Bupa Care Services New Zealand Limited

Registered Nurse, RN C

Registered Nurse, RN D

A Report by the

Deputy Health and Disability Commissioner

(Case 17HDC01706)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman while a resident at a Bupa facility. A number of failures in the services provided by Bupa resulted in staff failing to identify and respond to the woman's deterioration over a five-day period. Sadly, she later died in hospital.

2. This reports highlights the importance of careful monitoring and response to a deteriorating condition, effective communication, and clinical leadership by nursing staff to ensure compliance with relevant policies and procedures.

Findings

3. The Deputy Commissioner found Bupa in breach of Right 4(1) of the Code. A number of failures in the services provided by Bupa were identified, including a lack of critical thinking by multiple staff and an acceptance that the woman was for comfort cares, a failure by staff to comply with Bupa policies and procedures, and inadequate communication with the family.

4. The Deputy Commissioner found the Unit Coordinator in breach of Right 4(1) of the Code for failing to use appropriate care and skill when assessing the woman's health needs.

5. The Deputy Commissioner found the Charge Nurse Manager in breach of Right 4(1) of the Code for failing to ensure that the woman was provided with services of an appropriate standard.

6. The Deputy Commissioner made adverse comment about a nurse's delay in arranging a transfer to hospital.

Recommendations

7. The Deputy Commissioner recommended that Bupa outline the steps it has undertaken to ensure timely clinical review and transfer of residents to hospital; use this case to provide education to nursing staff at its facilities; undertake a review of cases where residents have either been referred to the GP for urgent review or transferred to hospital; and undertake an audit to ensure staff compliance with the oxygen administration policy.

8. The Deputy Commissioner recommended that Bupa, the Unit Coordinator, the Charge Nurse Manager and the nurse provide formal written apologies to the family.

Complaint and investigation

9. The Health and Disability Commissioner (HDC) received a complaint from Mrs B[1] about the services provided to her mother while a resident at the rest home. The following issues were identified for investigation:

- *Whether Bupa Care Services New Zealand Limited provided Mrs A with an appropriate standard of care in August 2017.*
- *Whether RN C provided Mrs A with an appropriate standard of care in August 2017.*
- *Whether RN D provided Mrs A with an appropriate standard of care in August 2017.*

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

11. The parties directly involved in the investigation were:

Mrs B	Consumer's daughter/complainant
RN C	Provider/registered nurse
RN D	Provider/registered nurse
Bupa Care Services Ltd	Provider/rest home service operator

12. Further information was received from:

District Health Board	
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse

13. Also mentioned in this report:

Mr I	Mrs A's son
RN J	Registered nurse
Mr K	Mrs A's son

14. Independent expert advice was obtained from Registered Nurse (RN) Julia Russell (Appendix A).

[1] Mrs B made the complaint on behalf of her family, who authorised her to speak on their behalf.

Information gathered during investigation

Background

15. In February 2016, Mrs A, aged in her nineties at the time of events, moved into a rest home and hospital, (the rest home), because she was unable to cope by herself in her own home. Mrs A's son, Mr I, held an Enduring Power of Attorney (EPA) for personal care and welfare.

16. Mrs A had a history of worsening dementia and hypertension, and a past history of bowel cancer. A "Do not resuscitate" advance directive was listed on Mrs A's clinical records.

17. Initially, Mrs A was placed in a unit in the rest-home wing, but in November 2016 she was transferred to the hospital wing after she was reassessed as requiring level 5 hospital care[2] owing to her worsening dementia and difficulty with incontinence and toileting and with self-cares.

18. A care plan was completed for Mrs A on 31 May 2017, with a planned review on 31 November 2017.

19. Other than the worsening dementia, Mrs A remained relatively stable. On 7 June 2017, Mrs A had a slight temperature, and her oxygen saturations (SpO_2) dropped to 93% on room air.[3] Mrs A recovered from this episode of unwellness without intervention. On 19 July 2017, Mrs A was seen by the GP for her three-monthly review, and no significant changes were noted.

Rest home

20. In 2017, the rest home was owned and operated by Bupa Care Services NZ Ltd (Bupa) and contracted by the district health board (the DHB) to provide rest-home and hospital-level care to consumers.

RN D

21. At the time of these events, RN D was the Unit Coordinator for the rest-home wing. She had been employed as a registered nurse at the rest home since 2013, and took on the role of Unit Coordinator in 2016.

22. RN D worked Monday to Friday 8am–5pm, and in her role as Unit Coordinator was responsible for the overall clinical care provided to the rest-home residents. RN D told HDC that while her role was clinical, it largely involved administrative duties. RN D's job description included under "Key Tasks and responsibilities" that she "Demonstrate commitment to professional development", "Maintain a working knowledge of the organisation's policies and procedures", and "provide consistent and effective leadership of the Unit".

[2] Requiring a very high level of assistance with care.
[3] Normal oxygen saturations are 95–100% on room air; 92% or less is considered low.

23. Included in RN D's orientation records provided by Bupa is a record of her orientation to Bupa policies, including "Clinical emergency — when to contact GP/Ambulance", "Standing orders", "Oxygen Administration", and "Nursing Assessment Tools". The Bupa training records also show that RN D achieved the "Oxygen Administration" assessment annually, which includes confirmation that the staff member can describe "[w]here to find [the] prescribed order for Oxygen to be administered".

24. RN D did not normally work on the hospital wing. However, she said that on the morning of 9 August 2017, after her arrival at work, she was asked to change her shift and provide nursing support on the hospital wing for the afternoon (3pm–11pm) owing to staff sickness. She said that she was told that her role was to provide nursing support to RN J, who was relatively new to the role, but that she was still expected to carry out her usual duties of Unit Coordinator, which included her administrative duties for the rest-home unit.

RN C

25. At the time of these events, RN C was the Clinical Nurse Manager (CNM) for the rest home, and had held this role for three years. In this role, RN C provided nursing oversight for both the hospital wing and the rest-home wing. RN C's job description included under "Key Tasks and responsibilities": "Provide leadership and clinical supervision to clinical and care staff — … All clinical care provided to residents is based on best practice." Under "Monitor the provision of clinical care to residents to ensure the highest standards are achieved and maintained", the job description states: "— Best practice care practices are implemented as per Bupa Care Services policies and procedures."

Tuesday 8 August to Wednesday 9 August 2017

26. On 8 August 2017 at 8pm, it is documented in the progress notes that Mrs A reported not feeling well, and that the registered nurse had been notified. No further action appears to have been taken in relation to this comment at that time. Overnight and the following morning, no further concerns were documented regarding Mrs A feeling unwell.

27. On 9 August 2017 from 3pm until 11pm, RN D was covering sick leave on the hospital wing. RN D told HDC that she attended handover at the beginning of the shift and that no concerns were raised in relation to Mrs A at that time. However, RN D recalls that shortly after handover, while in the nurses station, one of the caregivers came in and reported that Mrs A was "not quite right".

28. RN D and RN J, whom RN D was supporting that afternoon, attended Mrs A. RN J carried out an assessment, which RN D recorded in the progress notes. At 8.40pm, RN D documented Mrs A's observations in the progress notes as: blood pressure (BP) 103/68mmHg,[4] pulse 120 beats per minute (bpm),[5] temperature 35.5°C,[6] respiratory rate (RR) 20 breaths per minute,[7] and oxygen saturations (SpO_2) 75% on room air, which is

[4] Normal BP is generally considered to be between 90/60–140/90mmHg.
[5] Normal pulse rate is between 60–100bpm.
[6] Normal temperature is 37.5°C.
[7] Normal respiratory rate is 12–20 breaths per minute.

significantly lower than the accepted range of 95–100%. Mrs A was noted to have a "pale face colour, denies pain, chatting at usual level". RN D then contacted Mrs A's son, Mr I, to advise him "of the change in health status", and left a message for him.

29. At 9.15pm, Mrs A was noted to be asleep and snoring, with her bedhead slightly elevated. Mr I returned the call, advising that currently he was overseas. In her statement to HDC, RN D said that during this call she provided a detailed account of Mrs A's presentation, advising that she would keep Mr I updated. RN D said that on Mr I's request, she then contacted Mrs A's other son, Mr K, and updated him on Mrs A's presentation. RN D stated:

> "The family's expression to me was that they were concerned about keeping their mother comfortable and they kept asking whether she was in pain, which I reassured them she wasn't."

30. At 9.45pm, Mrs A's SpO_2 was documented as 62% on room air, and she was noted to be yawning but awake and chatty. She was started on 2 litres (2L) of oxygen via nasal prongs. At 10pm, her SpO_2 had increased to 75%. RN D told HDC: "[Mrs A] was speaking in her usual way, was not breathless, reported no pain when asked. She was comfortable and slept during the shift."

31. RN D said that although not reflected in the progress notes, nursing staff were in and out of Mrs A's room every 10–15 minutes checking that she had not removed the nasal prongs.

32. RN D said that at the end of her shift during handover at around 11pm, the nurse who was assigned to care for Mrs A overnight was advised that "there had been a change in [Mrs A's] condition and that she needed to be very carefully monitored overnight to see if her oxygen levels increased".

33. Mrs A's GP was not contacted, and there is no evidence that any consideration was given to requesting a medical review at that time.

Thursday 10 August 2017

34. According to the progress notes, overnight Mrs A was checked half-hourly and her SpO_2 remained between 74% on 2L of oxygen and 79% on 2.5L of oxygen. She was noted to sleep on and off throughout the night and had "no signs of discomfort".

35. At 6.50am on Thursday 10 August, Mrs A's SpO_2 was 81% on 3L of oxygen (it is not documented whether this was via mask or nasal prongs), and her pulse was 124bpm. Throughout the rest of the morning, her SpO_2 was recorded as being between 78% at 7.35am, and 84% at 10am. At 11.30am, Mrs A was noted to be short of breath while being changed.

36. The notes at 3pm record: "[Mr K visited and] explanation given re [Mrs A's] current health status, he will contact other family members." In her letter of complaint, Mrs B said that when Mr K saw their mother, he thought she "appeared gravely ill" and "appeared very blue around her nose and lips". Mrs B said that when Mr K spoke to a nurse, he was told

that Mrs A "appeared to have a cardio issue", and the nurse noted that Mrs A was not for resuscitation. Mrs B stated: "[Mr K] was initially surprised by this statement, however was in agreement but did discuss the need for active and appropriate care." Mrs B said that when he was leaving, Mr K spoke to another nurse and asked about Mrs A's prognosis, and was given the impression that Mrs A was dying and did not have long to live.

37. It is noted at 3.10pm that Mrs A's SpO_2 had dropped to 68% because she took off the nasal prongs. She was then started on 5L oxygen via a mask, and her SpO_2 increased to 90%.

38. RN D, who was again working the afternoon shift (3pm–11pm), said that she was present at handover. She stated:

> "My recollection was that the RN said that the Care Manager and RN had reviewed [Mrs A] and that the Care Manager had discussed [Mrs A] with family and that she was not for hospital admission but for comfort cares at [the rest home]."

39. Further, RN D stated:

> "I understood from the handover that [Mrs A] had been medically assessed during the day and that she was for comfort care and continuation of the management. I did not understand that there was any change to how we were monitoring her and there was no other instructions provided to vary the management plans."

40. RN G, who was also present at handover, told HDC:

> "On this shift, the hospital wing RN informed me that [Mrs A's] health had deteriorated, that [Mrs A] was on oxygen and that family were aware of her condition and were happy for her to be provided comfort care rather than have her sent to hospital."

41. However, there is no record of a medical assessment having been undertaken or requested, nor was the care plan updated or reviewed at that time. Furthermore, there is no record regarding the decision to provide Mrs A with comfort or palliative cares.

42. The notes record that at 7.30pm, Mrs A remained stable, her SpO_2 was between 86–90% on oxygen via a mask, and there were "nil signs of respiratory distress".

43. At 9.10pm, RN D documented that she telephoned Mr K to provide an update. Mr I and his brother subsequently called to request an update, and both spoke to Mrs A.

44. RN D stated in relation to the shift:

> "Although I have not recorded her assessment in the notes, we were regularly assessing [Mrs A's] observations and her oxygen saturations. On this shift I recall that the BP machine was not working and that I took her BP with a stethoscope and that I also listened to her chest and could not hear any wheezing[8] or creps[9] or anything of

[8] A high-pitched whistle caused by narrowed airways.

concern. [Mrs A] was also not reporting any pain that might have signaled an embolism. My previous experience with lung embolisms was of patients reporting significant pain and discomfort."

Friday 11 August 2017

45. Overnight on 10 August, Mrs A was noted to have had little sleep and kept taking off her nasal prongs. Her SpO_2 was documented as 74% on 3L oxygen.

46. During the morning of 11 August 2017, Mrs A's SpO_2 remained at around 77–80% on 3L oxygen via nasal prongs.

47. According to the family's complaint, at 12.30pm, Mr K visited Mrs A again. Mrs B said that during that visit, Mr K noted that their mother's breathing was still poor, and he remained concerned. Mrs B stated that Mr K spoke to RN C, who told him that Mrs A's SpO_2 had improved and she was "back to her feisty self", and was not "going anywhere soon". This discussion is not documented.

48. At around 2pm, Mrs B and Mrs A's granddaughter visited. Mrs B said that during the visit, she noted that Mrs A's SpO_2 levels were as low as 72%.

49. RN D, who was again covering staffing shortages and rostered on the afternoon (3pm–11pm) shift on 11 August, said that at handover from the morning shift, no changes in Mrs A's status were discussed, and "the plan was to continue with comfort cares as per the Care Manager's discussion with her family and that the focus was to keep [Mrs A] comfortable". Mrs A's SpO_2 remained around 77% on 3L oxygen via nasal prongs.

50. RN C told HDC that RN D told her that at the end of this shift Mrs A was happy, eating and drinking normally, and her usual "cheeky" self. RN C said that both she and RN D "told [Mrs A's] sons that the doctor would review [Mrs A] when he was scheduled to visit on Monday". This is not documented in the clinical records.

Saturday 12 August 2017

51. Mrs A was noted to have had broken sleep overnight. Her SpO_2 remained at 78% on 3L oxygen "on all checks".

52. RN G, who was rostered on the morning shift (7am–3.15pm), said that when he attempted to administer Mrs A her routine morning medications, Mrs A refused. RN G said that he checked Mrs A every 1–2 hours during the shift, and "[o]n each occasion she was alert and responsive and was continuing oxygen, via nasal prongs, with no signs of respiratory distress or discomfort".

53. Mr K, his partner, and Mrs B visited at 12.30pm and left around 1.30pm. Mrs B said that during that time they found Mrs A in bed without her oxygen on, and noted that it had not been pulled off by Mrs A because it had been left out of her reach.

[9] A crackling or popping sound caused by secretions in the lungs.

54. At 2.15pm on 12 August, Mrs A was noted to be "alert and responsive", and her SpO_2 remained between 86–90% on 3L oxygen.

55. RN H, who was rostered on the afternoon shift (3pm–11.15pm), said that she was told at handover by the morning nurse that "the plan of care for [Mrs A] was to keep her comfortable and that she was 'not for resuscitation'", and that RN C had said that this meant that "[Mrs A] was not having active treatment and was not for hospitalisation, but that she was to be kept comfortable". However, the clinical records contain no reference to this direction from RN C, nor any reference to the decision to initiate comfort or palliative cares for Mrs A.

56. In response to the provisional opinion, RN C stated:

> "I did not say '[Mrs A] was not [for] active treatment and was not for hospitalisation, but that she was to be kept comfortable' I have never used the word hospitalisation and I reiterated many times to the family ([Mr K]) and staff that [if] she deteriorated she must be transferred to hospital. The clinical records contain no reference to this, nor any reference to comfort cares, another phrase I have never used in my nursing career. This is because I never gave this directive."

57. At 3.30pm, Mr K, his partner, and Mrs B visited Mrs A again. Mrs B said that at that visit they found Mrs A "very wheezy and struggling more with her breathing". Mrs B said that the family requested that someone be contacted so that Mrs A could be reviewed by a doctor, and RN C was called but she declined to speak to them. Mrs B said that they left the rest home feeling that their concerns had been "brushed off".

58. At 3.50pm, RN H documented in the family contact record:

> "[Mrs A's] son [Mr K] & his wife visited from [overseas].[10] They questioned why [Mrs A] wasn't seen by a Doctor after recent changes in condition. They asked for [RN C] to be phoned at [around] 1550. … Phoned [RN C]. She didn't want to speak to [Mr K] as on a day off but said family is happy with what we are doing and [Mrs A] will be [seen by] Dr [on]Mon[day]."

59. RN H said that when she relayed her conversation with RN C to Mr K, he was not happy.

60. RN C told HDC that she recalls receiving this call at 1pm, not 3.50pm as recorded in the records, and was told that Mrs A's granddaughter, "someone [she] had never met", wanted to speak to her. RN C said that at the time of this call she was not working, and was in the middle of shifting house, so was unable to speak to the family. She said that she was not required to take the telephone call, and told RN H that on Friday evening Mrs A had been comfortable and not in pain, and that RN D had spoken to the family. RN C said that she has a "clear memory" of saying to RN H that if she wanted to call the GP she

[10] Mrs A's family advised that this detail is incorrect. Mr K and his wife live in NZ. They advised that Mrs B was also present at this visit.

should do so, or that she could call RN D, and that if Mrs A's condition deteriorated she should go to hospital.

61. At 7pm, RN H documented in the progress notes that Mr I called to see if they could "do anything". RN H said that at the time of this call she was not in the hospital wing, and that when she returned she noted that Mrs A's SpO_2 was 84%. RN H told HDC that while this was low, Mrs A was not in distress or having breathing problems. Further, RN H stated:

> "I was aware, from both [RN C] and the Unit Co-ordinator, [RN D], … that [Mrs A] was not for transfer to hospital and that the family were happy with this decision."

62. The other nurse on duty then called Mr I. The progress notes documented by RN H state:

> "Talked to [Mr I]. … Explained that she [Mrs A] is stable and observing her condition regularly. If there will be any sign of deterioration, family wants [Mrs A] to go to hospital. Assured about that. [Mr I] happy with that and wants to be informed anytime about [Mrs A's] health condition."

63. Mrs A's observations were recorded as: temperature 36.5°C, BP 128/76mmHg, respiratory rate 20 breaths per minute, pulse 126bpm, and SpO_2 84% on oxygen. Mrs A was noted to have an audible wheeze.

Sunday 13 August 2017

64. Mrs A was noted to have slept overnight, and her SpO_2 remained at 80% on 3L oxygen via nasal prongs. She was noted not to be in any discomfort.

65. RN E, who was the registered nurse rostered on during the morning shift (7am–3.15pm), said that at handover from the night staff she was told that Mrs A had been unwell since Wednesday, had had low SpO_2, and was on oxygen. RN E also stated: "The night RN also told us that the family were considering hospitalisation if Mrs A's condition continued to deteriorate." RN E's recollection is that Mrs A was the only unwell patient that day.

66. RN E told HDC that after handover she reviewed Mrs A's progress notes to see if there was further information about her condition. RN E stated:

> "I was surprised and concerned that [Mrs A's] oxygen saturations had remained low despite being given oxygen over this time. … I realised that this was serious but I did not fully understand the cause. …
>
> I felt it very important that [Mrs A] be seen by a doctor or transferred to hospital that day so that her condition could be diagnosed."

67. RN E said that from the progress notes she was aware that Mr I had requested that Mrs A be seen by a doctor and, if there was further deterioration, transferred to hospital. RN E said that she also noted that Mrs A's other son, Mr K, had asked to speak to RN C and had been told that Mrs A would be seen by the GP the following day. RN E stated: "As far as I

was aware [Mrs A] was to be given active treatment and [Mr I] and family were requesting medical review."

68. RN E said that at around 9.30–10am, she went into Mrs A's room to take her observations. At that time, Mrs A's granddaughter-in-law, Ms M, who is a health practitioner, was present. Mrs B said that Ms M was very concerned about Mrs A's presentation, and noted that she was "very blue around the nose and lips, and struggling to breathe".

69. RN E said that Ms M asked her what the GP had said about Mrs A's condition, and that she went to check this in the clinical records and confirmed that Mrs A had not been seen by a doctor but was on the list to be seen on his routine visit the following day. Mrs B stated: "Up to this very point, all family members had believed [Mrs A] had been assessed by the doctor."

70. RN E stated: "I was very surprised that [Mrs A] hadn't been seen by a doctor since becoming unwell." RN E said that she agreed to contact the GP, but asked Ms M whether she would be happy to wait until the following day if the doctor was unable to attend that day. RN E said that Ms M agreed to this. In contrast, Mrs B said that Ms M requested that the on-call doctor be called immediately for urgent review of Mrs A. Mrs B stated that Ms M did not agree to wait until Monday for a GP review.

71. Further to this, in response to the "information gathered" section of the provisional opinion, the family reiterated that Ms M was very clear on the need for the GP to be called immediately and, if the GP was not available, for transfer to hospital to be arranged as soon as possible. The family stated: "Categorically, [Ms M] did NOT agree that if the on-call Dr was not available for review of our Mother it would be OK to leave her until the next day for a GP review!"

72. RN E said that she "felt confident that [Mrs A] needed a medical review", and "felt it was likely [Mrs A] needed to go to hospital", but that this did not need to happen immediately. Furthermore, RN E stated:

> "During my shift on Sunday the 13th August I was aware that if I arranged for [Mrs A] to go to hospital I may need to explain the admission to the Clinical Manager on Monday, as she would have been aware that [Mrs A] had had low oxygen saturations since Wednesday, 9th August, and that the family requested medical review the day before, but were told she would be seen on Monday."

73. RN E said that she then went to attend another patient, commenced her medication rounds, and took a break, as she had not had a break that morning and "thought it would take some time to give the GP a full explanation about [Mrs A] on the phone". RN E said that by this time the residents were in the dining room for lunch, and she decided to hand out the lunch-time medications prior to calling the GP. In response to the provisional opinion, RN E said that residents are seated in the lunchroom by 12pm, and that the lunchtime medications take about 15 minutes to administer.

74. RN E said that Mrs B approached her in the dining room while she was handing out the lunchtime medications, and questioned whether the GP had been called. RN E said that she explained that she would do so after the medication round, and mentioned that Ms M and Mr I had both agreed that Mrs A could be seen by the GP the following day if the GP was not available that day. RN E stated that Mrs B said that this was not what had been agreed to.

75. RN E said that she quickly finished her medication round and then called the GP, who advised that he was away and to send Mrs A to hospital. RN E stated that she then arranged for an ambulance transfer to the public hospital.

Ambulance transfer

76. On arrival, ambulance staff noted that Mrs A had an audible wheeze, her SpO_2 was 70%, her pulse was 120bpm, and her temperature was 36.6°C. She was also noted to be peripherally and centrally cyanosed.[11]

77. Mrs A was then transferred to the public hospital.

Hospital admission

78. On arrival at hospital, Mrs A was assessed in the Emergency Department and noted to be short of breath with an audible wheeze and visible accessory muscle use, indicating that she was working hard to breathe. On auscultation[12] she was noted to have widespread wheeze/crepitations bilaterally (in both lungs). Her observations were recorded as SpO_2 71% on room air, respiratory rate 25 breaths per minute, and BP 100/70mmHg.

79. Initially Mrs A was thought to have a chest infection and was started on antibiotics. However, later she was diagnosed with a large pulmonary embolism with associated heart strain. Mrs A remained in hospital until 21 August, when she was discharged back to the rest home.

80. Sadly, Mrs A died a few weeks later. The family believe that her death was directly associated with this incident.

81. A doctor who cared for Mrs A while she was in hospital stated:

> "I am sorry to hear that [Mrs A] passed away a few weeks after discharge; the pulmonary embolism was massive and the mortality rate following such a large embolism would be very high even with the best cares, particularly in her age group."

Further comment/action by Bupa

82. In its response to the complaint, Bupa stated:

> "Our expectation is that such a change/deterioration in condition would at a minimum, warrant contacting the on-call doctor, and if the doctor was unavailable, a

[11] A blueish tinge to the skin caused by a lack of oxygen in the blood.
[12] Listening to the lungs, heart, or other organs, typically using a stethoscope.

transfer to hospital for assessment is appropriate, and we sincerely regret that this did not occur."

83. Bupa said that the decision not to contact the GP was "based on the fact that [Mrs A] was not for resuscitation, and comfort cares were instituted". Bupa stated:

> "Our review of this tragic incident indicated to us that the leadership of the Clinical Manager, [RN C], had contributed to a practice of, in some circumstances, managing care of the residents within the care home environment, rather than a consultative approach with the GP and/or DHB services."

84. In addition, Bupa stated:

> "We expect timely assessment and interventions to be undertaken to ensure that our residents receive care consistent with their changing needs. It is Bupa's opinion that sufficient guidance and support was provided to both the Clinical Manager and the Unit Coordinator in post at the time, however we remain disappointed that their inaction led to a lack of medical review despite [Mrs A's] deteriorating condition."

85. In relation to RN C's decision not to speak to Mr K when she was contacted by RN H on Saturday 12 August, Bupa said that "it would have expected [RN C] to have made time to speak with the family, or arranged to do so at another time".

86. Bupa advised that RN C resigned during its internal investigation, and it was unable to complete the investigation. Furthermore, Bupa stated that in light of its findings against RN D, she no longer works for Bupa. Bupa referred RN C and RN D to the Nursing Council of New Zealand.

Changes made by Bupa

87. Bupa advised that it has undertaken the following actions to ensure that a similar incident does not happen again:

- The appointment of a new Clinical Manager.
- A review of Bupa facilities by the Clinical Service Improvement team and regional Operations team.

88. In addition, at the site it has made the following changes:

- Reinstatement of clinical review meetings
- Review of reportable incident responsibilities
- Review of the short-term care plan process
- Review of competencies of all staff
- Discussion of care planning documentation and expectations
- Reaffirmation of a number of Bupa policies and processes.

Bupa policies

89. The relevant policies in place at the time of these events include:

- "Doctors — Contacting after hours", which states:

  "For **Urgent and unexpected medical events** — e.g. significant lacerations, acute illness — the GP should be contacted immediately.

  …

  In urgent medical situations when the on-call doctor cannot be contacted arrange an ambulance to take resident to the nearest emergency clinic/department."

- "Clinical Emergencies Residents — Guidelines for staff", which states that a clinical emergency includes when "a resident's condition changes or deteriorates suddenly". Under "Assessment of the situation", the policy states:

  "[S]taff will … Assess the condition of the resident … Take and record all relevant vital signs … Document all processes followed by staff in the management of the Clinical Emergency."

- "Oxygen — Safe Use of", which states:

  "Where a resident requires oxygen as part of their treatment plan — this must be prescribed by a Doctor on the medication chart stating: indications for use, flow rate, time of duration, method of administration."

  The policy states that oxygen may be administered without a doctor's order in an emergency situation.

Further comment from RN C

90. RN C said that she was very distressed by this complaint, and has since resigned from her role at the rest home. She now works as a registered nurse with no managerial duties.

91. RN C told HDC that between 9–13 August 2017, both she and RN D were in contact with Mrs A's family. RN C stated:

> "[We] told [Mrs A's] sons that if her condition deteriorated then hospital admission would be considered. I also stressed this to the other RNs caring for [Mrs A] during this period."

92. RN C said that "[t]here were no clinical indications that [Mrs A] had a clot on her lung, nor was there sign of infection".

93. RN C also stated: "[RN D] had more to do with [Mrs A] than I did, as I had three other deteriorating clients that I was attending during this time." RN C said that she had a very large workload at the time and always acted in Mrs A's best interests.

Further comment from RN D

94. RN D said that she was aware that Mrs A had a "Do Not Resuscitate" advance directive "that included that she was not for CPR [Cardio Pulmonary Resuscitation] but was for comfort care".

95. In relation to the use of oxygen, RN D said that she was not aware of the Bupa Oxygen Policy and Standing Orders policy, and she was not aware of any requirement for a doctor to be called to sign off oxygen administration. She stated:

> "That was not the practice at the time. At the time, it was routine that the oxygen was nurse initiated. I do not recall that the policy required a timeframe for the doctor to sign that off in. The practice was that it often happened at the next doctor's visit."

96. In relation to her involvement in Mrs A's care, RN D stated:

> "I also accept that there was a lack of critical thinking in assessing [Mrs A], and that I should have followed up on the plan of care by writing a short-term care plan. In hindsight there was a lack of specific information handed over regarding her care plan and documentation that led me, and other staff to believe that she had had a medical review and that the approach was for comfort cares only."

97. RN D said that since this incident she has recognised the benefits of the use of assessment tools for the monitoring of acute change. She noted that had they used an assessment tool to chart Mrs A's observations, "we would have been alerted to the deteriorating nature of this incident without the 'fogging' of her dementia diagnosis, in order to determine what action should be taken".

98. RN D noted that while covering the shifts in the hospital wing she continued to undertake her normal role. She stated that she has since reflected on the need to focus on the responsibilities of the current role "to prevent overloading and missing vital information".

99. RN D said that she has undertaken further training on the care of patients with dementia — the "Understanding Dementia" course.

Further comment from RN E

100. In her statement to HDC, RN E said:

> "I offer my sincere apologies to [the family] for the distress caused to them by the delay in obtaining medical review for [Mrs A] the day I cared for her on the 13th August, particularly as there had been no medical review from the time she became unwell 4 days previously. I recognised that I should have arranged medical review first thing rather than around midday."

101. RN E said that these events have highlighted the importance of thinking independently and ensuring that medical concerns are managed urgently when needed.

Nursing Council of New Zealand

102. Bupa notified the Nursing Council of New Zealand of concerns about RN D's and RN C's practice.

RN D

103. In relation to RN D, the Nursing Council of New Zealand undertook a review and determined that she should undertake a competence assessment.

RN C

104. In relation to RN C, the Nursing Council of New Zealand undertook a review and determined that a review of her competence to practise was not required.

Relevant standards

105. Principle 4.1 of the New Zealand Nursing Code of Conduct (June 2012) states that a Registered Nurse should: "Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care."

Response to provisional opinion

RN D

106. On behalf of RN D, RN D's lawyer advised that RN D had no comment to make in response to the provisional opinion, as it relates to her.

RN C

107. RN C's response to the provisional opinion has been incorporated in the "information gathered" section of this report where relevant. In addition, RN C made the following comments.

108. In relation to RN E's comment that if she sent Mrs A to hospital she would need to explain this to the CNM on Monday, RN C stated:

> "I do not understand [RN E's] statement … She could have phoned me to let me know or phoned the Care Manager. She didn't need permission as ***I had reiterated on many occasions that if [Mrs A's] condition deteriorated then she should be transferred to hospital.***" (Emphasis and italics in original.)

109. In relation to the practice of transferring residents to hospital, RN C stated:

> "In my 3 years of working for Bupa Care Services we had a close consultative approach with Allied Professionals, GP's, District Nurses, Support Net and the DHB. We sent many acute residents to hospital for treatment during my tenure.
>
> We were audited by [the DHB] at the start of my CNM position through [the Operations Manager]. We were told that [the rest home] was sending too many residents to hospital that need not have gone. [A Nurse Practitioner] came to audit us and see what was going wrong. She was with us for 2 years and by the end of it [the

> rest home] got an award from [the DHB] for the numbers dropping considerably and she felt she had done a good job as did [the DHB].
>
> Bupa's statement that the decision not to transfer [Mrs A] to hospital was based on the DNR statement and comfort cares instituted. Again, I refer to the fact that I spoke to [Mr I] (who was [overseas]) that if his Mother's condition deteriorated then she would be transferred to hospital. I cannot emphasise this enough. Again I do not use the words 'Comfort cares'."

110. RN C said that in her role she had no support from her line manager, who was not a registered nurse, and that she worked in isolation with seven registered nurses. She stated that at the time of these events she was not involved in the care of Mrs A, because she was busy caring for three other residents who were for palliative care. RN C said:

> "If I hadn't been heavily involved with 3 other residents who were palliative and their whānau I would definitely have taken over the full assessment and review of [Mrs A]. I regret this enormously. As I have stated I had empowered the RN's through Clinical Leadership courses that I had been sent to but obviously this did not occur."

111. In relation to her on-call duties, RN C said that she should never have been on call 24/7, and that this responsibility should have been shared with RN D. RN C stated: "I feel that this shared on-call would have made a significant difference to the error of communication omissions with the family."

112. In relation to the cause of death, RN C stated:

> "The family believe that [Mrs A's] death was directly related to the time lag in transferring her to hospital yet the doctor who cared for her in hospital stated that even with the best of cares the mortality rate would be very high with reference to her age."

Bupa Care Services NZ Ltd

113. In response to the provisional opinion, Bupa submitted that it should not be found in direct breach of the Code of Health and Disability Services Consumers' Rights (the Code). It stated: "It is submitted that there were no systemic or organisational shortcomings here that can sustain a direct liability finding against Bupa." Bupa provided two main arguments in relation to this point.

114. First, Bupa stated that it agrees that "the decision to not seek a clinical review in response to [Mrs A's] sudden condition change was inappropriate", but submitted that this failing was "solely attributable to RN C rather than a liability shared by Bupa". Bupa stated:

> "We believe that the departures from Bupa policies and procedures in August 2017 that led to [Mrs A] receiving suboptimal care were directly attributable to the actions of [RN C] and, to a lesser extent, [RN D], rather than failings by multiple staff."

115. Further, Bupa stated:

> "We remain deeply saddened that [Mrs A's] health was compromised by the lack of action by [RN C] and continue to hold the view that her inaction was contrary to Nursing Council of New Zealand registered nurse competencies and expected nursing practice."

116. Bupa submitted that the decision not to seek clinical review was RN C's, and that she did not disclose this decision, "and instead either actively communicated or allowed miscommunication and misunderstanding to propagate". Bupa stated:

> "The retrospective recall of the registered nurses is that both the Clinical Manager and Unit Co-ordinator communicated that [Mrs A] was not for transfer to hospital and the focus of her care was comfort and that this decision reflected the wishes of [Mrs A's] family."

117. Bupa submitted that the junior registered nurse team caring for Mrs A were of the belief that Mrs A was for comfort or palliative cares, and that the acceptance of this plan was reasonable since the direction came from their clinical leaders. Bupa stated:

> "All actions by the junior registered nurse team and all communications by them, were consistent with what they understood to be the agreed plan of care for [Mrs A], which involved 'comfort cares' and not transfer to an acute care hospital. We suggest that the acceptance of this plan by the junior registered nurse team was reasonable considering the communication received from their clinical leaders, [RN C] and [RN D]."

118. Further, Bupa submitted: "[W]e do not consider that this one case establishes a culture within the rest home of clinical concerns not being escalated to a GP or to acute hospital services."

119. Second, Bupa submitted that it had in place adequate checks and oversight to review and support RN C's provision of care and leadership, and the clinical care provided by the nursing team.

120. Bupa advised that RN C was appropriately experienced and qualified for her role, and no issues had been raised prior to this incident.

121. Further, Bupa noted that Mrs A's deterioration occurred over a three-day period, and there was no process or reporting that could have been expected to alert management of the issues. Bupa stated:

> "Bupa senior management have appropriate processes in place to monitor compliance with its policies. However, … we do not consider any reasonable reporting would have alerted senior management that in this case there was a failure to follow Bupa policy and enabled them to act over a three to five day period."

122. Bupa also stated:

> "Bupa notes that it did, and continues to have, in place adequate internal audits, training, policies and procedures, performance appraisal processes and is subject to external audits and certifications."

123. Bupa provided details of external audits[13] performed that identified no issues relating to staff seeking clinical review when necessary, which again it submitted "call into question the provisional opinion that there was at the time a culture of not escalating clinical concerns or consulting with GPs".

124. Bupa stated:

> "With respect, we submit that Bupa took such steps as were reasonably practicable in relation to having adequate systems and processes in place at the rest home. … We believe that the departures from Bupa policies and procedures in August 2017 that led to [Mrs A] receiving suboptimal care were directly attributable to the actions of [RN C] and, to a lesser extent, [RN D]."

RN E

125. In response to the provisional opinion, RN E stated that the time of the conversation between herself and Ms M, in which it was agreed that RN E would contact the doctor, was shortly before 10.30am on 13 August. She submitted that the time at which she contacted the doctor was approximately 12.15pm, and accordingly the delay in contacting the doctor was less than two hours.

126. RN E stated that during this time period, she needed to prepare syringe driver medications for another patient, and she also spoke to Mr I, took a short break, and administered the lunchtime medications.

Mrs A's family

127. Mrs A's family[14] responded to the "information gathered" section of the provisional opinion, and their comments have been incorporated into the report where appropriate. In addition, they provided the following comments.

128. In relation to the decision to care for Mrs A with comfort cares, the family stated: "At no stage were the family happy for our Mother just to be provided comfort care rather than have her sent to hospital. This was never discussed or documented as such."

129. Further to this they stated: "Yes — our mother was ['do not resuscitate'] but was to receive active care and at no stage was a deviation to this discussed or agreed to."

130. In relation to RN C's comment that Mrs A had no clinical signs of a clot on her lung or any sign of infection prior to her admission to hospital, Mrs A's family noted that on 9 August, a family member, who is a health practitioner, had a conversation with RN D, who advised

[13] HealthCERT Aged Residential Care surveillance audits, 2016 and 2019.
[14] Signed by Mrs B, Mr K, Mr I, and another of Mrs A's sons.

that Mrs A's heart rate and respiratory rate were elevated, her blood pressure was low, and her oxygen saturations were 75%. The family stated:

> "On hearing this [the family member] advised [RN D] that sounded more like a [pulmonary embolism] than a Cardiac event. She also asked had they considered a stat [dose] of Metoprolol (a beta blocker) to help regulate the heart rate."

131. The family said that RN D responded that they could try that. Further, the family stated:

> "The discussions [the family member] and [Mr I] had with staff re the DNR form is that [Mrs A] was not for CPR, but was to be given all options to assist her to survive. If treatment was to be withdrawn it would be a family decision.
>
> The family did not make that decision, but Bupa and BUPA staff took it upon themselves to make that decision which is unacceptable!"

132. In relation to RN E's apology, the family stated:

> "The family thank [RN E] for her sincere apology and acknowledging her part in our Mothers neglect and withholding of medical care by BUPA and staff.
>
> Sadly, it's unfortunate that [RN E] is the only one not to make excuses, take responsibility and genuinely apologise for her involvement."

Opinion: Bupa Care Services New Zealand Limited — breach

Introduction

133. Bupa had an organisational duty to provide Mrs A services with reasonable care and skill. This included responsibility for the actions of its staff.

134. Between 9 and 13 August 2017, Mrs A was seen by at least seven registered nurses. During this time, there were a number of deficiencies in the care provided to Mrs A. While the individual registered nurses who provided care to Mrs A during this time hold a degree of responsibility, particularly RN C and RN D, who held more senior roles (discussed further below), taking into account the number of registered nurses involved in Mrs A's care, I consider that Bupa holds primary responsibility at a systems level for the poor standard of care provided to Mrs A between 9 and 13 August 2017.

Delay in obtaining clinical review

135. I am very concerned about the failure of staff to undertake a formal nursing assessment or request an urgent medical review after Mrs A deteriorated suddenly on 9 August 2017.

136. The Bupa "Clinical Emergencies Residents — Guidelines for staff" includes as a clinical emergency, "a resident's condition changes or deteriorates suddenly". Under "Assessment

of the situation", the guidelines state: "[S]taff will … Assess the condition of the resident … Take and record all relevant vital signs … Document all processes followed by staff in the management of the Clinical Emergency."

137. The Bupa "Doctors — Contacting after hours" policy states: "For **Urgent and unexpected medical events** — e.g. significant lacerations, acute illness — the GP should be contacted immediately."

138. Mrs A was first noted to be feeling unwell on the evening on 8 August 2017. The following day, Mrs A was observed to have low oxygen saturations — around 74% on room air. This was severely low and a significant change in Mrs A's condition.

139. My expert nursing advisor, RN Julia Russell, stated:

> "[Mrs A] had been unwell in June and her [oxygen saturation] at the time was 93% so her recording on the 9 August 2017 were BP 103/68, P 120, T35.5 RR 20 [oxygen saturation] 75% — it dropped further to 62% before returning to 75% on the same evening. These recordings are a marked decrease, and this should have indicated to staff that a significant change had occurred."

140. Over the following days, Mrs A remained unwell with severely low oxygen saturations. During that time, at least seven different registered nurses were involved in Mrs A's care, including the Unit Coordinator for the rest-home unit, RN D, and the Clinical Nurse Manager for the rest home and hospital, RN C.

141. However, at no time was a formal nursing assessment carried out, nor was Mrs A assessed by a doctor, and there does not appear to have been any consideration of either requesting medical review or transfer to hospital by any one staff member involved in her care. Despite the family raising concerns, no action was taken by staff until Mrs A had been severely unwell for four days.

142. RN Russell advised that the appropriate response to Mrs A's low oxygen levels and significant change in health status was to escalate Mrs A's care and for a comprehensive assessment to be undertaken, which could have been undertaken by a skilled nurse specialist, a nurse practitioner, or a GP. RN Russell advised that the failure to escalate care in the circumstances was a severe departure from accepted practice.

143. I accept RN Russell's advice. It is very concerning that despite a sudden change in Mrs A's condition, clinical review was not sought, nor was any formal nursing assessment completed until Mrs A had been severely unwell for four days.

144. I note that Bupa also agrees. It stated:

> "Our expectation is that such a change/deterioration in condition would at a minimum, warrant contacting the on-call doctor, and if the doctor was unavailable, a transfer to hospital for assessment is appropriate, and we sincerely regret that this did not occur."

145. The cause of this lack of action by staff appears to have been driven, at least in part, by an inappropriate threshold for escalating care and seeking advice, and a lack of individual critical thinking.

146. RN D told HDC that it was her understanding that Mrs A had been assessed medically and that she was for comfort cares, and that RN C had discussed this with Mrs A's family, who were happy with this approach. This understanding was echoed by the other registered nurses involved in Mrs A's care:

- RN G, who was involved in caring for Mrs A on 9 August, told HDC that it was his understanding from the Clinical Nurse Manager that "[Mrs A] was not having active treatment and was not for hospitalisation, but that she was to be kept comfortable", and that the family were happy with this approach.
- RN H, who was involved in caring for Mrs A on 12 August, told HDC that when Mrs A's care was handed over, she was told that the plan of care for Mrs A was to keep her comfortable, and she was not for active treatment.
- RN E, who cared for Mrs A on 13 August, told HDC that it was her understanding that the plan was for Mrs A to be seen by the GP the following day, and that RN C had discussed this with Mrs A's family, who were happy with that approach.

147. However, nowhere in the notes is it documented that Mrs A had been reviewed and a decision made to manage her with comfort or palliative cares, nor is there any documentation that this had been discussed with the family. I note RN Russell's advice:

> "[I]t appears there was a culture of not calling the GP when residents became for comfort cares or had a DNR [Do Not Resuscitate directive]. This culture is driven by staff working in the area but should be being monitored by senior BUPA management to see that [Clinical Manager] and [Unit Coordinator] roles are working in ways consistent with BUPA standards. What has happened for [Mrs A] demonstrates a fundamental lack of understanding of the processes associated with caring for complex residents who experience an acute deterioration."

148. I note Bupa's own advice:

> "Our review of this tragic incident indicated to us that the leadership of the Clinical Manager, (CM) [RN C], had contributed to a practice of, in some circumstances, managing care of the residents within the care home environment, rather than a consultative approach with the GP and/or DHB services."

149. However, in response to the provisional opinion, Bupa submitted that the failings in this case do not indicate a culture of not escalating concerns or consulting with GPs. It stated:

> "With respect, we submit that Bupa took such steps as were reasonably practicable in relation to having adequate systems and processes in place at the rest home. … We believe that the departures from Bupa policies and procedures in August 2017 that led

> to [Mrs A] receiving suboptimal care were directly attributable to the actions of RN C and, to a lesser extent, [RN D]."

150. Further, Bupa submitted that it had adequate checks and oversight in place to review and support RN C and registered nursing staff in the provision of care and compliance with its policies, and that no reasonable reporting would have alerted senior management of the failure to do so in this case. While I accept that HDC has received no specific evidence that these issues were widespread, I remain very concerned that despite at least seven registered nurses being involved in Mrs A's care, no one checked whether Mrs A had been reviewed by a doctor, or questioned why there was no care plan in place, in accordance with the Bupa policy requirements. There appears to have been an assumption that because Mrs A was not for resuscitation, this meant that she was not for active treatment. I consider that Bupa must take responsibility for these failings.

Communication with family

151. Mr I held an Enduring Power of Attorney (EPA) for personal care and welfare. Two of Mrs A's other children — Mrs B and Mr K — visited Mrs A after she became unwell, and were involved in her care. It is documented in the progress notes that they wanted to be kept up to date with Mrs A's care, and that both Mr I and Mr K could be contacted at any time. While staff were in regular contact with Mrs A's family, the family were under the impression that Mrs A had been reviewed by a doctor and was being treated actively.

152. As noted by RN Russell, because no formal assessment was carried out, "there was no associated plan(s) of care and inadequate communication not only amongst staff but with the family".

153. I am critical of the communication with Mrs A's family. In particular, Mr I, holding the EPA for personal care and welfare, clearly should have been advised of Mrs A's change of condition and an associated care plan. Had this occurred, the family would have been aware that a GP review had not been sought.

Conclusion

154. Rest-home residents are vulnerable, and often without the ability to advocate for themselves. They therefore rely on staff to provide adequate care, and speak up for them when they have concerns. In Mrs A's case, it was only after the family continued to question staff and then request action that Mrs A's care was escalated appropriately. As noted by RN Russell:

> "What has happened for [Mrs A] demonstrates a fundamental lack of understanding of the processes associated with caring for complex residents who experience an acute deterioration."

155. In my view, it was the responsibility of Bupa to have in place adequate systems and appropriate oversight of staff in order to ensure that Mrs A received care of an appropriate standard and that complied with its policies and the Code of Health and Disability Services Consumers' Rights.

156. In response to the provisional opinion, Bupa argued that while it agrees that the decision not to seek clinical review in response to Mrs A's sudden condition change was inappropriate, this failing was "solely attributable to [RN C] rather than a liability shared by Bupa". Further, Bupa submitted that the actions of the registered nurses were "consistent with what they understood to be the agreed plan of care for [Mrs A], which involved 'comfort cares' and not transfer to an acute care hospital", which it considered "reasonable" because this direction came from their clinical leaders.

157. I do not accept this as a defence. While, as noted above, I agree that the individual registered nurses who provided care to Mrs A hold a degree of responsibility, each registered nurse in this case had the opportunity to consider Mrs A's care plan, identify that she had not been reviewed clinically despite her deterioration, and consider whether steps needed to be taken to escalate her care — as was undertaken by RN E on 13 August. Nowhere in Mrs A's notes is there any reference to a decision being made to manage her with comfort or palliative cares, nor is there any evidence that Mrs A had been reviewed clinically, either by a doctor or a registered nurse. Accordingly, I consider that the failures of the multiple registered nurses, over a number of consecutive days, demonstrate a pattern of suboptimal care that is directly attributable to Bupa as the service operator. In particular:

a) The decision not to seek clinical review after Mrs A's sudden change in condition on 9 August 2017 was inappropriate and a departure from Bupa policy.

b) The acceptance over the subsequent days that Mrs A was for comfort cares demonstrates a concerning lack of critical thinking by multiple staff, driven by an inappropriate threshold for seeking medical review for unwell patients.

c) The failure by multiple staff to comply with Bupa policies and procedures in failing to seek urgent medical review in light of Mrs A's sudden deterioration, and the administration of oxygen without a prescription.

d) The inadequate communication with Mrs A's family by multiple staff, which led them to believe that she had been reviewed by a GP.

158. Overall, as set out above, I consider that the care provided by Bupa, as the service operator, to Mrs A was inappropriate. Accordingly, I find that Bupa did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[15]

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

Opinion: RN C — breach

159. At the time of these events, RN C was the Clinical Nurse Manager responsible for the overall care provided to residents in the hospital unit. She was also responsible for providing supervision to clinical staff.

160. Although RN C was not involved in providing direct nursing care to Mrs A, she was aware of Mrs A's deterioration, from at least 11 August, as well as being involved in communication with Mrs A's family.

161. At no time did RN C suggest a review by a GP, or follow up with staff regarding a review, other than to place Mrs A on the GP's list for the following Monday.

162. RN C said that she told staff, including RN H when she called her by telephone on Saturday 12 August, that if they were concerned they should call the GP.

163. In contrast, it was the general view of staff that the decision not to refer Mrs A for urgent GP review was largely driven by RN C. RN D, RN G, and RN H all said that it was their understanding that RN C had reviewed Mrs A and had directed that she was for comfort cares. I note RN E's comment that she understood that if she transferred Mrs A to hospital, she "may need to explain the admission to the Clinical Manager on Monday".

164. As noted by RN Russell:

> "Even if they [the nurses caring for Mrs A] thought [Mrs A] was dying it would be expected there should have been a review and that would have been shared with the GP so that appropriate communication with the family advising them of this could have occurred."

165. I note RN C's submission in response to the provisional opinion that she never instructed staff that Mrs A was for comfort cares, and that she had made it clear to staff that Mrs A should be transferred to hospital if she deteriorated.

166. While noting systemic issues that influenced decision-making by all staff, RN Russell considered that RN C's failure to initiate a GP review, document a full assessment adequately, and communicate the situation accurately to the family was a significant departure from accepted standards. I accept that advice.

167. Regardless of whether or not RN C knowingly directed staff that Mrs A was for comfort or palliative care, RN C had a responsibility to ensure that Mrs A received appropriate and timely care, and to follow up with staff to ensure that this occurred. Overall, I consider that RN C held a level of responsibility for ensuring that Mrs A was provided with services of an appropriate standard. I consider that RN C failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.

Opinion: RN D — breach

168. At the time of these events, RN D was the Unit Coordinator responsible for the overall clinical care provided to residents in the rest-home unit. RN D was not responsible for the services provided to the residents on the hospital unit, nor was she responsible for providing clinical oversight to nursing staff.

169. On Wednesday 9 August 2017 until Friday 11 August 2017, owing to staffing shortages, RN D was asked to work alongside a newly employed nurse, RN J, on the hospital unit. RN D told HDC that it was her understanding that she was providing nursing support to RN J, but otherwise was expected to complete her usual duties during these shifts.

170. Shortly after handover on 9 August 2017, the caregiver looking after Mrs A alerted staff, including RN D, that Mrs A was "not quite right". RN D attended to assess Mrs A, together with RN J. On assessment, Mrs A's oxygen saturations were noted to be 75% on room air. RN D said that they started oxygen and informed Mr I of Mrs A's change in health status.

171. The Bupa "Oxygen — Safe Use of" policy states:

> "Where a resident requires oxygen as part of their treatment plan — this must be prescribed by a Doctor on the medication chart stating: indications for use, flow rate, time of duration, method of administration."

172. The policy states that oxygen may be administered without a doctor's order in an emergency situation.

173. There is no evidence that RN D considered calling the GP for review at that time, nor did she discuss it with RN C. Furthermore, she did not contact Mrs A's GP when she commenced the oxygen.

174. RN D told HDC that she had known Mrs A prior to 9 August, as she had been a resident in the rest home previously. RN D said that she was aware that Mrs A had a "Do Not Resuscitate" advance directive "that included that she was not for CPR but was for comfort care". RN D stated that she was not aware of the Bupa oxygen policy that required a GP to prescribe oxygen.

175. RN D said that when she received handover the following day, it was her understanding that Mrs A had been reviewed by RN C, and that she had discussed the situation with Mrs A's family and they had agreed that Mrs A was not for transfer to hospital and was for comfort cares.

176. Accordingly, despite Mrs A continuing to have very low oxygen saturations, RN D took no steps to request a medical assessment for Mrs A.

177. As noted by RN Russell:

> "[T]he deterioration of the 8 and 9 August 2017 was considerable and even though [Mrs A] had a DNR that does not mean in the event of a potentially reversible situation should have undergone a medical assessment with possible treatment."

178. While noting systemic issues that influenced decision-making by all staff, RN Russell considered that RN D's failure to initiate a GP review, document a full assessment adequately, and communicate the situation accurately to the family was a significant departure from accepted standards. I accept RN Russell's advice.

179. I note that on the days RN D was caring for Mrs A, she was working outside of her usual duties. I also note that RN D was the first of six other registered nurses who failed to respond appropriately to Mrs A's deterioration. However, RN D was an experienced nurse, and the first to assess Mrs A following her quick and significant deterioration. Furthermore, RN D commenced Mrs A on oxygen without seeking GP review, despite the Bupa policy requiring her to do so. As such, in my view, RN D must hold some level of individual responsibility for the failings in this case.

180. Principle 4.1 of the New Zealand Nursing Code of Conduct (June 2012) states that a Registered Nurse should "[u]se appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care".

181. In my view, RN D failed to use appropriate care and skill when assessing the health needs of Mrs A, and I conclude that RN D breached Right 4(1) of the Code.

182. I note RN D's reflections on this incident:

> "I also accept that there was a lack of critical thinking in assessing [Mrs A], and that I should have followed up on the plan of care by writing a short-term care plan. In hindsight there was a lack of specific information handed over regarding her care plan and documentation that led me, and other staff to believe that she had had a medical review and that the approach was for comfort cares only."

Opinion: RN E — adverse comment

183. RN E was first involved in Mrs A's care on 13 August 2017, after Mrs A had been unwell for four days. RN E and Mrs A's family have provided slightly different accounts of their interactions on the morning of 13 August. However, what is clear is that this is when the family first became aware that Mrs A had not been reviewed by a doctor since becoming unwell, and requested that she be reviewed by a doctor, and that RN E agreed to arrange this.

184. However, after RN E agreed to contact the doctor, there was a delay in her doing so, and she was prompted again to contact the doctor by Ms M. RN E explained that during the

period between agreeing to contact the doctor, and contacting the doctor, she needed to prepare syringe driver medications for another patient, she spoke to Mr I, she took a short break, and she administered the lunchtime medications.

185. RN Russell considered that RN E's failure to act promptly in contacting the doctor on the morning of 13 August, after Mrs A's family had requested her to do so, was a serious departure from accepted standards.

186. I am also concerned about RN E's failure to act promptly in contacting the doctor. It is concerning that despite apparently being aware of the need for Mrs A to be reviewed by a doctor that day, and specifically being asked by the family, RN E decided to undertake other tasks, including completing medication rounds and taking a break, before doing so, and then acted only after further insistence by the family. However, I note that Mrs A had been significantly unwell since 9 August, and that RN C had been contacted the previous day, and it was documented in the progress notes that she had advised that Mrs A was to be seen by the GP on Monday. I also note RN E's comment that she would have to explain an admission to RN C the following day.

187. I note that RN E recognises that she should have acted more promptly.

Recommendations

188. I recommend that Bupa Care Services Ltd:

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

b) Within three months of the date of this report, provide details of any further improvements it has undertaken relating to ensuring timely clinical review and transferring residents to hospital. The purpose of this is to provide reassurance to HDC that concerns regarding the culture of providing residents with "Do not resuscitate" advance directives with comfort cares only have been addressed adequately.

c) Use an anonymised version of this report as a case study to provide continuing education to nursing staff at its facilities.

d) Schedule regular and ongoing education sessions for all the rest home nursing staff on the following topics:

i. Short-term care plans
ii. Use of oxygen
iii. Use of assessment tools
iv. Clinical review and transferring patients to hospital.

189. I also recommend that the rest home:

a) Undertake a review of cases where residents have either been referred to the GP for urgent review or transferred to hospital, to ensure that there was no inappropriate delay.

b) Undertake an audit to ensure staff compliance with the oxygen administration policy.

190. Regarding a) and b) above, Bupa should ensure that an adequate sample is reviewed, and provide details of steps it has taken to address any issues identified. This information should be provided to HDC within three months of the date of this report.

191. I recommend that RN C provide a written apology to Mrs A's family. RN C's apology for her breach of the Code is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

192. I recommend that RN D provide a written apology to Mrs A's family. RN D's apology for her breach of the Code is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

193. In the provisional opinion, I recommended that RN E provide a written apology to Mrs A's family for the deficiencies of care identified in this report. RN E has provided an apology, and this has been forwarded to the family.

Follow-up actions

194. A copy of this report with details identifying the parties removed, except Bupa Care Services New Zealand Limited and the expert who advised on this case, will be sent to the Nursing Council of New Zealand. The names of RN C and RN D will be included in the covering letter.

195. A copy of this report with details identifying the parties removed, except Bupa Care Services New Zealand Limited and the expert who advised on this case, will be sent to the district health board, and it will be advised of the rest home's name.

196. A copy of this report with details identifying the parties removed, except Bupa Care Services New Zealand Limited and the expert who advised on this case, will be sent to the Health Quality & Safety Commission and the Ministry of Health (HealthCERT) and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Julia Russell:

"BUPA [the rest home] 17HDC01706

This report is to consider the care provided to [Mrs A] over a period of three days from the 10 August–13 August 2017. Specifically, this includes the communication that occurred with [Mrs A's] family following her deterioration on the 10 August 2017 and decision by staff not to refer [Mrs A] for a medical review — despite her deterioration. In reviewing these issues the following points are considered: what is the standard of care and accepted practice; has there been a departure from the accepted or standard of care; how this would be reviewed by your peers and any potential for improvements.

Documents used to undertake this review include: the BUPA progress notes; education records; notes from [the] District Health Board; report from [BUPA]; BUPA policy Clinical Emergencies for residents; complaint by [Mrs A's] family.

Background
[Mrs A] was a [resident in her nineties] who had moderately advanced dementia and hypertension. She had been a resident at the BUPA [rest home] since [2016], having moved into hospital level care [later in the year]. Prior to the 10 August 2017, [Mrs A's] condition appeared relatively static — with few changes. [Mrs A] had four children — [Mr I] who had the enduring power of attorney for health and wellbeing [and three other siblings].

On the 19 July 2017 [Mrs A] was seen for her three-monthly review with no significant changes. She sustained a fall on the 21 July with no further concerns noted. [Mrs A] had a DO NOT RESUSCITATE order signed in March 2016 and reviewed in October 2016 and again in May 2017. [Mrs A] deteriorated on the 9 August 2017, observations were taken: blood pressure, respirations and SPO2 and family was contacted on the 10 August. This family contact was recorded in the progress notes and on the Family Contact sheet. To assist in reviewing the communication between the family and [the rest home] staff a timeline was created (see below).

Timeline

Information from BUPA progress notes and *Family/Whānau contact record about family contact*	**Information from the Family complaint about family contact**
Tuesday 8 August *Rang [Mr I] at 0840 left a message — message on answer phone.* Carer notes [Mrs A] was unwell about 2000 hours and she was not eating.	

Wednesday 9 August Observations taken at 2040 hours BP 103/68, P 120, Temp 35[5] — RR 20 SPO2 75% — [Mr I] EPOA contacted to advise [Mrs A] had become unwell. [Mrs A] was placed on O2 and reviewed 15 minutes later at which time her SPO2 had returned to 75% (previously 62%).	[Mr I] advised by [the rest home] that [Mrs A] is unwell.
Thursday 10 August [Mr K] in to visit at 1500 hours and info given regarding [Mrs A's] health status. [Mr K] will contact other family. [Mr K] rang at 2110 hours [Mr I] spoken to at 2150 hours	[Mr I] EPOA contacts [Mr K] (another son). [Mr K] went to [the rest home] spoke to Nursing Staff — he was very concerned about [Mrs A's] general condition. Felt that he had been told [Mrs A] was dying. At the time [Mr K] arrived [Mrs A] had an O2 mask in her hand. [Mr K] was reminded [Mrs A] had a DNR but did talk to the Nurse about the need for active and appropriate care. [Rest home] staff called [Mr K] to advise [Mrs A] had become breathless while being toileted.
Friday 11 August Family in to visit 1420 hours	[Mr K] arrived at [the rest home] at lunch time — [Mrs A] had nasal prongs in and appeared better. [Mrs A's] daughter and granddaughter also visited. O2 levels were down to 72%.
Saturday 12 August 1550 hours [Mr K] questioned why [Mrs A] hadn't seen a doctor and requested [RN C], Clinical Manager be called. [RN H] records that [RN C] said [Mrs A] will be seen by Doctor on Monday and that family was happy with that. 1930 hours staff [RN H] spoke to [Mr I] who requested [Mrs A] see a doctor to see if anything could be	1530 hours family insisted staff on shift request to speak to someone who could approve accessing a doctor. Staff speak to [RN C], Clinical Manager RN, who declines to speak to them.

done. The RN notes state that [Mrs A] is alert, saying the things she usually does and is comfortable. [RN F] (unsure if that is the correct name) also speaks to [Mr I] and records in the progress notes 'if there be any sign of deterioration Family want her to go to hospital. Assured about that. [Mr I] was happy about that and wants to be informed anytime about [Mrs A's] health condition'.	
Sunday 13 August 1420 hours [RN H] records that Family want a Doctor called, as Doctor not available ambulance called. Family advise staff they will be putting in a complaint with Health and Disability Commissioner. [Mr I] advised by [rest home] RN [Mrs A] has left in the ambulance at 1330 hours.	0900 hours [rest home] [RN E] speaks to [a] (family member). This is when the family becomes aware [Mrs A] has not had a medical review — the 'doctor only come Wednesdays and Mondays and if there is an emergency.' Family left [the rest home] at 1030 hours believing a doctor was being called. 12 noon — other family arrived back at [the rest home] to be told that the doctor had not been called. On call doctor was not available so a family member asked for an ambulance. The nurse completed her medication round and called for a medical transfer not an urgent transfer.

1. **Communication that occurred with [Mrs A's] family following her deterioration on Thursday 10 August 2017.**

   a. The timeline assisted in determining what communication was had between the staff and [the family]. The primary contact was [Mr I] (EPOA) who was out of the country on the 10 August 2017 and had advised [rest home] staff his phone was on at all times and he could be contacted. Contact occurred between other family members who were visiting and staff. However, contact, general updates and events such as ambulance transfers, was provided as it should have been to [Mr I]. This level of contact is consistent with the standards of care expected.

   b. The information on the 12 August between [Mr K] and [Mr I] and [RN H], [RN F] and [RN C], Clinical Manager, does not seem consistent with the actions that had been taken by [rest home] staff as it appears [the family] believed a Doctor had

already seen their mother. [RN C], Clinical Manager, chose not to speak to [the family] that afternoon. If she had spoken to [the family] herself rather than relying on her on site staff the situation may have been more clearly recorded as the notes recorded are not very clear (see below).

> 'if there be any sign of deterioration Family want her to go to hospital. Assured about that. [Mr I] was happy about that and wants to be informed anytime about [Mrs A's] health condition'.

As the position description for the Clinical Manager has not been provided it is not clear what the out of hours requirements for the position are, however, given the family had requested they call her and they were wanting a doctor called it would be expected practice that a Clinical Manager would make time to speak to a family. If she was unable to speak at the time, she could have arranged to do so at another time.

c. On the 13 August 2017 the family insist a doctor is called and leave the facility believing this was to happen. The inaction by [RN E] in contacting a doctor, and the reason given to family that she had forgotten, do not seem cognisant of the concerns that [the family] had and that it is evident by her own recordings that [Mrs A's] condition had further deteriorated.

Points b and c are not consistent with the standards of care expected and are serious departures from what is expected by registered staff. It is impossible to clearly identify what the root cause of these issues are: lack of education and training provided to the staff involved or the professional competencies of the registered staff. However, it appears that BUPA, through its corrective action plan, is working to improve this situation.

2. Care provided to [Mrs A] over a period of three days from the 10 August–13 August 2017. Specifically, this includes the decision not to refer [Mrs A] for a medical review, despite her deterioration.

The care provided over the days 10–13 August 2017 in regard to a medical review not being sought are not consistent with [Mrs A's] physical situation and the expectations of care provided in a long-term care facility where there is 24 hour registered nurse cover. Not only is there not a request for a medical review there is no formal nursing assessment done either. If this had occurred then given the comparison of the recordings it would be assumed that these would be shared with the GP.

[Mrs A] had been unwell in June and her SPO2 at the time was 93% so her recording on the 9 August 2017 were BP 103/68, P 120, T 35[5] RR 20 SPO2 75% — it dropped further to 62% before returning to 75% on the same evening. These recordings are a marked decrease, and this should have indicated to staff that a significant change had occurred. As the BUPA Oxygen Policy and Standard Order Policies are not available it cannot be determined at what strength: litres per minute, how long oxygen is able to be used with a resident and or how long BUPA staff are able to use before they seek

further advice. Even if they thought [Mrs A] was dying it would be expected there should have been a review and that would have been shared with the GP so that appropriate communication with the family advising them of this could have occurred.

[The] BUPA Head of Clinical Services, improvement report in response to the complaint identifies that Staff did not follow policies and procedures when setting up the oxygen and not seeking a medical review. Further to this, the inactions taken by [RN E] on the 13 August when she agreed to contact a doctor but did not as she became busy, do not seem cognisant of the concerns that [the family] had and that it is evident by her own recordings that [Mrs A's] condition had further deteriorated. These actions are also not consistent with the standards of care expected and a serious departure from the standard that would be expected.

[The] BUPA Head of Clinical Services, improvement response to the 29 September complaint letter acknowledges a number of issues at [the rest home] and the actions that are being taken including items in a clinical action plan: actions to improve staff education, communication, competencies for registered nurses as well as professional issues with some of the registered nurses. As in point 1. it is difficult to determine what the root cause of these issues are, however, the ability to identify when a family member is feeling concerned about health issues such as [Mrs A's] family on the afternoon of the 13 August 2017 seems to be lacking in competence for a registered nurse.

In conclusion [Mrs A] did not undergo any type of formal assessment by either a nurse or her GP — given her health status was stable as identified at her previous three-month assessment on the 19 July 2017. The deterioration of the 8 and 9 August 2017 was considerable and even though [Mrs A] had a DNR that does not mean in the event of a potentially reversible situation should have undergone a medical assessment with possible treatment. [Mrs A] responded to the treatment she was given in the hospital and should have had the opportunity for medical review prior to this time. Also, if it had been decided that [Mrs A] was dying then a formal review of that should have occurred with proper communication with the family advising them of this.

The general communication that occurred with [Mrs A's] family following her deterioration on the 10–13 August 2017 did meet the expected standards of communication to a family and the EPOA. However, the communication that occurred between the family and [RN H], [RN F] and [RN C], [RN E] and other RNs are not consistent with the expectations of care and communication expected by registered nurses and these are serious departures from the care that should be provided.

There is no way to remove the communication and the inactions by staff in ensuring [Mrs A] received appropriate care over these days in particular with having a review of her situation. Initially, this should be done by a skilled RN handing over information to the GP. This did not occur and is a serious breach of the care a resident at this level of care should expect to receive.

It is not possible to clearly identify what the root cause of these issues are; lack of education and training provided to the staff involved or the professional competencies of the registered staff. However, it appears that BUPA through its corrective action plan is working to address and improve this situation."

The following further advice was received from RN Russell:

"The purpose of this report is to further review the care given to [Mrs A] (deceased) between 10–13 August 2017. Following the 4 January 2019 report there has been further information provided by [the rest home] and the registered nurses (RNs) involved in this matter. A review of this new information will determine if there are changes in the findings from the initial report. The new material reviewed included:

— Response to the expert advisor report January 2019 from [Mrs A's] family.
— Letter from Bupa 10 May 2019
— Includes as appendices previous responses (21 Dec 17, 11 Feb 19, 30 July 18)
— Responses from:
  - [RN D] — Unit Coordinator
  - [RN C] — Clinical Manager
  - [RN E] — Registered Nurse
  - [RN F] — Registered Nurse
  - [RN H] — Registered Nurse

The conclusions drawn in the 4 January 2019 report was that there were serious departures from the expected standards of care, and these included:

1. The lack of communication that occurred between the family and the RNs involved in [Mrs A's] care; [RN H], [RN F] and [RN C], [RN E], [RN D].
2. No formal documented review of [Mrs A]. Initially this should be done by a skilled RN handing over information to the GP.

The 4 January 2019 report questioned the actions taken by the RNs involved with [Mrs A's] care but did not determine whether the cause of these departures from the standards were due to their competence and skill or the education, training and resources available to them as a larger systems issue. The 21 December 2017 report provided by [BUPA] identifies a number of actions taken in the form of a corrective action plan to address the issues they identified to improve this situation. The actions taken at the time included reinstating clinical meetings, review of reportable event responsibilities, review of the short-term care plan process, review of competencies for all staff, discussion of care planning documentation expectations, reaffirming a number of BUPA policies and procedures, education and training. Included in this letter is a response to a question regarding staffing — the ratio is 1 staff member to 5 residents.

10 May 2019 BUPA responses to the 4 January 2018 report

[BUPA] concurs with the points made in the 4 January 2019 report regarding [Mrs A's] care. [BUPA] advised both [RN D] and [RN C] have left [the rest home's] employment

and as BUPA were unable to complete their investigation the RNs were reported to the New Zealand Nursing Council (NZNC).

BUPA concurs with the 4 January 2019 report in 4 areas:

1 — *that it would be expected that the CM made time to speak to the family or arranged another time to do this.*

2 — *The communication between the RNs and the family was not of the expected standard.*

3 — *The delay by nursing staff to seek review*

4 — *The lack of formal nursing assessment of [Mrs A's] condition.*

Policy and procedures

BUPA have provided comprehensive policies and training records, education programme and documents. The policies are clear and thorough, the education programme and training records demonstrate training has been undertaken.

Staff responses

a. [RN D], Unit Coordinator

The investigation between [the rest home] with [RN D] was unable to be concluded as she left their employment, this was reported to NZNC. In the 28 March 2019 letter [RN D] records she worked in [the rest home] area and had known [Mrs A] when she was a resthome resident. On the 9 August she was a last-minute roster addition to the afternoon staffing to support an RN who had recently started in the area. This is a commendable action and good practice by the assistant manager. However, [RN D] was advised to continue with her own tasks/work as she was not being replaced in her daytime role. [RN D] acknowledges in her 28 March 2019 letter that the documentation of observations, not using a short-term care plan, not using critical thinking, lack of use of assessment tools, lack of clarity regarding oxygen management, what Do Not Resuscitate (DNR) status meant in the event of a potentially reversible condition, receiving poor handover information meant that the care provided did not meet the standards expected. [RN D] recalls a sense of a large workload, staff were stretched to their limits which affected their ability to complete tasks and she records her own inability to bring this to BUPA's attention. In her letter she notes that despite BUPA's assurance of adequate education and familiarisation with policies that was not her experience.

b. [RN C], Clinical Manager

The investigation between BUPA with [RN C] was unable to be concluded as she had left BUPA's employment, this was reported to NZNC. [RN C] explains in her 22 February 2019 letter why she did not speak to [the family] as she was shifting the weekend of the 10–13 August. Further to this she states there was an on-call component to her role, as is confirmed by her employment agreement. The agreement says that call will be shared but no other is provided. [RN C] notes that she

was not on call 24 hours/7 days per week as that would be unreasonable and unacceptable. [RN C] also says she further advised [RN H] to send [Mrs A] to hospital if she felt it was necessary. [RN H] states in her letter that [RN C] told her that [Mrs A] would be seeing the doctor on Monday 14 August, she does not say [RN C] told her to send [Mrs A] to hospital if she needed her to. [RN C's] explanation for not speaking to [the family] member is understandable and acceptable. There are however other points in her letter that do not match what other RNs say.

[RN H] confirms [RN C's] comments where she was advised by [RN C] to speak to the Unit Coordinator ([RN H] names [RN D], so it would be assumed that [RN D] was on call that weekend as she was not at work).

[RN C] states she advised the RNs if [Mrs A] needed to go to hospital that she should be transferred. [RN E] in her letter appears to be concerned that if she did transfer [Mrs A] to hospital, she would need to explain this to [RN C] on Monday. As noted above [RN H] does not record a further instruction to send [Mrs A] to hospital if she needed to when she spoke with [RN C] on the 12 August. [RN H] also doesn't mention a text to [RN C] assuring her things were fine. [RN C] describes [RN D] as the lead while [RN D] says she was working in the resthome and knew [Mrs A] from her time there. [RN C] notes she had a large workload at the time with 3 other deteriorating residents on syringe drivers.

[RN C] states in her 22 March 2019 letter that the NZNC wrote and advised her she did not require any further training and development although she was willing to undertake any that may be required.

c. [RN E]

[RN E] records her actions on the morning of the 13 August 2017. [RN E] does not seem to have understood what it is [Ms M] required of her — to call the GP and if the GP was not available then an ambulance was to be called (as recorded).

In paragraph 38 she records she was confident [Mrs A] needed a clinical review but had read in the notes that the CM had been contacted the previous day and [Mrs A] was for a GP review on Monday 14 August. In paragraph 41 she notes that if she transferred [Mrs A] to the hospital, she would need to explain that to [RN C] on Monday. [RN E] states that the reason for the delay in the ambulance arriving was due to the conversation she had had with [Mr I] that she would call the GP after she had finished the lunch time medications and that [Mr I] had said that if the GP was not available [Mrs A] would be seen the next day — 14 August. When [Mrs A's daughter] arrived at lunch time and was told this by [RN E] — her response was that is not what [Ms M] agreed to at 9am at which time [RN E] said she would call the ambulance immediately. [The family's] Response states this was at approximately 1pm. [RN E] also comments on the extensive workload.

d. [RN F]

[RN F's] recollection of the incident is of the days she worked and the conversation she had with [Mr I] (he was the only family member she spoke to). [RN F] understood [Mr I] was happy with the care [Mrs A] was being provided with, understood that there had been no change in condition over the previous few days and that given [Mrs A's] condition — she had a DNR she would not be transferred to hospital unless there was a significant change. [RN F] did not observe a significant change from the days of the 9, 10, 11 which explains why she didn't think there was need for a transfer to the hospital. In paragraph 12 she explains her understanding of the plan for [Mrs A] was without active intervention. In paragraph 11 she states the BUPA practice was when a patient was for comfort cares and was not in pain, was that the doctor would not usually be called.

e. [RN H]

[RN H] 10 August 2018 letter states she was aware from both [RN D] and [RN C] that [Mrs A] was not for transfer to hospital and family were happy with this. In her conversation on the 12 August with [RN C] she says that [RN C] advised her that [Mrs A] would be seen by the GP on 14 August. [RN H] does not say she contacted [RN D] or advised [the family] they could do that.

In conclusion the primary issues following [Mrs A's] change in health status was no comprehensive assessment of [Mrs A] — this could have been by a skilled nurse specialist or Nurse Practitioner/GP. It seems this did not occur because she had a DNR and that it was a busy time. As there is formal assessment done there is no associated plan(s) of care and inadequate communication not only amongst the staff but with the family. RNs working with [Mrs A] made assumptions regarding the level of care she was to receive given her health status and the deterioration of the 8 and 9 August.

The new information regarding the care and support of [Mrs A] on the 10–13 August 2017 is helpful as it provides the policy and procedure information BUPA is using and the action plan that was undertaken after this occurred. However, the documentation and communication are overall not consistent with the expected standards of care for residents. This is acknowledged in [RN D's] response and by [RN E] who noted there were several improvements at [the rest home] after this. Comments are made by several nurses regarding the workload at the time and the shortage of RNs as evidenced by [RN D] doing afternoon shifts. Having the expertise of [RN D] should have been a positive for [Mrs A] as she was more experienced than many of the RNs who would have been working afternoon shifts. However, [RN D] was still doing her UC role as well as being responsible with another new to the role RN for […] people — [half] of whom were at hospital level. [BUPA] states that the patient staff ration is one to 5. There is no clear description of the RN availability, [RN D] records the decrease in RN staffing following the BUPA take over. [RN E] records there is usually 1 RN in the hospital and 1 RN in the resthome. There were 2 RNs on the afternoon of the 12 August: [RN H] and [RN F] — one of these was a short shift.

[RN C] not speaking with [the family] has been explained in her March 2019 letter. However, comments made by [RN F] regarding residents seeing their GPs, it appears there was a culture of not calling the GP when residents became for comfort cares or had a DNR. This culture is driven by staff working in the area but should be being monitored by senior BUPA management to see that CM and UC roles are working in ways consistent with BUPA standards. What has happened for [Mrs A] demonstrates a fundamental lack of understanding of the processes associated with caring for complex residents who experience an acute deterioration.

Communication between staff and family was a problem and unfortunately, this series of events occurred when the EPOA, son [Mr I] was away for the weekend, [RN C] was unavailable — it was her weekend off, [RN D] was working afternoons and then off, but possibly on call but was not called by [RN H].

There are severe departures from the standards of care that would be expected for [Mrs A] by the RNs — [RN D] — around assessment, communication and documentation, [RN E] — not clearly understanding what [Ms M] was requesting her to do and not seeking clarification of this, this meant the GP and then ambulance was not called until 4 hours after the initial discussion. [RN C] explained why she did not speak with the family. However there appears to have been a culture of not calling GPs which [RN C] was responsible for but this should have been observed by BUPA senior leadership or brought to their attention from other areas of reporting. Given the number of corrective actions identified by [BUPA] it appears there were inadequacies in the overall system at [the rest home] which will have led and contributed to this complaint. Since this complaint there has been considerable work done by the RNs involved who have reflected and learned from this as well as the work BUPA has done at [the rest home] to work with staff and systems to minimise the risk of this recurring.

Julia Russell RN, MPhil (Nursing)"