Oceania Healthcare Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC00812)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the nursing and end-of-life care provided to a man in his nineties by staff at a rest home in 2017. At the time of events, the rest home was owned by Oceania Healthcare Limited (Oceania). The man had a number of co-morbidities and had recently undergone an amputation when he was admitted to the rest home.

2. The man's condition began to deteriorate owing to an infection.

3. The man did not undergo review by a medical practitioner until the next day, by which time his condition had deteriorated significantly. Antibiotics were charted by a Nurse Practitioner who serviced the rest home, but there was a delay in receiving the required medical approval for prescribing the antibiotics, and therefore a delay in administering the antibiotics to the man. He was transferred to hospital and passed away later that day.

Findings

4. The prescribing system in place at the rest home at the time was inadequate, as was the monitoring and documentation of the man's condition. There were missed opportunities to administer medication as needed, and to undertake urinalysis. Further, staff at the rest home fell short in terms of their communication with the man's family over the course of his deterioration, and the decision to transfer the man to hospital not long before he died was inappropriate in the circumstances.

5. The Deputy Commissioner acknowledged that there was a lack of stable management at the rest home at the time. Notwithstanding this, the man was let down by various aspects of the care provided to him by numerous staff on numerous occasions, and the Deputy Commissioner considered that the deficiencies in his care occurred as a result of systems and organisational issues. Oceania was found to have breached Right 4(1) of the Code.

Recommendations

6. The Deputy Commissioner recommended that Oceania apologise to the family and review its national systems to ensure consistency across all facilities with regard to prescribing processes and the escalation of care to GPs and on-call GPs.

7. The Deputy Commissioner also recommended that Oceania reflect on a number of improvements to end-of-life care, and incorporate these into all Oceania facilities nationwide, as appropriate, and provide HDC with an update on the action taken.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her late father, Mr A, by the rest home. At the time of events, the rest home was owned by Oceania Healthcare Limited.

9. The following issue was identified for investigation:

- *Whether Oceania Healthcare Limited provided Mr A with an appropriate standard of care in 2017.*

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

The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Complainant
Oceania Healthcare Limited	Provider

11. Also mentioned in this report:

Dr C	General practitioner

12. Further information was received from:

District health board	Group provider
Medical Centre 1	Provider
Medical Centre 2	Provider

13. Independent expert advice was obtained from Registered Nurse (RN) Rachel Parmee (Appendix A).

Information gathered during investigation

Background

14. Mr A, aged in his nineties at the time of events, was a resident at the rest home for a few months until his death. His medical history included Parkinson's dementia,[1] hypertension,[2] peripheral vascular disease,[3] chronic heart failure,[4] and Type 2 diabetes.[5] Mr A had severe

[1] A disorder of the central nervous system that affects movement, often including tremors.
[2] High blood pressure.
[3] A circulatory condition in which narrowed blood vessels reduce blood flow to the limbs.
[4] A chronic condition in which the heart does not pump blood as well as it should.

problems with ischaemia[6] to his extremities, and had undergone a recent amputation when he was admitted to the rest home.

15. Nurse practitioners[7] (NPs) employed by Medical Centre 1 attend weekly clinics at the residential care facilities in the region, including the rest home, and are on call between Monday and Friday for any urgent reviews.

16. At the time of these events, the two NPs servicing the rest home were yet to become authorised medication prescribers, although they were in the process of becoming authorised. This meant that after any clinical assessment, they were required to refer back to Mr A's registered general practitioner (GP) for any medication changes or further medications needed. At the time, it was policy at the rest home that referral to a GP for any pharmacological recommendations and review of medications was done via fax or face to face. Any acute or chronic concerns were outside the scope of the NP, and residents would be reviewed by a GP.

17. The NP who regularly serviced the rest home was on leave at the time of these events, and so another NP had assumed her responsibilities and was servicing the rest home, and therefore treated Mr A.

18. Mr A's registered GP was Dr C at Medical Centre 2.

19. The scope of this investigation is limited to the actions of rest home staff in relation to the nursing and end-of-life care provided to Mr A from Day 2[8] until he was admitted to the public hospital on Day 3.

Day 2

20. On Day 2, Mr A had intermittent episodes of being unsettled and confused, and he experienced pain from the stump area of his amputation. His temperature was noted to be raised and he was not eating well. Ms B, Mr A's daughter, visited Mr A around lunch time on this day and recalls having to change her father's clothing as "his shirt was wet from sweating". She also recalls being told that Mr A had an infection.

21. At 1.17pm, nursing staff at the rest home faxed the NP, who recommended that a urine sample be collected, and said that the results would be reviewed by the NP the following day.

22. At 10.35pm, Mr A was again noted to be confused, and the registered nurse on duty noted that his abdomen was slightly distended, so administered a laxative for constipation. She documented that an enema would be given to Mr A early the following morning.

[5] A chronic condition where the body either does not produce enough insulin, or it resists insulin.
[6] Inadequate blood flow.
[7] Nurse practitioners are health practitioners who have advanced education, clinical training, and demonstrated competency. They have the legal authority to practise beyond the level of a registered nurse and, in some cases, can prescribe medication.
[8] Relevant dates are referred to as Days 1–3 to protect privacy.

23. The registered nurse on duty also noted that the antibiotic charted[9] for Mr A on Medimap[10] had yet to be delivered to the rest home.

Day 3

24. At approximately 5am on Day 3, Mr A began calling out and demonstrated increased confusion, and according to the clinical documentation was "not his usual self". Both his temperature and respiratory rate were elevated.

25. In response to these symptoms, Mr A was given analgesia at 5.23am (his regular paracetamol prescribed for pain relief) and oxygen therapy with good effect. He became settled and was responding to staff as usual. Documentation states that Mr A was monitored until the end of the morning shift, and that he had a possible chest infection and a urinary tract infection.

26. At 6am, Mr A was given clonazepam[11] to reduce his anxiety, and a suppository for his bowels.

27. Oceania told HDC that at 7.35am nursing staff telephoned Ms B to inform her of Mr A's condition earlier that morning, and to advise of the interventions that had been taken and to let her know that he had been stabilised and would be reviewed by the NP later in the day. According to the communication log, Ms B was content with this explanation and appreciative of the call.

28. Conversely, Ms B told HDC that at approximately 5am she received a voicemail on her cell phone from the registered nurse on duty at the rest home to inform her that Mr A was not well, had a high temperature, and was receiving oxygen therapy. Ms B did not receive the voicemail until she woke that morning and turned on her cell phone, and did not receive a telephone call on her landline. She telephoned the rest home at approximately 7am before travelling to the rest home.

29. At 8.25am, Mr A's heart rate was recorded as 123 beats per minute (bpm) (his usual heart rate was 78–80bpm).

30. A registered nurse on duty telephoned the NP at 8.40am to request a visit. The NP saw Mr A at 9.44am and spoke with the family members who were present, including Ms B. The NP noted that Mr A's temperature was elevated and he was short of breath, but that his amputation site showed no signs of infection. Her impression was of a chest infection, and she recommended oral antibiotics and a review in the morning. However, because she was yet to be authorised to prescribe medication, the NP was required to discuss her

[9] The process of "charting" involves adding medication prescriptions to a charting system so that the information is available for all the healthcare providers who have access to the system.
[10] A cloud-based medicine charting system used in many aged-care settings.
[11] A benzodiazepine medication used to calm the brain and nerves.

assessment with Mr A's GP, Dr C, so that Dr C could authorise the prescription.[12] However, authorisation of the prescription did not occur.

31. Dr C told HDC that the procedure at the time for prescribing in the local rest homes involved the NP performing an assessment of unwell patients, and then, if required, telephoning or visiting their GP practice to ask them to authorise any prescriptions on the online prescribing system (in this case Medi-map). The NP told HDC that she was in contact with a registered nurse at the GP practice but was unable to be transferred directly to Dr C, so she sent her notes through to the practice on Medi-map and also faxed a request for Dr C's approval of the antibiotics, as per policy at the time.

32. At 1.55pm it was documented that Mr A's temperature had elevated further, and that his oxygen saturation[13] had dropped rapidly when oxygen therapy was discontinued for a short time. Mr A's respiration rate had varied over the course of the day. Nursing staff were told by the NP that Augmentin[14] for a possible chest infection was to be charted, as was a request for urinalysis.[15] Paracetamol could not be administered for Mr A's raised temperature at this time because he had received his lunch-time dose one hour previously. His temperature was managed with a fan and tepid sponging.

33. It was also documented at 1.55pm that a text had been received from the NP, requesting confirmation of what medications Mr A had been given on the night of Day 2. The NP advised through text message that codeine should be withheld to reduce Mr A's constipation, and that she would be charting antibiotics soon. The NP also advised that she had discontinued Mr A's charted flucloxacillin[16] because the Augmentin she had charted would cover his infection. Laboratory forms were faxed to obtain blood tests and urinalysis that week.

34. When the registered nurse on duty checked Medi-map at 2.30pm, before handover to the afternoon nursing staff, she noticed that the antibiotics the NP said would be charted were not yet visible in Medi-map.[17] She advised the afternoon staff that the antibiotics were to be charted by the NP.

35. The registered nurse on duty at the time told HDC that she telephoned Ms B at 2.45pm to update her on the interventions ordered by the NP, and to let her know that the new antibiotic was still not available. However, Ms B told HDC that no such telephone conversation occurred. The "Communication with Family/Friend/Resident" log records this telephone conversation as having taken place at 2.25pm.

[12] Additions to patients' medications through Medi-map can be seen only by rest home staff and GPs, and do not become available for viewing by a pharmacy until the GP has selected "confirm" in the application.
[13] The level of oxygen in the blood.
[14] A broad-spectrum antibiotic used to treat a number of bacterial infections.
[15] Urine test used to detect and manage a wide range of disorders such as urinary tract infections.
[16] A narrow-spectrum antibiotic used to treat minor bacterial infections.
[17] If the GP has not yet approved the medication charted by the NP, it is not visible to other providers in Medi-map.

36. Oceania told HDC that when the antibiotic was eventually charted in Medi-map by the NP (time unknown), it had not been authorised by the GP in the system, which meant that staff were still unable to administer the medication as it was not visible on their prescription screen.

37. Oceania stated that the rest home received a pharmacy delivery at approximately 4pm. The delivery included flucloxacillin but no Augmentin. The registered nurse telephoned the pharmacy to follow up on the new antibiotic, and was advised that the pharmacy had assumed that there had been an administration error in charting, as authorisation had still not been made by the GP.

38. Ms B arrived back at the rest home at approximately 5pm. She told HDC that Mr A was in a distressed state with no staff in his room, or anywhere near his room, and no staff were available in the nurses station. Ms B reported having to seek assistance for her father from registered nurses who were occupied with other tasks.

39. Mr A was administered paracetamol elixir at approximately 6pm.[18] No opiate pain relief was given despite reports in the progress notes that Mr A was experiencing significant pain at a number of sites.

40. Authorisation for the charted Augmentin was completed, and the pharmacy delivered it to the rest home. Mr A was administered the Augmentin, but by this point a decision had been made to transfer him to hospital because he was febrile[19] (temperature 39.7°C) and had decreased oxygen saturations (88–89%).

41. The registered nurse on duty telephoned the Emergency Department (ED) and arranged transfer to the public hospital via ambulance at approximately 7pm. Oceania told HDC that Mr A's GP was not consulted prior to the decision being made, and that this is standard practice.

42. Mr A's End of Life form had been completed on admission to the rest home, with Ms B as his Enduring Power of Attorney (EPA). The form indicated that in the event of Mr A's health declining, comfort cares were to be provided on site as opposed to hospital admission. The nurse on duty when Mr A was transferred to hospital advised that she consulted Ms B with regard to the transfer.

43. Mr A was seen in the ED at approximately 8pm. He was diagnosed with suspected septicaemia and noted to be deteriorating. Intravenous Augmentin was administered.

44. Mr A continued to deteriorate rapidly, and at 10.15pm he passed away with his family around him.

[18] Ms B told HDC that she is concerned that there was more than a four-hour gap between doses of paracetamol being administered to Mr A.
[19] He had a fever.

Further information from Medical Centre 1

45. The NP's understanding was that the registered nurses at the rest home would continue to monitor and provide the required level of care to Mr A, and would contact the on-call GP if he deteriorated after hours.

46. As part of the review process after the events that preceded Mr A's death, the NP and a GP from Medical Centre 1 together identified the following areas for improvement:

- Improve accessibility to GPs of non-registered patients, with a clear pathway and understanding by all parties.
- Direct access/phone contact with GPs of non-registered patients to discuss acutely unwell patients.
- Direct access/phone contact to GP when requesting urgent medication changes based on individual clients, assessments, and diagnosis. This should ensure a reduced delay in time to be loaded into Medi-map and then approved, that is, it would be done directly by the GP.

Further information from Medical Centre 2

47. Dr C explained to HDC that when the NP performed an assessment of Mr A on Day 3, she charted Augmentin onto Medi-map but did not make verbal contact with the GP practice in the usual way. Instead, she sent an online "consult template" through to Dr C, which detailed her assessment and recommendations. This document was received in Dr C's inbox at 2.00pm, and she did not see it until much later in the day after the GP practice had closed.

48. Dr C told HDC that she reviews her inbox over the lunch-time period, but the document from the NP requesting Augmentin arrived after this time period, and she was not made aware that there was anything urgent required of her.

49. When Dr C did review the "consult template", she went online to authorise the prescription and found that it had already been done.

50. Dr C advised HDC that GPs now take full responsibility for the care of their rest-home patients when the NP allocated to the rest home is absent from work, rather than another NP covering for them.

Further information from Oceania

51. Mr A had a regular prescription for paracetamol to be administered four times daily. He was administered four doses on Day 1, four doses on Day 2, and three doses on Day 3. He was unable to have the fourth dose on Day 3 as he had been transferred to hospital.

52. On Day 3, between handover to the afternoon staff and Ms B's visit at dinner time, there had been three resident incidents that required the assessment skills of the nursing staff on duty. Two registered nurses were rostered on duty as per the usual roster, and an

additional registered nurse had been contacted before dinner time to provide additional support to the site to cover this busy period.

53. In this instance, the Augmentin had been entered on Mr A's patient chart by the NP in the early afternoon, but the GP had not authorised the prescription, meaning that there was a delay in the pharmacy dispensing it and the rest home receiving it.

54. At the time of events, the rest home was being managed by an offsite permanent manager from Oceania, and Oceania was actively recruiting for a permanent Clinical Manager. A temporary Clinical Manager was being utilised for day-to-day oversight. Currently the rest home is being managed by a permanent Business and Care Manager, with support from a permanent Clinical Manager.

55. At the time of events, the rest home did not have a policy relating to the escalation of care to GPs. The registered nurses were responsible for contacting GPs whenever they assessed individuals as requiring medical review, within and outside of daytime business hours.

56. External audits of the rest home undertaken in 2018 highlighted partial attainments, and ongoing corrective actions are taking place as a result of this.

Further information from the DHB

57. Ambulance notes from Mr A's transfer indicate that Mr A was feeling a little better in the cooler temperature of the ambulance. Ambulance staff also recorded that Mr A's oxygen saturations were 94–95% prior to administration of oxygen, and 98% after administering oxygen.

58. In October 2018, a meeting was arranged between members of the Planning and Funding Team (Health of Older People Portfolio Manager and the DHB Primary Nurse Lead) and the rest home's Clinical Nurse Manager, Facility Manager, and Regional Operations Manager. The following was discussed:

- At the time of events, the rest home did not have a Clinical Nurse Manager or on-site Facility Manager. The rest home was being overseen remotely by Oceania, but did not have regular consistent on-site leadership or management support.
- The rest home now has a stable Clinical Nurse Manager and a Facility Manager.
- The Regional Operations Manager at the rest home has secured an experienced Clinical Nurse Manager to provide mentoring and support for the rest home's Clinical Nurse Manager.
- Te Ara Whakapiri[20] was provided to the rest home's Clinical Nurse Manager. This will help staff to recognise end-of-life symptoms and assist communication with family members.

[20] An educative document to provide guidance to healthcare providers to promote quality care at the end of life for all adults in New Zealand.

- A hospice was contacted and asked to provide training support to staff. This has been completed.

59. Staff allocation and effective rostering have been a focus, as well as ensuring clear, consistent, and sensitive communication to residents' EPAs and whānau.

Response to provisional decision

60. Ms B was provided with an opportunity to respond to the "information gathered" section of the provisional decision. She reiterated that the experience was very stressful for her and her family, and that they are disappointed with what occurred. She also expressed her wish that other families not go through what hers did. Further, Ms B noted the changes to the services at the rest home since the incident, as outlined by the rest home, and hopes that they have indeed been implemented.

61. Further comment from Ms B has been incorporated into the report as appropriate.

62. Oceania was provided with an opportunity to respond to the provisional decision. Where appropriate, its comments have been incorporated above.

Relevant standards

63. The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) state:

> "Service Management Te Whakahaere Ratonga
>
> Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.
>
> …
>
> Family/whānau participation Urunga Whanau
>
> Standard 2.6 Family/whānau of choice are involved in the planning, implementation, and evaluation of the service to ensure services are responsive to the needs of individuals."

Opinion: Oceania Healthcare Limited — breach

Prescribing process

64. At the time of these events, the two NPs servicing the rest home had yet to be authorised to prescribe medication, but were entitled to make prescribing decisions that then required authorisation by the patient's GP. This was the accepted process at the rest home at the time.

65. On Day 3, the NP servicing the rest home prescribed Mr A antibiotics for a chest infection, but these were not visible in Medi-map (and therefore not administered to Mr A) until much later in the day. Mr A's GP had been unaware that the antibiotics had been charted, and therefore had not authorised the prescription.

66. My expert advisor, RN Rachel Parmee, said that this is an unusual prescribing system. She stated:

> "If … the nurse practitioner was not authorised to prescribe, I would not expect that they would be carrying out a clinical assessment leading to a prescription which is charted on Medi-map awaiting authorisation of the GP. I would expect the person making the prescription to be the person who authorises it and to have the recognised qualification and authority to authorise the prescription. In other words if the nurse [practitioner] was not an authorised medication prescriber, she should not have been making prescribing decisions."

67. I note that in this case, the NP was following the accepted process at the rest home at the time. Further, at the time there was no direct access/phone contact with the GP when requesting urgent medication changes based on individual clients, assessments, and diagnosis.

Monitoring and documentation

68. Over the course of the day on Day 3 there was a steady rise in Mr A's temperature, and his oxygen saturations varied in response to oxygen therapy. His respiration rate also varied, and on the one occasion when his heart rate was checked it was elevated. Documentation records that Mr A was "not his usual self". This is in the context of Mr A's age and history of peripheral vascular disease presumably related to his diabetes and heart disease.

69. RN Parmee advised that these symptoms are all indicators of pain, infection, and significant deterioration in status. She noted that Mr A's clinical notes show that his temperature was recorded when it was first noted that he was exhibiting signs of delirium, but his temperature was not recorded in the observation chart. RN Parmee advised that it is very important that such recordings are charted in order to provide a clear clinical picture of the development of a period of deterioration.

70. RN Parmee also advised that in the case of ongoing cognitive difficulty, as was the case for Mr A, expected practice would be to use a pain tool and to record pain observations, along with the effects of any interventions.

71. RN Parmee noted that given Mr A's change in normal eating habits, as documented in his progress notes, it would have been useful to implement a food and fluid monitoring chart, especially in light of his potential inability to self-report.

72. RN Parmee advised:

> "Each of these records is important in providing a clear clinical picture for both medical and nursing staff. Progress notes and verbal handovers cannot be relied on when multiple carers are involved.
>
> …
>
> [T]here does not appear to be a clear picture which would communicate the severity of [Mr A's] condition and decline over [Day 2 and Day 3].
>
> …
>
> This is a reasonably significant departure given that [Mr A] appeared to end his life with an emergency transfer to hospital amidst the assertion by [rest home] staff that they were not aware that he was dying. More comprehensive monitoring in terms of recording all observations [and] the use of pain and food and fluid measurement may well have made the rapid decline in [Mr A's] status more apparent."

Medication and urinalysis

73. Mr A's paracetamol was administered regularly over the course of Days 2 and 3. RN Parmee advised that this fell within an acceptable time frame.

74. Mr A was observed to be experiencing pain, discomfort, and agitation. However, despite this, all the available options in the form of PRN medication[21] to provide comfort and relief to Mr A were not utilised. Clonazepam was administered only once despite several reports of unusual levels of confusion and agitation. RN Parmee noted that no opiate pain relief was given despite reports in the progress notes that Mr A was experiencing significant pain at a number of sites. Codeine, an opiate, was withheld owing to its potential to exacerbate Mr A's constipation.

75. RN Parmee advised:

> "Available PRN medications should have been given consistently and reviewed for their effectiveness, thus providing [comfort cares]. I accept there was a rapid decline in [Mr A's] status but believe, based on the information provided, that the integration of more robust monitoring and use of PRN medication may have led to a more comfortable outcome for him."

76. A urinalysis did not occur prior to Mr A's admission to hospital despite being requested by the NP during her visit to the rest home on the morning of Day 3.

[21] Pro re nata medication, meaning to be taken as needed.

77. RN Parmee advised that although the urinalysis in itself would not have changed the outcome for Mr A, it would have provided further evidence of the source of infection and cause of his delirium, thus prompting the use of interventions other than antibiotics alone.

Communication with family

78. There are discrepancies in the information provided to HDC regarding the number and nature of communications with Ms B, in particular on Days 2 and 3.

79. Documentation indicates that Ms B was informed of her father's condition on the morning of Day 3, but does not indicate how the information was relayed. Ms B states that she did not receive the voicemail from the registered nurse until 7.00am, as it was left on her cell phone, which was turned off. She also told HDC that she did not receive a telephone call on her landline.

80. Oceania told HDC that a telephone call was made by the registered nurse on duty after 2.00pm on Day 3 to let Ms B know that her father's condition had deteriorated. Ms B told HDC that no such telephone call occurred. I note that contemporaneous records show that the telephone call was made, and therefore find it more likely than not that the call did take place.

81. RN Parmee advised that it is standard practice not to leave messages unless other avenues have been exhausted, such as using a landline if available (as it was in this case) or contacting another listed family member. RN Parmee considers that the practice of leaving messages or texts is a serious departure from accepted practice, unless this has been specifically agreed to, for the following reasons:

- Messages may not be received in a timely manner.
- The information being relayed is likely to be of an urgent or sensitive nature and should be given through a person-to-person conversation to ensure that the message is given clearly and in a timely manner, and so the recipient is given the opportunity to seek clarification and be provided with comfort.
- Leaving messages is always open to misinterpretation or the possibility that messages are not received.

Hospital transfer

82. Mr A was transferred to the public hospital at approximately 7pm on Day 3, as he was febrile and had decreased oxygen saturations. Although this was contrary to his End of Life documentation, the transfer was discussed with and agreed upon by Ms B, who held an EPA for Mr A. Mr A's GP was not consulted prior to the transfer, and the decision was made during a telephone call between a registered nurse at the rest home and the ED, as was standard practice at the rest home.

83. RN Parmee advised:

> "[T]he decision to transfer [an elderly person in Mr A's condition to hospital] should be clearly documented with rationale based on the reasonably anticipated outcome

> for such an intervention. There were measures in place to provide satisfactory care of [Mr A's] increased temperature and fluctuating oxygen saturations. It is agreed that he was deteriorating rapidly and would have benefitted from continued comfort cares in his home environment. I believe the decision to transfer to hospital was based on poor assessment of the context of [Mr A's] health issues and therefore constitutes a significant departure from accepted practice."

Conclusion

84. The NZHDSS require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.[22] Oceania, who owned the rest home at the time of the care in question, had the ultimate responsibility for ensuring that Mr A received care that was of an appropriate standard and that complied with the NZHDSS and the Code of Health and Disability Service Consumers' Rights (the Code). Oceania needed to have in place adequate systems, policies, and procedures, and then ensure compliance with those policies and procedures, so that the end-of-life care provided to Mr A was appropriate. His deteriorating health should have been closely monitored at the time, with a clear plan of care established to ensure that the support provided and the actions of nursing and support staff were well co-ordinated and responsive to his rapid decline. Oceania also has a responsibility for the actions of its staff.

85. I accept RN Parmee's advice on the care provided to Mr A at the rest home on Days 2 and 3. In my view, the prescribing system in place at the time was inadequate in that it inappropriately allowed NPs who were not authorised prescribers to make prescribing decisions. Further, the system did not allow for decisions regarding urgent medications to be fast-tracked, and there was no means for enabling direct or urgent access to a GP (although I note that improvements have been made in this regard). The monitoring and documentation of Mr A's condition was also inadequate, and there was a missed opportunity to administer PRN medication and to undertake urinalysis. Further, I agree with RN Parmee that staff at the rest home fell short in terms of communication with Mr A's family, and that the decision to transfer Mr A to hospital not long before he died was inappropriate in the circumstances, and that comfort cares could have been provided at the rest home as per Mr A's End of Life documentation.

86. Whilst I acknowledge that there was a lack of stable management at the rest home at the time of these events, in my opinion Mr A was let down by various aspects of the care provided to him by numerous staff at the rest home. I have carefully considered the extent to which the deficiencies in Mr A's care occurred as a result of individual staff action or inaction, as opposed to systems and organisational issues. The problems that arose with Mr A's care were not the result of isolated incidents involving one or two staff members. Several staff members provided care to Mr A over the course of the last two days of his life and, as outlined above, there were a number of occasions on which poor care was provided.

[22] NZS 8134.1:2008, Standard 2.2.

87. I therefore find that Oceania did not provide Mr A services with reasonable care and skill, and, accordingly, that it breached Right 4(1)[23] of the Code.

Recommendations

88. I recommend that Oceania provide a written apology to Mr A's family. The apology is to be sent to HDC within five weeks of the date of this report, for forwarding.

89. I note that the rest home is no longer owned and operated by Oceania and has a new Clinical Nurse Manager and a Facility Manager. With this in mind, I recommend that Oceania review its national systems to ensure that consistent policies are in place at all of its facilities relating to appropriate prescribing processes and the escalation of care to GPs and on-call GPs, and that Oceania report back to HDC on this within five months of the date of this report.

90. I also recommend that the following improvements to end-of-life care, as outlined by my expert advisor, be reflected upon and broadly incorporated as appropriate into all Oceania facilities nationwide, and that Oceania provide HDC with an update on this within five months of the date of this report:

- Implementation of objective pain assessment tools and stringent recording of observations and attention to the pattern of these observations.
- Education around the consistent planning of care based on observations, around the use of PRN medications, and around the recognition of rapidly changing status and discussion of appropriate interventions.
- Consultation with a GP when there is a significant deterioration in an elderly patient's status.
- Implementation of policies that messages to next of kin be relayed person to person, and that discussions with the patient and the patient's family take place prior to admission to hospital.

Follow-up actions

91. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Oceania Healthcare Limited, will be sent to HealthCert (Ministry of Health), the DHB, and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"1. Thank you for the request to provide clinical advice regarding the complaint from [Ms B] in relation to the care of her late father [Mr A] at [the rest home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is co-ordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mr A] at [the rest home] was reasonable in the circumstances and why. With particular comment on:

a. Monitoring of [Mr A's] condition from [Day 1] onwards.

b. The appropriateness of the care provided to [Mr A], including the provision of medication.

c. The standard of documentation, including medication administration records.

d. The standard of communication with [Mr A's] attending clinicians.

e. The standard of communication with [Ms B].

f. Any other matters that I consider warrant comment.

For each question I am asked to advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

c. How would it be viewed by peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

4. In preparing this report I have reviewed the documentation on file:

1. Letter of complaint […], with supporting documentation.

2. Response from Oceania Healthcare dated [2017].

3. Clinical records from Oceania Healthcare [dated 2017].

4. Comments on Oceania's response from [Ms B].

5. Background. [Ms B] raises concerns about the nursing and end of life care provided to her late father, [Mr A], at [the rest home]. She is concerned that his condition was not monitored carefully enough, and staff were therefore unresponsive to his rapid decline. She questions the medication given to her father, and whether adequate comfort cares were provided. She also has concerns about the level of information she received regarding her father's deteriorating condition, and the quality of the staff's documentation. My comments are confined to the actions of [rest home] staff.

6. Monitoring of [Mr A's] condition from [Day 1] onwards. Evidence provided to indicate how [Mr A's] condition was monitored from [Day 1] is contained in forms recording observation of vital signs and restraint monitoring, along with comments made in progress notes. The observation chart recording vital signs (temperature, pulse and blood pressure) indicates that recordings were last taken [about three weeks' previous] prior to recordings being taken on ten separate occasions [a week earlier]. These recordings consisted of temperature recordings being taken four times during the night shift (2300 to 0700), twice on the morning shift (0835 and1330) and twice on the afternoon shift at 1800 and 1820 prior to [Mr A's] transfer to hospital. Respiration rate and oxygen saturation percentage were recorded on five occasions during the night shift, two occasions during the morning shift and once on the afternoon shift. There was a steady rise in [Mr A's] temperature over this period from 37.5 degrees (Celsius) at 0500 through to 39 degrees at 1800. His oxygen saturations varied from 83% to 97% in response to oxygen therapy. His respiration rate ranged from 28 to 32 breaths per minute over the day. Heart rate was only recorded once at 0825 elevated from [Mr A's] usual 78 to 80 beats per minute to 123. All of these recordings are indicators of pain, infection and significant deterioration in status. [Mr A] had bedrails in place to prevent him rolling out of bed. This is considered a form of restraint and required formal consent and hourly monitoring while [Mr A] was in bed. As [Mr A] was in bed all day on [Day 3] hourly checks were recorded. These notes indicate that [Mr A] was awake and in pain from 0500 to 0700. He is then recorded as

being awake and receiving usual care between 0800 and 1400. Between 1400 and 1600 he is recorded as sleeping. He is recorded as awake and eating a very small amount at 1700 and having a temperature of 39 degrees at 1800. Progress notes from [Day 1] record that [Mr A] was eating and drinking well and receiving dressings to his wounds and not complaining of pain. On [Day 2] notes state that his temperature is recorded at 38.7 degrees at 0140 (not noted on observation chart). The 1300 notes state that [Mr A] was confused and in a lot of pain. It was also noted that he had little appetite and that the Nurse Practitioner would see him the following morning. Additional notes on [Day 2] again refer to a raised temperature (not recorded on observation chart) confusion and anxiety. The Nurse Practitioner was contacted via fax. In her response she asked for a urinalysis to be completed (to identify possible urinary tract infection). Afternoon notes state [Mr A] was very confused and refusing meals. At 2235 it again states that [Mr A] was confused and had a distended abdomen following 3 days with no bowel movement. Medication (Lactulose) was given for his bowels and his temperature was stated to be 36.2 degrees (not charted). On [Day 3] at 0743 it was noted that [Mr A] had increased confusion and 'was not his usual self'. His temperature and respiration rate were increased. He was given paracetamol for the fever, clonazepam drops for agitation, and a suppository for his bowels. These measures are stated to have had a good effect. The notes also state that [Mr A] was 'monitored all throughout until end of shift'. The notes also state that [Mr A] may have a chest infection — 'quite chesty earlier' and urinary tract infection (urinalysis not completed). Notes from the morning shift of [Day 3] (0845) state that [Mr A] did not appear well and notes observations of elevated temperature, respiration rate and decreased oxygen saturation. Notes written at 1355 note his elevated temperature and rapid drop in oxygen saturation after oxygen therapy was discontinued for a short time. It is also noted that he has been charted Augmentin for a possible chest infection and a further request for urinalysis.

a. What is the standard of care/accepted practice? The expectation for recording vital signs in residential aged care settings, such as [the rest home], is that they are done once a month unless there is a change in health status. Therefore it is reasonable that the last set of observations taken was nearly a month earlier. However the clinical notes state that temperature recordings were taken when it was first noted that [Mr A] was exhibiting signs of delirium (increased confusion and anxiety). These were not recorded on the observation chart. It is important that these are charted in order to provide a clear clinical picture of the development of a period of deterioration such as [Mr A's] fever and related infection(s). It would also be expected that a pain tool would be used and pain observations recorded along with the effects of any interventions. It appears that [Mr A] had some ongoing cognitive difficulty which would indicate the need for an objective pain measurement tool rather than relying on him to report pain. The Abbey Assessment Scale is an example of such a tool (Brown, 2011). It also appears from the progress notes and restraint chart observations that [Mr A] had a change to his normal eating habits. Again given his potential inability to self-report and the possibility that he was constipated it would have been useful to implement a food and fluid monitoring chart. Each of these

records is important in providing a clear clinical picture for both medical and nursing staff. Progress notes and verbal handovers cannot be relied on when multiple carers are involved.

b. If there has been a departure from the standard of care or accepted practice, and how significant departure this is? While monitoring is evident on at least a four hourly basis (vital signs) and one hourly in relation to the restraint protocol there does not appear to be a clear picture which would communicate the severity of [Mr A's] condition and decline over [Day 2] and [Day 3]. This is a reasonably significant departure given that [Mr A] appeared to end his life with an emergency transfer to hospital amidst the assertion by [rest home] staff that they were not aware that he was dying. More comprehensive monitoring in terms of recording all observations, the use of pain and food and fluid measurement may well have made the rapid decline in [Mr A's] status more apparent.

c. How would it be viewed by your peers? I believe my peers in education and practice would agree that more consistent and congruent monitoring may have led to an earlier understanding of the severity of [Mr A's] condition and the implementation of end of life comfort cares.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future. I would recommend implementation of an objective pain assessment tool such as the Abbey pain scale and more stringent recording of observations and attention to the pattern of these observations. A clearer picture in terms of documentation and review of this documentation would potentially lead to timelier introduction of end of life care.

7. The appropriateness of the care provided to [Mr A], including the provision of medication. There was clearly an issue in the timeliness of prescribing and administering antibiotics to [Mr A]. However it is beyond my brief to discuss this. I can however comment on the response to assessments made by [rest home] staff. Inspection of the Medications Administration Record indicates that [Mr A] was administered his prescribed regular Paracetamol 4 times on [Day 2] and [Day 3]. [Ms B] notes that there was more than a four hour gap between doses administered. She also notes that the bedtime dose of Paracetamol was recorded as given when [Mr A] was in hospital rather than at [the rest home]. The 1600 (given at 1720) dose of Paracetamol given on [Day 3] is noted in the progress notes as being in the form of elixir (presumably as [Mr A] was unable to take tablet form at this stage). This change is not commented on in the Medication administration chart. [Mr A] was given Clonazepam (prescribed to reduce anxiety) on one occasion at 0600 on [Day 3]. [Mr A] was given additional pain relief in the form of Codeine Phosphate at 0145 for sacral pain on [Day 2] and Tramadol for stump pain [2 days earlier] at 2030. Non pharmacological methods, 'cooling measures and sponge' used to provide comfort and reduce fever were noted in the progress notes as being provided during the early morning on [Day 3] (0743) and again at 1355. The progress notes indicate that a urinalysis did not occur prior to [Mr A's] admission to hospital despite being requested

by the Nurse Practitioner during her visit on the morning of [Day 2]. [Mr A] was transferred to hospital during the evening of [Day 3] where he subsequently passed away.

a. What is the standard of care/accepted practice? The standard of practice is that regular medications are given at prescribed times. In this case the regular paracetamol (prescribed for pain relief) was given 4 times each day. While the ideal situation would be that patients are given medications exactly on time this is not a reality in the residential care setting where a number of patients are prescribed medications to be administered at the same time and is physically impossible for staff to administer all at the same time. [Mr A's] paracetamol was given on [Day 2] at 0718, 1230, 1615 and 20.04. On [Day 3] the breakfast dose was given early at 0523 in an attempt to reduce his temperature and then at 1157 and 1720 (elixir as recorded in progress notes). These times fall within an acceptable time frame. The bedtime dosage for [Day 3] is recorded twice firstly as administered and immediately noted that this was an error which was corrected to 'not administered' in the record. PRN (as necessary) medication is prescribed for administration when there is a predictable change in status such as increased pain or agitation. Each time PRN medication was recorded as being administered nursing staff have provided a rationale for giving the medication. For example Clonazepam for anxiety and Codeine Phosphate for sacral pain. This is accepted practice and meets the standard. It is reported often in the literature (Brown, 2011) that PRN medication, particularly for pain is underutilised in the elderly, particularly those with cognitive impairment.

b. If there has been a departure from the standard of care or accepted practice, and how significant departure this is? As stated above I believe there has not been a departure in the standard of care with regard to the regular timely administration of Paracetamol. Although not recorded in the medication chart the substitution of paracetamol elixir appears reasonable for the 1600 dose on [Day 3]. Had circumstances been different it would be expected that the medication subsequently be re charted by the prescriber to reflect the change in form of the drug. However, the use of PRN medication was a significant departure from the expected standard of care given the descriptions of [Mr A's] pain, discomfort and agitation. It appears that these symptoms were observed and documented without the use of available options to provide comfort and relief for [Mr A]. Opiate pain relief was given only once [just prior to these events] despite reports in the progress notes that [Mr A] was experiencing significant pain at a number of sites ([Day 2], 1300). Clonazepam was administered only once despite several reports of unusual levels of confusion and agitation. It was stated that codeine phosphate was withheld due to its potential to exacerbate [Mr A's] constipation. Available PRN medications should have been given consistently and reviewed for their effectiveness, thus providing the comfort cares [Ms B] states that her father did not receive. I accept that there was a rapid decline in [Mr A's] status but believe, based on the information provided, that the integration of more robust monitoring and use of PRN medication may have led to a more comfortable outcome for him. While the urinalysis in itself would not change the outcome for [Mr A] it

would have provided further evidence of the source of infection and cause of his delirium and thus prompting the use of interventions other than antibiotics alone.

c. How would it be viewed by your peers? I believe my peers in education and practice would agree that there were measures available to increase [Mr A's] comfort during [Day 2] and [Day 3]. They would agree that planned interventions should have taken place given [Mr A's] evidence of infection, pain and agitation.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future. Along with recommendations made in the section on monitoring of [Mr A's] condition I would recommend education around the consistent planning of care based on observations and the use of PRN medications. I would also recommend recognition of rapidly changing status and discussing appropriate interventions in order to prevent the situation of emergency admission to hospital in a situation of impending end of life.

8. The standard of documentation, including medication administration records. The standard of documentation, including medication records have been discussed in earlier sections. To reiterate, there appear to be several discrepancies between statements (particularly observations) made in the progress notes and records on other documents (e.g. temperatures noted in progress notes and not recorded on observation charts and information on restraint monitoring documents). I have also recommended the use of an objective pain assessment tool and recording of effectiveness of interventions. Along with this records of food and fluid intake needed to be implemented to monitor nutrition and hydration status. Monitoring of hydration is particularly important in the light of infection and delirium. These discrepancies and the lack of use of appropriate tools have contributed to what appears to be an incomplete picture of [Mr A's] rapidly declining status and consequent possible lack of provision of all possible comfort cares. I have commented that the record of administration of regular medications indicates that the standard of care is being met. While I strongly challenge the lack of use of PRN medication the documentation of such medications when given is acceptable.

9. The standard of communication with [Mr A's] attending clinicians. The evidence provided indicates that there was a reasonable standard of communication with staff at the medical centre in terms of reporting [Mr A's] vital signs and requesting that he be seen on [Day 3] following his deterioration during the previous night. There were also regular inquiries about the arrival of the prescribed antibiotics. Discussion of the events surrounding the acquisition of the antibiotics is beyond my brief. It is not clear in the progress notes how the decision to transfer to hospital was arrived at. It is not clear whether consultation with the general practice took place prior to hospitalisation.

a. What is the standard of care/accepted practice? Given that [Mr A] had been seen by the nurse practitioner earlier in the day I would assume that his deteriorating condition would be discussed with the general practice prior to admission to hospital.

It is unclear what the rationale was for admission. The only reported indication that [Mr A's] condition was grave was the report of [Ms B] that the ambulance officers stated that he was very unwell.

b. If there has been a departure from the standard of care or accepted practice, and how significant departure this is? There is insufficient evidence for me to comment on a departure from the standard of care as it is not clear how the decision to admit [Mr A] to hospital came about or whether the general practice was consulted. In my experience of working in older adult residential care it would be accepted practice to admit to hospital only if there was a clear indication that advanced secondary care (eg IV medications or surgery) were clearly indicated as being beneficial to the patient in terms of quality of life in contrast to comfort cares in a familiar environment, with the decision being the result of discussion with family and the patient.

c. How would it be viewed by your peers? I believe my peers would agree with my position but I am reluctant to make a comment about decisions in this particular case.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future. I would recommend that the GP be consulted when there is a significant deterioration in an elderly patient's status and that a conversation takes place with family and patient prior to admission to hospital.

10. The standard of communication with [Ms B]. There appear to be discrepancies in terms of the amount and nature of communications with [Ms B] particularly during [Day 2] and [Day 3]. Progress notes indicate that [Ms B] was informed of her father's condition on the morning of [Day 3]. The note does not indicate how this information was relayed (e.g. message left or spoke directly to [Ms B]). [Ms B] states that the message was not received until 0700 as it was left on her cell phone which was turned off. She says she did not receive a call on her landline. She also states that she did receive a message that was left for her at 1425 on [Day 3] stating [Mr A's] condition had deteriorated. [The] (Clinical and Quality Manager, Oceania Health care) states in her letter of [2017] that a phone call was made at 1425 on [Day 3]. There is no information indicating that the caller actually spoke with [Ms B] or that a message was left.

a. What is the standard of care/accepted practice? The accepted practice in residential care facilities is that a record of correspondence with relatives is kept in a separate log in patient's notes. This record notes whether there was a conversation or message left, the information relayed and the signature and designation of the staff member making contact. It is standard practice not to leave messages unless other avenues have been exhausted such as using a landline if available (as it was in this case) or contacting another listed family member.

b. If there has been a departure from the standard of care or accepted practice, and how significant departure this is? The practice of leaving messages or texts is a reasonably serious departure from accepted practice, unless this has been specifically

agreed to, for a number of reasons. Firstly, as in this case, there can be the possibility that messages are not received in a timely manner. Secondly, the information being relayed is likely to be of an urgent or sensitive nature and should be given through a person to person conversation to ensure that the message is given clearly and in a timely manner and there is opportunity for the recipient to seek clarification or be provided with comfort. Leaving messages is always open to misinterpretation or the possibility that messages are not received. It is in the interest of all concerned that messages are relayed person to person and recorded in a separate record in the patient's notes.

c. How would it be viewed by your peers? My peers in education and practice would agree with my comments with the view that it is beneficial to all parties.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future. Implement a policy that messages to next of kin be relayed person to person and that a form be developed to record all such correspondence. In conclusion I believe there were discrepancies in the nature and standard of monitoring of [Mr A's] condition. I have recommended that all observations be recorded along with the implementation of objective pain assessment tools and monitoring of food intake and hydration. Regular medications were administered in a timely fashion and recorded appropriately. The restraint observation recordings indicate that [Mr A] was seen hourly but do not provide sufficient information about responses to observations and consequent planning of care. Response to observations and the utilisation of PRN medications and comfort cares in response to [Mr A's] deteriorating condition were, I believe, below accepted standard. Communication with the General Practice was appropriate in response to [Mr A's] condition earlier in the day but there is no evidence to state that their input was asked for in the decision to transfer to hospital. Discrepancies exist between [Ms B] and [rest home] staff reports of communication with [Ms B] about her father's deteriorating condition. Recommendations have been made about the nature and recording of such conversations.

Reference

Brown, D. (2011) Pain Assessment with Cognitively Impaired Older People in the Acute Hospital Setting Rev Pain. 5(3): 18–22. doi: 10.1177/204946371100500305 Rachel Parmee 20/12/2017

Additional Comments (13/04/2019)

Thank you for the opportunity to provide further advice on this case. In particular I am reviewing:

1. Events surrounding [Mr A's] transfer to [the public hospital] on [Day 3].

2. The standard of communication with [Mr A's] family during the lead up to his admission to [the public hospital].

I have been provided with the following information to assist with my review:

a) Clinical notes from [the public hospital] Emergency Department, [ambulance service] summary and transfer documents from [the rest home].

b) Further response from [the rest home])

c) Additional clinical notes from [the rest home] and statements from [the] (Quality Manager) and [two nurses].

1. Events surrounding [Mr A's] transfer to [the public hospital] on [Day 3]. [Mr A] was transferred to the public hospital following a call to [the ambulance service] at 7.05pm on [Day 3]. I have received further information on the rationale for the transfer and who was involved in the decision to transfer. [The] (Facility Manger) quotes progress notes written by [two nurses] to provide rationale for the decision to transfer [Mr A] to the public hospital at 22.40. The rationale for the transfer appears to be that [Mr A] was febrile (temperature 39.7) and had decreased oxygen saturations (88–89%). [Mr A] states that the GP was not consulted at the time the decision to transfer was made and that the decision to transfer was made during a phone call between [a nurse] and the Emergency Department at the public hospital. [Mr A] states that this is standard practice. [The public hospital's Chief Executive] states in his letter dated 11th March 2019 that there was no record of a call from [the rest home] to the Emergency Department, which does not necessarily imply that the call did not happen. In her notes written at 2240 [a nurse] states that ED was contacted and ambulance called. She does [not] state a time for this or the content of the conversation with ED. It appears from these notes that the rationale was raised temperature and lowered oxygen saturation. I believe there has been a significant departure from accepted practice in terms of rationale for transfer and poor documentation of the decision making process. This finding is based on the following information.

1. Increased temperature. [Mr A's] temperature had been increasing through the day and was responding to the use of Paracetamol and cooling cares. The Nurse Practitioner had put in place measures to assist with identifying the source of infection (testing of urine and blood). She had arranged for a further antibiotic to be prescribed. Although there had been a delay in obtaining the second antibiotic it had arrived and been administered prior to [Mr A's] transfer to hospital. There was no indication in the notes written earlier in the day that the Nurse Practitioner recommended transfer to hospital. Given [Mr A's] status, when he was visited by the Nurse Practitioner, and subsequent communication between her and nursing staff I would expect that she would have made such a recommendation if warranted. The ambulance staff noted that [Mr A] said he was feeling a little better in the cooler temperature of the vehicle which may indicate that continued cooling cares at [the rest home] would have been effective in managing his comfort.

2. Decreased oxygen saturation. The clinical notes indicate that [Mr A's] oxygen saturations had dropped during the day and that he responded well to the administration of oxygen on these occasions. The progress notes indicate that [Mr A's] oxygen saturation had dropped to 88/89% prior to the decision to transfer him to hospital. As he was mouth breathing the decision was made to change delivery

of oxygen from nasal prongs to a mask. There is no record of oxygen saturations being taken to assess the effectiveness of this intervention. The ambulance staff recorded that [Mr A's] oxygen saturations were 94/95% prior to administration of oxygen and 98% after administering oxygen. Therefore prior to admission to the Emergency department [Mr A's] oxygen saturations had reached normal range using interventions that were available at [the rest home]. Lapum, Verkuyl, Garcia, St Amant and Tan (2018) state in their online textbook for nurses that older adults typically have lower oxygen saturation levels than younger adults. For example, someone older than 70 years of age may have an oxygen saturation level of about 95%, which is an acceptable level. They also state that underlying pathophysiology may affect oxygen saturation levels such as peripheral vascular and heart disease. Given that [Mr A], who was [in his nineties], had peripheral vascular disease presumably related to his diabetes and heart disease he fitted well within the parameters for a lower oxygen saturation level to be acceptable.

3. End of life decisions. The documentation provided by [the public hospital] includes a Not for Resuscitation decision. In my experience of caring for older adults, my colleagues and I would consider that a 'Not for Resuscitation' discussion should include not only what measures should be taken in the event of cardiac arrest, but also discussion about the use of intravenous antibiotics and fluids which appear to be the only conceivable rationale for hospitalisation. There is no documentation of the discussion which took place when the Not for Resuscitation decision was made. Had this discussion taken place with [Mr A] and his family prior to his deterioration it may well have influenced the decision to transfer to hospital. In conclusion, the decision to transfer to hospital of an elderly person in [Mr A's] situation should be clearly documented with rationale based on the reasonably anticipated outcome for such an intervention. There were measures in place to provide satisfactory care of his increased temperature and fluctuating oxygen saturations. It is agreed that he was deteriorating rapidly and would have benefitted from continued comfort cares in his home environment. I believe the decision to transfer to hospital was based on poor assessment of the context of [Mr A's] health status and therefore constitutes a significant departure from accepted practice.

2. The standard of communication with [Mr A's] family during the lead up to his admission to the public hospital. In my initial report I commented that it was acceptable practice that a log be kept of communication with relatives. Such a log has been provided subsequently. The entry timed at 0735 on [Day 3] clearly documents the conversation with [Ms B] describing [Mr A's] fever, shortness of breath and anxiety and the plan for review with the Clinical Nurse Specialist (?Nurse Practitioner). This entry also notes that [Ms B] was appreciative of the call. The second entry at 1415 simply states 'updated about GP plan'. It does not state whether [Ms B], or any other family member, was actually spoken to or a message left and does not indicate there was information given that [Mr A's] condition was deteriorating. While this information does document that there was a phone call at 0735 it does not provide any further information that can throw light on discrepancies between [Ms B's]

recollections and those of the nursing staff. My decision remains that this represents a significant departure from expected practice.

Further Reference

Lampum, J. L., Verkuyl, M., Garcia, W., St-Amant, O., & Tan, A. (2018). Vital sign measurement across the lifespan: 1st Canadian Edition. doi:https://opentextbc.ca/vitalsign/ Rachel Parmee (13/04/2019)."

The following further advice was received from RN Parmee:

"I have reviewed my report on this case and your question regarding the prescription charting and administration of medications at [the rest home] during the time [Mr A] was resident there. You have asked that I comment on the process of a nurse practitioner (in this case not an authorised medication prescriber) visiting the rest home, performing a clinical assessment and referring back to the patient's GP for any medication changes or further medications needed. Once added to Medi-map by the nurse practitioner the GP had to authorise the prescription before it would show in the system.

By way of background I am aware that there have been recent changes to the legislation around Registered Nurse prescribing. My understanding from the Nursing Council of New Zealand is that Nurse Practitioners, by definition, are authorised to prescribe within their area of competence and assume that this was the case in 2017. From 2019 nurses who have completed a post graduate qualification in prescribing (i.e not Nurse Practitioners) are able to prescribe in community and primary health settings such as General Practice. The Council states that these nurses can prescribe from a restricted list of medicines for specific common and long-term conditions including the following: hypertension, respiratory diseases including asthma and COPD, anxiety, depression, heart failure, gout, palliative care, contraception, vaccines, common skin conditions and infections. [Mr A's] situation would fall into this category.

While I acknowledge that the incidents related to [Mr A] at [the rest home] occurred in 2017, prior to the change in legislation, I would expect that a nurse employed as a nurse practitioner in a General Practice would be qualified and working within the Nurse Practitioner scope of practice for primary health care, including authorisation to prescribe for the conditions listed above.

If, as you state, the nurse practitioner was not authorised to prescribe, I would not expect that they would be carrying out a clinical assessment leading to a prescription which is charted on Medi-map awaiting authorisation of the GP. I would expect the person making the prescription to be the person who authorises it and to have the recognised qualification and authority to authorise the prescription. In other words if the nurse was not an authorised medication prescriber, she should not have been making prescribing decisions."