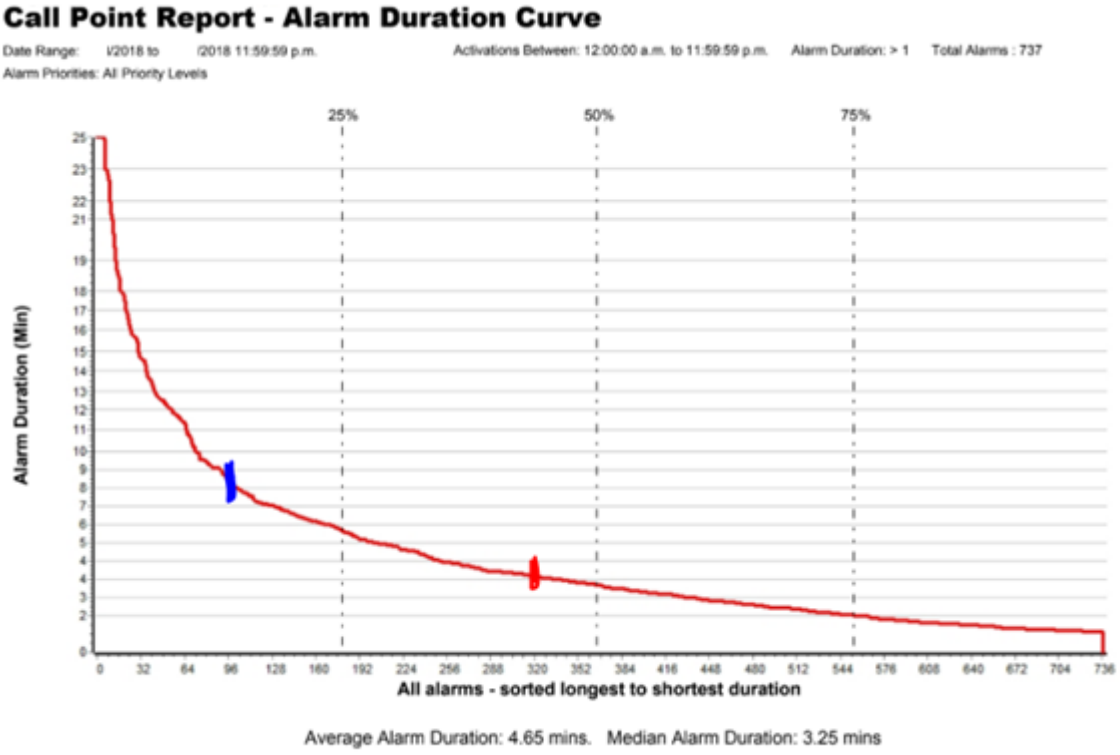
Issues

1. The timeliness of responding to [Mrs A's] call bells

A review of the call bell and sensor mat policies and the letter of 11 February 2019 letter from [Ms J] show that at the time of this complaint there was no expected time of response or review process in place to see how long call bells were taken to be answered. As [Ms J's] letter states this has since been remedied with the actions below.

In conjunction with our call bell policy, a report is printed monthly for review by myself and if a call bell is unanswered after 8 minutes the call is escalated to my mobile phone and then after 12 minutes the call is escalated to our General Manager's mobile.

The call bell records initially provided were for the evening of the 24 [Month2] to the evening of the 26 [Month2]. Had the new protocol for reporting non-answered call bells been in place then the General Manager and [Ms J] would have been notified 4 times of calls that did not meet the expectations of being answered within 8 minutes. In reviewing the call point report which logged every call between 1 [Month2] and 19 [Month5], there were a total of 736 calls made [and] approximately 35% (320 calls) took longer than 4 minutes to answer with 13% (96 calls) taking longer than 8 minutes.



The above graph is part of a number of features call bell system has got several reporting aspects in place which includes a report about calls made by specific rooms and the length of time calls take to be answered — however the report needs to be printed and reviewed and as noted above this does not appear to have been in place at the time [Mrs A] was living there. As call bell management is a regular topic of complaints in aged care it would be anticipated that a reporting process would be in place to ensure regular and timely reviews of the call bell audit.

At the time of complaint there was no ongoing formal review of the reporting of the call bell system. As such this is seen as a moderate departure from the standards as the call bell system is the only way that the frail and dependent residents can communicate with staff and it is the responsibility of all staff, at all times to ensure the call bell is in place. Whilst this is disappointing that [the rest home] did not have this level of oversight occurring at the time of this complaint it is pleasing to see that this is now in place.

2. Adequacy of relevant policies and procedures in place for managing and treating urinary tract infections

The catheter policy is comprehensive and covers all areas that would be expected to be covered: bag care, changing a catheter, catheterisation — male and female, irrigations, suprapubic catheters, removal of catheters, application of uritip and fluid balance chart used. The urinary tract infections policy is also comprehensive covering identification and prevention of urinary tract infections as well as laboratory testing and the flow chart for laboratory testing. This policy states that if symptoms persist then a re-test after 48 hours should occur. [Ms J] states in her letter that according to their process — which is not included in the policy — a re-test occurs at 10 days.

On page 3 of her September 2018 letter [Ms J] acknowledges that staff did not meet the expected standards of care for the management of the catheter bag with regards to emptying it and that it leaked on several occasions. There has been training provided to assist registered nurses and carers to be better able to provide this level of care. Given the impact the overfull catheter bags had on [Mrs A] regarding pain and infection potential this is a serious departure from the expected standards. However, it appears that [the rest home] has now put in suitable strategies to ensure these things do not re occur.

a. The management of [Mrs A's] urinary tract infections

[Mrs A] returned to [the rest home] on the 19 [Month2] with 5 days of oral antibiotics. These antibiotics would be finished on the 24 [Month2]. Her progress notes for the 24 [Month2] record her as a little confused and short of breath — over the next few days there are recordings of sore stomach, tired and sleepy and her O_2 saturation was down to 84% (26 and 27 [Month2]). On the 29 [Month2] [Mrs A's] O_2 saturation remained at 84% and the General Practitioner saw her and commented that she 'remains settled' and discussed the decision to use morphine to manage her pain. Over the next few days 30 [Month2]–2 [Month3] she appeared more comfortable.

The 29 [Month2] comments by the General Practitioner that she remains settled with back pain not an issue seem in contrast to the [family's] letter of complaint — on the bottom of page 2 that 3 of the sisters met with [rest home] nursing staff regarding their numerous concerns regarding the pain and discomfort. The progress notes record there was a family staff meeting however there is no action plan established or short-term care plans until 11 [Month5]. The use of short-term care plans following

with action lists are opportunities to ensure that residents' needs are met, and the family's requests are followed up.

The catheter output chart records that the urine was clear when the catheter bag was emptied. There are times in the output chart that there are no comments regarding the urine; it is not possible to know at these times if the urine was clear or not clear, and this demonstrates the importance of ensuring consistent recording of information. Family members were concerned about [Mrs A's] urinary situation however the facility staff appear to be more focussed on her congestive heart failure — this is apparent with no alerts to other staff to undertake a urinary test when the staff member on 4 [Month3] was unable to. Urinary tract infections were a recurrent problem for [Mrs A] and along with her congestive heart failure were serious health issues which needed to be considered in conjunction with each other not in isolation. The fluid restriction that was part of the treatment for the congestive heart failure limited the normal treatment from a urinary tract infection which would be to encourage fluids. There was a recommendation for the utilisation of prophylactic antibiotics which her General Practitioner decided not to use — this decision is outside the scope of this report.

In [Ms J's] 25 September 2018 letter, she comments that the 10 day post antibiotic review was done on the Friday 6 [Month3] and that result meant [Mrs A] was back on oral antibiotics by the Thursday 12 [Month3]. The specimen result of the 6 [Month3] test says it was tested on the same day which means it should have been reported on the 9 or 10 [Month3] so a further 2 days seems an unacceptably long period of time for the prescribing of an antibiotic to be given and does not meet the expected provision of care.

Unfortunately, the urinary tract infections continued and along with the catheter bag problems that the family noted became recurrent issues that more proactive management may have been able to minimise. Nowhere in the notes/careplan does it appear that there was a possible link made between her bowel incontinence and urinary tract infections.

The management of [Mrs A's] health was complex, and [the rest home] demonstrate the use of the multi-disciplinary team in doing this with regular reviews by the General Practitioner and Nurse Practitioner as well as the Pharmacist review of her medications. It does appear that basic management of catheter care complicated by faecal incontinence was not identified and the direct care staff seeing this as a priority. The family concerns regarding [Mrs A's] care was not acted on quickly and not documented in the [the rest home] as evidenced by the detail provided by the family in their letter of complaint.

The overall management of [Mrs A] was adequate however there are basic areas of nursing; updating of the care plan — use of short-term care plans and the management of a person with a catheter and who is faecally incontinent. This information does not appear in the care plan and documentation. There are gaps in

attending to the family's concerns and this is a serious departure from the expected standards of care and will be improved by the education for staff that has already been done and will need to be done regularly. The training sessions undertaken by staff in September do seem to have covered the hygiene aspects of catheter management however further training around bowel incontinence and catheter management would be appropriate.

3. Whether the catheter bags were changed in a timely manner

The timing of the changes is identified in the [rest home] policies — the catheter (3 monthly) and tubing (6 weekly) and catheter bags (weekly or as required). [Mrs A] returned from hospital on the 19 [Month2] with a catheter therefore it would be due to be changed by the 19 [Month5]. The presence of a catheter was added to the careplan on the 25[Month2] however there are no details mentioned about planned dates for bag changes. [Ms J] states on page 3 of her September 2018 letter that the catheter tube is changed 6 weekly — neither this nor the bag changes (weekly) are recorded in the progress notes. There is an understanding in health documentation if it is not written it didn't happen, therefore the changing of catheter bags and tubing did not meet the expected standards established by [the rest home].

The catheter output form records when the catheter bags were emptied and that generally the urine was clear. [Ms J] acknowledges that there were occasions that the bed linen was wet from over full catheter bags therefore it is seen as a departure from the expected standard. These issues were of serious concern to [the family] therefore not recording the catheter bag and tubing changes is seen as a serious departure from the excepted standards. Utilising a catheter change form would be an improvement opportunity and one that their new electronic record should be able to address.

4. The quality of the clinical documentation

The clinical documentation that has been provided is adequate in most areas with the progress notes by the care and registered staff relevant and provide information about the care provided. There was a multi-disciplinary team with General Practitioner and Nurse Practitioners involved providing medical advice and expert clinical assessment to support the Registered Nurses. The care plan was updated on the 25 [Month2] which notes [Mrs A's] decline — she is now 'fully dependent for all cares' and updates the plan for the new level of care required.

The care plan would be improved by including how the catheter needed to be managed — bag and tubing changes and when the catheter should have been changed. The care plan should have included information about managing a person who is incontinent of her bowels and has a catheter which had the potential to impact on the frequency of urinary tract infections. There is no mention in the progress notes/careplan about the potential for infection due to faecal incontinence except by [RN E] who comments on the afternoon of the 21 [Month2] that she has a urinary tract infection secondary to incontinence.

The general progress notes, charts and associated clinical material meet the expected standards. However, the careplan update on the 25 [Month2] did not have enough detail regarding bag changing and dates for the catheter to be changed. Charts are an integral part of monitoring a resident's health and it is essential that they are completed consistently — there are gaps in the comments areas of the catheter output form. Clinical documentation is the recording of a resident's life in a facility and there are areas of the care plan around catheter management that do not meet the standards. As this is the primary element in the complaint and a matter that the family was most concerned about this is a serious departure from the expected standard of care provided. Staff received catheter care training later in 2018; training in care planning would also benefit the provision of care for residents.

In conclusion, [the rest home] demonstrated considerable effort in providing care for [Mrs A] who was a complex and frail elderly woman. There was a detailed care plan updated in a timely manner with appropriate monitoring charts in place. Despite this there are four serious departures from the standards of care identified which include: the adequacy of relevant policies and procedures in place for managing and treating urinary tract infections,[1] the management of [Mrs A's] urinary tract infections, whether the catheter bags were changed in a timely manner and the quality of the clinical documentation. The timeliness of call bell response was identified as a moderate departure from the expected standard and this is because there were no time frames identified as a standard in place at the time [Mrs A] was at [the rest home].

End of report

Julia Russell RN, M Phil (Nursing)"

The following further advice was obtained from RN Russell:

"Re: [Mrs A] (dec) 18HDC01468

23 September 2019

The purpose of this report is to review the material provided and consider if this changes the consideration that there were 4 serious and 1 moderate departures from the expected standards of care identified in the March 2019 report. [The] General Manager's letter outlines the response to the matters identified as part of an internal report and demonstrates they have taken further significant steps to rectify the issues that arose from this complaint. Further to this the December 2018 surveillance audit reports there are no issues around continence/catheter management. As well as this and the initial actions taken in response to this there has been ongoing work to address this complaint; meetings with staff assisted in developing corrective action

[1] RN Russell retracted this criticism in her subsequent advice. See the appended advice dated 23 September 2019.

plans, internal audits, catheter bag management, a new catheter care chart and registered nurse schedule.

Further documents were provided for review and included:

- Progress Notes covering [Month1] to 27 [Month5].
- Prescription records from [two pharmacies]
- Medication Charts by GP [Dr D].
- Medication Charts by [Nurse Practitioner].
- Corrective Action Plan for Call Bells.
- Attendance record for bowel incontinence training session.
- Corrective Action Plan for Care Plans.
- Catheter Care Chart.
- Statement from GP [Dr D].
- Statement from [RN C], [the rest home's] Clinical Co-ordinator.
- Position Description for Clinical Manager.
- Position Description for Clinical Co-ordinator.
- Spot Surveillance Audit Report for [the rest home]

Responses to expert advisor report provided by [the] General Manager, 19 July 2019 letter include further information and comment on:

Call bell responses — there has been considerable work done in this area including working with the staff group to improve response times and increased awareness of senior staff. [The General Manager] identifies a 4-minute delay in answering the call bell is acceptable and would meet the standards in other facilities. The moderate departure from the standards identified in the March report was because in the policies there was no identified response time for those that read the policy.

Care planning — the actions taken to improve RN work in this area are substantial and demonstrate [the rest home] are committed to providing best practice with the utilisation of the RN Care Guides as well as training on bowel management.

Electronic resident file — the movement to an electronic resident file and not changing policies until this has occurred is understandable. This has not prevented [the rest home] from bringing into documentation processes a catheter care form from a sister site.

Catheter management policies — noted is the error in the conclusion section of the March 2019 report regarding the policies relating to management of continence and treating UTIs was not comprehensive. This was related to the comment in [Ms J's] letter about the 10 day follow up which was not evident in an otherwise adequate policy. In [the General Manager's] letter, point 7 the timing and reasons for the tests taken on the 4th and 6th [Month3] are both acceptable and good practice.

Family discussion and documentation (point 6) are important and critical components of the RN, Clinical Manager's role. Whilst [RN F] recalls her conversation

with the family, the lack of more thorough documentation contributes to the lack of information available in the event of a complaint or a file review and on this occasion contributes to the serious departure from the standards expected in this area.

In conclusion it is evident that there has been considerable effort and energy gone into ensuring that [the rest home] addresses the deficits that this complaint identified and that the work has been ongoing. The extra material has meant that the earlier advice regarding the catheter policy has been reviewed and removed as a departure from the expected standards. The three remaining areas of serious departure are: the management of the urinary tract infection, the timeliness of changing the catheter bags and the quality of the clinical documentation which includes the lack of detail regarding the discussion with the family by [RN F]. The call bell response is now a mild departure from the expected standard of care as there was no identified standard for readers of the policy (care assistants) to see that the call bells were required to be answered in.

End of report.

Julia Russell, RN, MPhil (Nursing)"