Rest Home

Registered Nurse, RN C

A Report by the

Deputy Health and Disability Commissioner

Case 17HDC01484

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mrs A, aged 85 years, was a resident at a rest home.

2. In 2017, Mrs A was discovered choking in the dining room of the rest home by a caregiver, Ms D. Ms D administered two back slaps before Registered Nurse (RN) RN C took charge.

3. RN C found Mrs A to be unresponsive, with no signs of breathing and no radial pulse. She instructed another nurse to call 111, and administered four hard back slaps.

4. When the back slaps proved to be ineffective, RN C moved Mrs A from the dining room and lowered her onto the floor, where she again checked for a pulse and any signs of breathing. RN C made no attempt to perform CPR while waiting for the ambulance to arrive.

5. When the paramedics arrived, they found that mashed potato was blocking Mrs A's airway. No cardiac pulse could be found, and subsequently Mrs A was pronounced dead.

Findings

6. The Deputy Commissioner found that by failing to commence CPR once Mrs A was first assessed as non-responsive, RN C failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

7. Adverse comment was made about RN C's incomplete documentation of the event, as well as her inadequate communication with the family following Mrs A's death.

8. By providing annual "Basic Life Support" training to staff, the Deputy Commissioner found that the rest home had taken such steps as were reasonably practicable to prevent RN C's breach of the Code. As such, the rest home company was not found in breach of the Code.

Recommendations

9. The Deputy Commissioner recommended that RN C provide a written apology to the family for her breach of the Code.

10. The Deputy Commissioner recommended that the Nursing Council of New Zealand undertake a competency review of RN C's emergency responses.

11. The Deputy Commissioner recommended that the rest home develop a system for monitoring compliance of practical training of "Basic Life Support" for its non-clinical staff, and send all staff involved in this event to a full first aid/CPR Level 2 course.

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

Complaint and investigation

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

- *Whether RN C provided Mrs A with an appropriate standard of care in 2017.*
- *Whether the rest home provided Mrs A with an appropriate standard of care in 2017.*

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

14. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant
Rest home	Provider
RN C	Provider/registered nurse

Also mentioned in this report:

Ms D	Caregiver
Ms E	Caregiver

15. Independent expert advice was obtained from a registered nurse, Megan Sendall, and is included as Appendix A.

Information gathered during investigation

16. Mrs A, aged 85 years, was a resident at the rest home. When Mrs A's nutritional preferences were reviewed, it was noted that she had swallowing difficulties, but no risk of choking was identified.

17. Shortly after 12.30pm, Mrs A was discovered choking in the dining room when the desserts were being delivered.

18. An incident report completed after the event indicates that the choking episode occurred around 12.45pm. A caregiver, Ms D, stated in the incident report:

> "[Mrs A] touched my hand and I realised that she was choking. I called to [another caregiver,] [Ms E, who] ran and got [RN C] … I banged on her back X2 to try and dislodge what was there. That didn't work, [and the registered nurse] [RN C] came and took over straight away …"

19. RN C's report of the event was attached to the incident form:

> "On assessment, [Mrs A] was cyanosed and struggling to take a breath. I instructed [assistant] to ring 111 for an ambulance. I attempted a back slap but this was of no effect. [Mrs A] was becoming more cyanosed and unable to take a breath. She began to have involuntary movement of [her] shoulders as if she was going to vomit which did not happen. I pushed [Mrs A] from the dining room on her chair. When I reached the doorway [Mrs A] slumped further in her chair and involuntary body movement occurred. At this stage [another nurse] had returned from lunch. Neither her nor myself could feel a radial pulse, and I could not feel the carotid pulse. We then moved [Mrs A] on her chair away from the doorway and out into the foyer … we lowered [Mrs A] to the floor, at this time the ambulance arrived and ambulance staff took over her care."

20. RN C reflected on the incident, and on 30 June 2017 amended her statement to say that she gave four back slaps in the dining room.

21. RN C told HDC:

> "[A]t approximately 12.45pm I was in the office when [Ms D] came in and said … [Mrs A] was choking. I got up and ran to the dining room. Before reaching her, I instructed [a nurse] to ring 111 … I found [Mrs A] to be totally unresponsive, face, tongue and lips were cyanosed, her mouth was open, her eyes were wide open, pupils were involuntary flickering side to side and gurgling sounds were audible.
>
> I attempted to look in her mouth to see if any foreign body was visible, this was not successful due to the position of her tongue. There were no signs of breathing, and I could not feel a radial pulse …
>
> I immediately commenced back slaps. As I was administering the slaps I needed to hold [Mrs A's] torso to stop her from falling forward because she was unconscious … When I reached [Mrs A], [Ms D] advised me that she had administered 2 back slaps. I carried out four hard back slaps, these were ineffective … There was still no response from her …
>
> [Mrs A] was unconscious. I realised at this time that I would not have been able to deliver chest thrusts with any benefit due to the position [Mrs A] was in …
>
> My plan was to get her on the floor and administer compressions to try and dislodge whatever was blocking her airway …
>
> At this stage I considered my options. The overriding factor that influenced my decision to move [Mrs A] from the dining room was limited space where she was but there were other factors that influenced my decision to move her. Space in the room, accessibility to where she was for Ambulance staff to carry out their treatment and how quickly I could remove her from the dining room. Dignity was a small part of the

> decision but was not the deciding factor … I knew I could quickly and safely remove her from the dining room."

22. RN C said that it took her between 15 to 30 seconds to move Mrs A the eight metres to the door.

23. RN C told HDC:

> "On reaching the doorway, [Mrs A] suffered a full body convulsion, she went completely flaccid, she slid further down in her chair, her skin was changing to a pale grey. Her head had dropped forward. I could not feel a carotid or radial pulse. Another Registered Nurse had arrived she also tried to locate a pulse but was unable to do so. We called for a Caregiver to help lower [Mrs A] onto the floor a short distance to where there was more room. She was completely flaccid and showing no signs of life. Following lowering her to the floor, the other RN and I again checked for pulse, checked chest for any signs of breathing. There were no signs of pulse or breathing, I again checked in her mouth to see if any foreign body was visible there was nothing visible. I was then informed that the ambulance had arrived."

24. The ambulance was called at 12.44pm and arrived at 12.49pm. The paramedics positioned ECG[2] leads on Mrs A and discovered no cardiac output. A paramedic advised RN C that mashed potato was blocking her airway. No cardiac pulse could be found, and Mrs A was pronounced dead.

25. Ms B told HDC that the following day she discussed the event with RN C, who advised her that she had given back slaps but not chest thrusts, and had "dragged the chair out of the dining room to preserve [Mrs A's] dignity". Ms B said that she complained to HDC because she was concerned that the correct choking procedure had not been followed, and that the correct procedure may have saved her mother's life.

Further information from RN C

26. RN C told HDC that she did not prioritise Mrs A's privacy over maintaining her life. She thought that it would be quicker to move Mrs A a distance of eight metres as opposed to moving chairs and residents — "many of who[m] have walkers" — out of the way, and to lower Mrs A to the floor in the dining room.

27. RN C acknowledged that her communication could have been better. She stated:

> "I am … aware that when talking with [Mrs A's daughter] after her mother's death that I informed her that I removed [Mrs A] from the dining room for her dignity … I should have extended this statement with expressing the other factors that [led] to my decision to remove her Mother from the dining room and that by not having a much fuller conversation with them at the time has left them with questions and I apologise for this. At the time I should have been much more detailed in what had happened. I was motivated to try and minimise the shock for them."

[2] Electrocardiogram — a machine that measures the electrical activity of the heart.

28. RN C also acknowledged that her documentation was "below standard", and has caused unnecessary additional stress and raised questions for Mrs A's family. RN C stated: "After the event I was in shock and distracted. I should have thought more fully about leaving a comprehensive record." She said that she has reflected on how she can do this in the future.

29. RN C offered her sincere apologies for the distress and concerns the family had surrounding the circumstances of Mrs A's death.

Further information from the rest home

30. The rest home told HDC that Ms D did not administer chest thrusts because she understood from her training that chest thrusts were not to be administered because they could break ribs. The rest home confirmed with the trainer that it had told staff not to give abdominal thrusts because they can cause damage. The rest home told HDC that Ms D had become confused between chest and abdominal thrusts. The trainer was asked to clarify this distinction at further training sessions.

31. The rest home reiterated that RN C believed that it would be quicker to move Mrs A to provide treatment for choking, and that CPR[3] would have been her next step, but the ambulance arrived just after they lowered Mrs A to the floor.

32. The rest home told HDC that the trainer delivers "Basic Life Support" training, which includes training about what to do in the event of choking. This is delivered annually, and complies with the Ministry of Health's Health and Disability Standards. The revalidation certificate is valid for a period of two years.

33. Ms D completed her refresher course in September 2015, and RN C completed hers in September 2016.

34. At the time of the incident, the rest home did not have a dedicated choking policy.

35. In response to this incident, the rest home developed a choking policy,[4] provided documentation training for RN C, and held a reflective practice discussion for the registered nurses at their professional development day on 26 September 2017.

36. The choking policy states that if a patient is responsive, the staff member is to administer five back blows, alternating with five chest thrusts and, if the patient is unconscious, the staff member is to continue with CPR until the ambulance arrives.

Responses to provisional opinion

37. Mrs A's family was provided with an opportunity to comment on the "information gathered" section of the provisional opinion. The family reiterated their concerns about the treatment Mrs A received, and stated: "[I]f [Mrs A] had no pulse and was not breathing

[3] Cardiopulmonary resuscitation — chest compressions, often with artificial breathing, to attempt to preserve circulation and brain function until further treatment can occur to restore circulation.
[4] Implemented in October 2017.

before being moved from the dining room, we would have expected that she would be lowered to the floor and CPR commenced immediately."

38. The rest home and RN C were provided with the opportunity to comment on the relevant sections of the provisional opinion, and both advised that they had no further comments.

Opinion: RN C

Response to choking — breach

39. RN C was the registered nurse who responded to caregiver Ms D's call for help when she discovered Mrs A choking in the dining room. RN C told HDC that when she was alerted at around 12.45pm, she was in the office. She ran to the dining room and instructed another nurse to ring for an ambulance.

40. RN C told HDC that she immediately commenced back slaps. She said that Mrs A was unconscious at this time. RN C stated that she administered four backslaps without effect, but no chest thrusts, because of Mrs A's positioning in her chair.

41. RN C told HDC that her decision to move Mrs A to the foyer was made predominantly because of the limited space in the dining room, but also because of accessibility for the ambulance staff, and that dignity was also a small part of the decision. RN C said that she believed she could remove Mrs A from the dining room very quickly, and that it took between 15 and 30 seconds.

42. RN C stated that she and another registered nurse then checked Mrs A's pulse and breathing multiple times. RN C said that she checked in Mrs A's mouth again for a foreign object, and sought assistance from a caregiver to lower Mrs A onto the floor. RN C told HDC that she intended to begin CPR, but the ambulance arrived. The ambulance was called at 12.44pm and arrived at 12.49pm.

43. My expert advisor, RN Megan Sendall, noted that the New Zealand Resuscitation Council (NZRC) Guidelines related to choking require a responder to assess the choking person quickly and ensure that:

> "5 back blows followed by 5 chest thrusts are immediately instigated and repeated until the blockage is dislodged or the person loses consciousness. If the latter occurs, whether or not the blockage is considered in situ, the responder is required to commence CPR. The rationale is to maintain circulation to the vital organs regardless of the person's ability to receive breathing support. Chest compressions may dislodge the obstruction hence the need to act swiftly."

44. RN Sendall advised that despite the rest home not having a choking policy, the training provided by the trainer was consistent with the requirements of the NZRC, and she considers that RN C had been trained sufficiently.

45. RN Sendall noted that RN C documented in her sequence of events four separate observations that Mrs A was unresponsive or unconscious. RN Sendall said:

> "It is considered important to commence CPR as prescribed as soon as loss of consciousness occurs … It is considered a [matter] of urgency to identify loss of consciousness or unresponsiveness to commence CPR. Following initial assessment of [Mrs A's] loss of consciousness, action should have included lowering [Mrs A] to the floor in the dining room to continue with emergency actions. Moving [Mrs A] to another space, alongside not responding at the first sign of unresponsiveness caused a delay in action and used valuable time."

46. I accept this advice. Five minutes had elapsed from the time of calling the ambulance, to the time of its arrival, during which time RN C should have commenced CPR.

47. RN Sendall advised:

> "I have little doubt that [RN C] and [Ms D] acted with the best of intentions however in this instance the delay in acting in accordance with training requirements is noted."

48. RN Sendall considers RN C's conduct in the circumstances to have been a moderate departure from accepted practice.

49. I acknowledge that the ambulance staff discovered that the foreign object was soft mashed potato, and therefore it was unlikely to have been dislodged even with chest compressions. Regardless, when Mrs A was first assessed as non-responsive, RN C should have proceeded to commence CPR urgently. Accordingly, RN C failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1).

Communication and documentation — adverse comment

50. Initially, RN C documented that she administered a back slap with no effect, so she moved Mrs A to the foyer to continue treatment. She in fact administered four back slaps, and then made a decision to move Mrs A (for a number of reasons, not initially documented, as set out above). Despite her other reasons, RN C initially told Ms B that the decision to move her mother from the dining room was made "for [her mother's] dignity".

51. RN C acknowledges that she should have left a more comprehensive record of events, and that her documentation was "below standard" and caused additional unnecessary stress for Mrs A's family. RN C also acknowledges that her communication with Mrs A's family should have been better, and that she should have provided more detailed reasoning for Ms B.

52. I am critical of RN C's incomplete documentation and inadequate communication, which caused uncertainty and stress for Mrs A's family. I remind RN C of the importance of effective communication, including her responsibility to give full and clear information and to ensure that the person to whom she is communicating understands the information given. I also remind RN C of the importance of real-time robust and thorough documentation.

Opinion: Rest home — no breach

53. RN C was an employee of the rest home at the time of the incident. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing authority may be vicariously liable for any act or omission by an employee. Under section 72(5) of the Act, it is a defence for an employing authority if it can prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

54. The rest home told HDC that it provided training according to the Ministry of Health requirements, which included what to do in the event of choking. However, Ms D, having attended the training, was not sure what to do. She said she thought that providing chest thrusts was not allowed because it would break the person's ribs. I acknowledge that she correctly called for help from a registered nurse and then administered two back blows before the nurse arrived and took over treatment. The rest home has requested that its trainer address the misunderstanding regarding chest and abdominal thrusts, in all future training sessions.

55. RN C knew what to do but failed to follow the prescribed training she had received. She did not administer five back blows followed by five chest thrusts, and did not perform CPR when she had assessed Mrs A as unconscious.

56. I am satisfied that by providing annual "Basic Life Support" training to staff, the rest home had taken such steps as were reasonably practicable to prevent RN C's breach of the Code.

Recommendations

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

58. I recommend that the Nursing Council of New Zealand undertake a competency review of RN C's emergency responses (including to choking), to ensure that in future her responses will be timely and adequate. The Nursing Council of New Zealand is to provide HDC with a copy of the completed review.

59. I recommend that the rest home:

    a) Develop a system for monitoring compliance of practical training of "Basic Life Support" for its non-clinical staff such as caregivers, for example by running regular practice sessions over and above the official training sessions. Evidence of the system developed should be provided to HDC within six months of the date of this report.

b) Send all staff involved in this event to a full first aid/CPR Level 2 course, and provide evidence of this within three months of the date of this report.

Follow-up actions

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

61. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Coroner and the New Zealand Resuscitation Council, and will be 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 Megan Sendall:

"Assessment of care provided to [Mrs A] was conducted through review of relevant documents supplied to [the] Health and Disability [Commissioner] by [the rest home]. Key areas of enquiry relate to care, in this case emergency response to resident choking provided to [Mrs A] by [RN C].

In particular:

- Whether [RN C] should have removed [Mrs A] from the dining room to the foyer of [the rest home] before contemplating chest thrusts and subsequently CPR or whether she should have administered chest thrusts in the dining room.

Advice includes:

- The accepted standard of care/practice
- Departure from standard practice and how significant this is considered to be
- How this is viewed by my peers
- Recommendations for improvement

The review process considered the following aspects of internal resources to support staff in the implementation of their duties alongside experience of key staff and application of policy:

- Policy
- Cardio Pulmonary Resuscitation (CPR) training
- [RN C's] length of employment at the facility/experience

Policy and CPR Training

[The rest home] provides a range of policy documents to guide care however a specific policy related to choking was not available to staff at the time of the event. Regardless of the absence of a specific choking policy, records show staff had undergone and completed training in CPR including choking during the last two years as per District Health Board Aged Residential Care contract requirements. New Zealand Resuscitation Council (NZRC) Guidelines are utilised in New Zealand CPR education across a range of training providers and include [the training provider] utilised by [the rest home]. These are consistent throughout New Zealand to provide all recipients of training a clear understanding of effective response in a range of life threatening events.

Choking happens from time to time in aged residential care for both people assessed as high risk of choking and others with multiple comorbidities who are frail but not assessed and identified as at risk of choking. In all cases choking should be responded to with speed and skill as CPR guidelines indicate this reduces the likelihood of avoidable death.

New Zealand Resuscitation Council (NZRC) Guidelines related to choking require responders to observe a person's attempts to alert others of their situation generally through gestures of distress alongside observation of absence of speech and breathing or difficulty in breathing. Following swift assessment, 5 back blows followed by 5 chest thrusts are immediately instigated and repeated until the blockage is dislodged or the person loses consciousness. If the latter occurs whether or not the blockage is considered in situ, the responder is required to commence CPR. The rationale is to maintain circulation to the vital organs regardless of the person's ability to receive breathing support. Chest compressions may dislodge the obstruction hence the need to act swiftly.

In this case accepted practice was not followed by administering 5 back blows followed by 5 chest thrusts and repeated as required until the blockage was dislodged or as in this case [Mrs A] lost consciousness. It is considered a matter of urgency to commence CPR and immediate action following [Mrs A's] loss of consciousness would include lowering [Mrs A] to the floor in the dining room to commence CPR and maintain circulation until emergency services arrived.

Summary

CPR guidelines for choking record a sequence of 5 back blows followed by 5 chest thrusts repeated until the obstruction is cleared or the person loses consciousness in which case CPR is immediately commenced. [RN C] failed to administer back blows and chest thrusts as prescribed by NZRC followed by commencing CPR immediately following [Mrs A's] loss of consciousness where the event occurred in the dining room. Instead, moving [Mrs A] to another space may have consumed vital moments when action could have occurred.

Choking occurs quickly and in all cases training includes swift response to promote an optimal outcome. It was considered by [RN C] that removing the resident from the dining room to preserve her privacy was a higher priority than completing the cycle of back blows and chest thrusts and following [Mrs A's] loss of consciousness, commencing CPR. It is viewed by my peers that attempts at maintaining life is a higher priority than preserving privacy when choking occurs. In this case there was a significant departure from the standard of care and accepted practice in responding to a person choking and following NZRC guidelines to prevent avoidable death.

Education and training was available to support staff maintaining knowledge and skills appropriate to services delivered. [RN C] had completed appropriate training within 2 years prior to the [events]. In this instance she varied from accepted practice and moved the resident prior to completing the prescribed NZRC action. She did not immediately start CPR upon identifying loss of consciousness.

Recommendations

Staff involved were not clear about appropriate actions required when responding to a resident choking. One staff member failed to initiate required NZRC choking

response and called for an RN. She did however give 2 back blows and call for help. This was the first responder who would have saved vital time if she had started a sequence of back blows and chest thrusts immediately after calling for assistance and before help arrived. When [RN C] arrived at the scene, a sequence of back blows and chest thrusts was again not immediately initiated although some attempts at back slaps were recorded as delivered. Vital moments were lost.

- It is recommended that all staff involved in this event complete a full First Aid/CPR Level 2 course to ensure all aspects of first aid are clear and practised, information up to date and refreshed. This would include rationale for moving a person to perform vital life support in the event of choking.
- Competency review should be undertaken and completed by [RN C] to ensure that competencies related to direction and delegation and emergency response are completed. In this way [RN C] can ensure her future response and actions related to choking are timely and appropriate to meet NZRC guidelines and meet Nursing Council of New Zealand direction and delegation responsibilities for Health Care Assistants under her supervision."

RN Sendall provided the following additional expert advice:

"Assessment of care provided to [Mrs A] was conducted through review of relevant documents supplied to the Health and Disability Commissioner's office by [the rest home]. Key areas of enquiry relate to emergency care provided to [Mrs A] by [RN C].

In particular:

1. Whether [RN C] should have removed [Mrs A] from the dining room to the foyer of [the rest home] before contemplating chest thrusts and subsequently CPR or whether she should have administered chest thrusts in the dining room.
2. Whether [RN C] should have administered back slaps to a patient she had determined was unconscious.
3. Whether [RN C] should have commenced CPR immediately following observation of loss of consciousness, in accordance with the trainer training requirements for choking.

Advice included:

a. The accepted standard of care/practice
b. Departure from standard practice and how significant this was considered to be
c. How this was viewed by my peers
d. Recommendations for improvement

The review process considered the following aspects of internal resources to support staff in the implementation of their duties alongside experience of key staff and application of policy:

- Policy

- Cardio Pulmonary Resuscitation (CPR) training and programme content
- [RN C's] experience and length of employment at [the rest home].

In addition to the expert advice provided to the Commissioner's office regarding care provided to [Mrs A], a second request was made by the Commissioner's office to review a statement from [RN C] following her receipt and consideration of expert advice and notification of investigation. Documents from [the rest home] were received 15th August 2018 and included:

- [RN C's] statement dated 29.6.18
- CPR training attendance documents 2017
- CPR training programme contents 2017

The request required the expert advisor to 'consider whether the responses to notification changes your advice with regards to the severity of the breaches and if so please set out the reasons why'.

A request to review a recently developed choking policy dated October 2017 was sent on 28 August 2018 by the advisor and received 29 August 2018. The policy, titled Choking Policy, references [the trainer's first aid manual], is labelled [rest home] and signed by [the General Manager].

Review of additional documents and a second statement provided by [RN C] considered a more detailed account of her actions prior to moving [Mrs A] from [the rest home] dining room. Review of the later statement notes [RN C's] sincere and heartfelt apology to the family. [RN C] documents reflective activities have occurred following the incident which include a response to her lack of documentation, incomplete information to family that identified maintaining dignity as the reason for moving [Mrs A] to the foyer in order to minimise 'the shock' to family. [RN C] went on to document that a more detailed explanation of the rationale to move [Mrs A] should have occurred.

[RN C] documented her immediate actions following a request from CA [Ms E] to attend [Mrs A] in the dining room. Her second statement includes rationale for her decision making regarding her sequence of actions that day. Her sequence of observations and actions were as follows:

1. Observation of [Mrs A] as slightly slumped in chair with CA [Ms D] standing by her side. In her statement [RN C] documents the first responder was 'standing, leaning over her ([Mrs A]) but was not administering any treatment'.
2. Instructing [an enrolled nurse] to ring for emergency assistance and inform the emergency call receiver that a resident was choking.
3. Assessment was described as follows 'I found her to be totally unresponsive.' [RN C] documents she called [Mrs A's] name 3 times. She went on to record she

observed [Mrs A's] face, tongue and lips were cyanosed, and her eyes wide open, pupils flicking from side to side. She was making audible gurgling sounds.

4. [RN C] then proceeded to attempt to identify the obstruction 'I attempted to look in her mouth'.

   This was unsuccessful due to [Mrs A's] position and level of consciousness.

5. [RN C] documented 'There were no signs of breathing and I could not feel a radial pulse.' During this time [Mrs A] remained in the dining room and in her chair.

6. [RN C] documented her attempts to deliver back blows whilst noting [Mrs A] was 'unconscious'. 'I immediately commenced back slaps.' 'As I was administering back slaps I needed to hold [Mrs A's] torso to stop her from falling forward because she was not conscious.' 'I placed my elbow in front of her shoulder and put my hand on her other shoulder and put my forearm under her chin to hold her head up.'

7. [RN C] went on to document that she delivered 4 back slaps with no effect.

8. Following administering 4 back slaps, [RN C] recorded [Mrs A] experienced jerky, involuntary movements of her shoulders. She remained 'unresponsive' at this time. Her body then began to 'slouch down in the chair'.

9. [RN C] described her next actions by recording she stood in front of [Mrs A's] chair and pushed the chair 8 meters to the entrance of the dining room. She estimated this took 15 to 30 seconds.

10. At the dining room door, she recorded she observed [Mrs A] having a 'full body convulsion' following which [Mrs A] 'went completely flaccid, slipped further down her chair and her skin changed colour to pale grey. Her head dropped forward.' [RN C] reported she could not feel a carotid or radial pulse at this time.

11. [RN C] documents she called for another CA. Another RN had arrived. They helped [RN C] move [Mrs A] a 'short distance where there was more room' and lowered her to the floor. 'She ([Mrs A]) was showing no signs of life.'

12. [RN C] documented that her assessment of the situation continued when she and the other RN again 'checked for pulse, checked for signs of breathing, checked the oral cavity for a foreign body' at which stage [RN C] recorded the ambulance arrived and paramedics took over care of [Mrs A].

Earlier advice to the Commissioner's office included the following statement:

> *'[The trainer's] CPR course description records dated 2017 include a sequence of actions prescribed to effect the most positive outcome for a choking adult.*
>
> *In this instance [RN C], although attending swiftly at the request of another staff member and with the best of intentions described in her statement, deviated from the prescribed course of action provided through the [trainer's] training programme.*

[RN C] and the first responder were both trained to deliver emergency support to residents. This included adult choking.'

During the sequence of events described by [RN C] in her second more detailed statement several assessments and observations were made and actions taken. At 4 separate points in the sequence of events described and documented by [RN C], it is noted that [Mrs A] was observed as unresponsive or unconscious (points 3, 6, 8 and 11). Information provided to [RN C] and [Ms D] during CPR training identifies the course of action required following identification of a person suspected of choking and following observation of loss of consciousness. This includes commencing CPR. It is thought that chest compressions can support dislodging an airway obstruction if not relieved earlier by back slaps and or chest thrusts prior to loss of consciousness. For this reason, it is considered important to commence CPR as prescribed as soon as loss of consciousness occurs.

[The rest home] provides a range of policy documents to guide care however a specific policy related to choking was not available to staff at the time of the event. Regardless of the absence of a specific choking policy, records show staff had undergone and completed training in CPR including choking during the last two years as per District Health Board Aged Residential Care contract requirements. New Zealand Resuscitation Council (NZRC) Guidelines are utilised in New Zealand CPR education across a range of training providers and include [the training provider] utilised by [the rest home]. These are consistent throughout New Zealand to provide all recipients of training a clear understanding of effective response in a range of life threatening events.

As advised earlier, choking happens from time to time in aged residential care for both people assessed as high risk of choking and others with multiple comorbidities who are frail but not assessed and identified as at risk of choking. In all cases choking should be responded to with speed and skill as CPR guidelines indicate this reduces the likelihood of avoidable death.

New Zealand Resuscitation Council (NZRC) Guidelines related to choking require responders to observe a person's attempts to alert others of their situation generally through gestures of distress alongside observation of absence of speech and breathing or difficulty in breathing. Following swift assessment, 5 back blows followed by 5 chest thrusts are immediately instigated and repeated until the blockage is dislodged or the person loses consciousness. If the latter occurs, whether or not the blockage is considered in situ, the responder is required to commence CPR. The rationale is to maintain circulation to the vital organs regardless of the person's ability to receive breathing support. Chest compressions may dislodge the obstruction hence the need to act swiftly.

In this case accepted practice was not followed by administering 5 back blows followed by 5 chest thrusts and repeated as required until the blockage was dislodged or as in this case [Mrs A] lost consciousness. It is considered a matter of urgency to

identify loss of consciousness or unresponsiveness to commence CPR. Following initial assessment of [Mrs A's] loss of consciousness, action should have included lowering [Mrs A] to the floor in the dining room to continue with emergency actions. Moving [Mrs A] to another space, alongside not responding at the first sign of unresponsiveness caused a delay in action and used valuable time.

Summary

[RN C] has offered a heartfelt apology to family which is noted as genuine and sincere. This has been a stressful time for all concerned in particular [Mrs A's] family and others close to her but also for staff who were involved in this event. I have little doubt that [RN C] and [Ms D] acted with the best of intentions however in this instance the delay in acting in accordance with training requirements is noted.

After reviewing the response/statement provided by [RN C] and additional documentation provided including the [rest home's] Choking Policy developed after this event, my advice to the Commissioner's office remains unchanged.

Training provided by [the trainer] attended by both [RN C] and CA [Ms D] included actions following identification of a choking person and management of the unconscious/unresponsive person suspected of choking. Intervention to manage a choking resident failed to meet training expectations following which CPR was not facilitated as required immediately upon assessment for responsiveness which may have potentially dislodged an obstruction.

Valuable, vital moments were lost when both the first and second responder in this situation failed to follow [the trainer's] training requirements for choking."

HDC requested the following clarification from RN Sendall:

"I note your comment in the previous advice:

> 'It is considered a [matter] of urgency to identify loss of consciousness or unresponsiveness to commence CPR. Following initial assessment of [Mrs A's] loss of consciousness, action should have included lowering [Mrs A] to the floor in the dining room to continue with emergency actions. Moving [Mrs A] to another space, alongside not responding at the first sign of unresponsiveness caused a delay in action and used valuable time.'

Can you please indicate whether you consider [RN C's] actions to be a mild, moderate or severe departure from the accepted standard of care?"

RN Sendall provided the following comment:

"After revisiting this complaint/advice and considering the events as they presented, I believe there was a moderate departure from expected practice."