Bupa Care Services NZ Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 17HDC01279)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided by a rest home to a woman whose condition deteriorated over a four-day period in 2017. During that time, the woman experienced confusion, constipation, pain, and urinary incontinence. She was admitted to hospital after she lost consciousness and, sadly, she died from sepsis and cellulitis. The Deputy Commissioner commented that the woman's medical history suggested that she was likely to experience a progressive decline in her general function, and as such the various nursing staff involved in her care should have been alert to changes in her condition, and reacted more rapidly to new symptoms as they manifested.

2. The rest home was found in breach of Right 4(1) of the Code for an overall lack of response to the woman's declining condition, for nursing staff not assessing her blood sugar levels to rule out hyperglycaemia or hypoglycaemia in light of her diabetic history, for failing to contact a doctor earlier in response to her confusion and disorientation, and for missing opportunities to take into account her daughter's concerns. The Deputy Commissioner was also critical of a nurse for failing to manage the emergency situation appropriately when the woman lost consciousness.

3. The Deputy Commissioner recommended that the rest home provide a written apology to the family, schedule specific education sessions for the facility's nursing staff, use an anonymised version of this report as a case study to encourage staff reflection and discussion, and review its policy on clinical emergencies.

Complaint and investigation

4. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by Bupa Care Services NZ Limited to her late mother, Mrs A. The following issue was identified for investigation:

   - *Whether Bupa Care Services NZ Limited provided Mrs A with an appropriate standard of care in 2017.*

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

6. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Bupa Care Services NZ Limited	Provider

7. Further information was received from:

Dr C	General practitioner
Medical centre	
District Health Board	Provider
RN D	Registered nurse
RN E	Registered nurse
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
Ms I	Caregiver

8. Also mentioned in this report:

RN K	Registered nurse

9. Independent expert advice was obtained from Registered Nurse (RN) Megan Sendall (Appendix A).

Information gathered during investigation

Introduction

10. The facility provides rest-home and hospital-level care. It is owned and operated by Bupa Care Services NZ Limited (Bupa).

11. Mrs A (then aged in her eighties) was admitted to the rest home in 2017, initially for respite care. She was transferred to permanent hospital-level care. Mrs A's medical history included rectal and renal cancer, atrial fibrillation, congestive heart failure, osteomyelitis,[1] back pain, and diabetes mellitus. On admission, Mrs A was noted to have bilateral pitting oedema,[2] and three leg ulcers on her left leg, which were to be managed with silver and dressings. At the time of these events, Mrs A's dressings were being changed every two days. Mrs A had used oxygen treatment for congestive heart failure for a number of years at home, and this was continued at the rest home.

12. Mrs A was assessed as being continent, but required assistance for toileting and personal cares owing to her decreased mobility. The rest home stated:

> "[S]he was noted to be cognitively intact and communicated effectively and appropriately with staff. She would use her call bell to request assistance for her toileting needs."

[1] A bone infection.
[2] Observable swelling of body tissues due to fluid accumulation.

13. In response to the provisional opinion, Mrs A's daughter, Ms B, said that she and other family members witnessed that often her mother would wait for 15 minutes or longer for someone to answer her call bell to assist her with toileting.

14. Mrs A signed a "not for resuscitation" order but this did not exclude hospital admission for treatable conditions. In 2016, Mrs A had appointed her daughter, Ms B, to be her enduring power of attorney (EPoA) for her personal care and welfare, although this was not activated, as Mrs A retained capacity to make her own decisions.

15. This report considers the care provided to Mrs A over the period of four days prior to her admission to hospital.

Day 1[3]

16. On Day 1, Ms B visited Mrs A and reported to RN E that her mother had had an episode of haematochezia[4] the previous day. RN E updated the GP notebook with this information.[5] RN E documented that no bleeding was observed when Mrs A was toileted that day. There were no further observed incidences of bleeding.

17. Ms B told HDC that on this day, Mrs A told her that she was "not feeling right" but she could not explain what was wrong. Ms B said that she told her mother to make sure she saw the GP when he visited next.

Day 2

18. Mrs A was administered morphine at 6.24am by a nurse. Caregiver Ms I told HDC that she assisted Mrs A with her personal cares in the morning. Ms I documented in the progress notes that Mrs A's bowels did not open when toileted. Ms I stated that Mrs A did not complain of any discomfort or pain.

19. Mrs A's left lower leg dressing was changed on Day 2. The wound evaluation form states that the wound was 100% sloughy, yellow, and had a moderate amount of moisture. This was consistent with the previous two evaluations.

20. Ms B told HDC that she visited her mother on the evening of Day 2, and Mrs A told her that she "felt strange and had an odd body pain". Ms B stated that she told staff that her mother would like to see the GP, and was advised that her mother had been given morphine to settle her pain. There is no record of this conversation in the clinical notes.

21. The medication charts show that Mrs A was administered morphine at 9.16pm by RN H. RN H said that although he recalls seeing Mrs A's daughter visiting her, he did not have any direct contact with Mrs A's family.

[3] Relevant dates are referred to as Days 1–4 to protect privacy.
[4] The passage of blood in the faeces.
[5] Bupa told HDC that it uses this book to record the residents who need to be seen by the GP at the next clinic. It stated that during the GP's round, the nurse on duty makes notes, including the outcomes of the visit, and the GP then checks these off as completed.

Day 3

22. On Day 3, Mrs A was visited by her other daughter, and was found on her chair wet with urine from the waist down.

23. Ms I said that she assisted Mrs A with her personal cares at around 8.45am, and found that Mrs A's night pad and recliner chair were wet. Ms I stated that usually Mrs A was able to take herself to the toilet or ring her bell for assistance, but she did not do so that morning. Ms I told HDC that when she had served Mrs A breakfast at about 7.40am, the call bell was within her reach.

24. Ms I said that she assisted Mrs A to the toilet, and while Mrs A was sitting on the toilet, she replaced Mrs A's chair with a clean one, then washed, moisturised, and dressed Mrs A and changed her pad. Ms I documented that Mrs A's bowels did not open.

25. In respect of Mrs A being found wet with urine when visited by her family, Bupa stated:

> "Bupa accepts full responsibility that [Mrs A's] care needs were clearly not identified by staff at this time nor her care needs met. Bupa apologises unreservedly to her family for this."

26. RN F worked the morning shift on Day 3. She stated that she received a handover that Mrs A had had no bowel movement for four days, and that she had "on and off pain" that had been going on for the past few days and was managed by regular and PRN (as needed) pain relief. RN F said that otherwise she was not informed that Mrs A was unwell or that she had reported to her family that she was not feeling right.

27. RN F gave Mrs A her regular laxative and a Kiwi Crush drink, but she still did not have a bowel movement. Accordingly, RN F updated the GP notebook to request that the GP chart a further PRN laxative.

28. GP Dr C attended the rest home for his scheduled weekly visit on the afternoon of Day 3. There had been an earlier request from one of Mrs A's family members for Dr C to prescribe Mrs A diclofenac gel[6] for shoulder pain, and this was documented in the GP notebook. Dr C did not review Mrs A but prescribed diclofenac gel as well as an increased dose of the laxative Laxsol.

29. RN H worked the afternoon shift on Day 3. He said that there was no note in the GP notebook that Mrs A's family had requested that Dr C examine Mrs A physically. RN H stated: "If I had known that was what the family wanted, I would have followed this up in handover as to the reason and then requested the doctor examine [Mrs A]."

30. RN H documented at 10pm that Mrs A's bowels still had not opened even with the increased dose of Laxsol. He told HDC that the caregiver who had attended Mrs A during the afternoon shift had noted that Mrs A had had episodes of confusion at times, and recalled that this was slight disorientation as to time. RN H stated: "However, when I went

[6] An anti-inflammatory gel.

to check on [Mrs A] at the bedtime medication round, she seemed very settled and compliant."

Day 4

31. On the morning of Day 4, Ms I assisted Mrs A with her personal cares. Ms I documented that Mrs A's bowels had not opened, but her food and fluid intake was good. Ms I also recorded: "She's a bit confused and unsettled this morning, RN informed."

32. RN K worked the morning shift on Day 4. She recalls Ms I alerting her to the fact that Mrs A was a little confused and unsettled. RN K said that she interrupted her medication round and immediately went to see Mrs A. RN K stated:

> "I undertook … cardiovascular and pulmonary assessments, took her vital signs which were all within her normal range.[7] I noted that she had no increase in work of breathing, no peripheral or central blueness. [Mrs A] appeared to be more anxious rather than confused. At that time, I thought this was perhaps her wanting to go home and so I arranged for her to speak to her daughter by telephone. I was present while she spoke to her daughter and after that she appeared to be more settled. I spent a significant amount of time with [Mrs A], reassuring, hydrating, and repositioning her, and ensuring her comfort and alleviating signs of mental and physical distress."

33. Regarding the telephone call with her mother, Ms B said:

> "She made a couple of comments to me that didn't seem right at the time. I told her that I would come after work. She asked me to take her home (which we had promised to do in her last days of life, when that time came), then she said 'goodbye'. I asked the nurse how much morphine had she had that day. The reply was 'none, as she said she never had any pain and didn't need it'. I asked the nurse what was wrong with Mum then and her reply was 'we don't know'."

34. Ms B told HDC that she told RN K that her mother "was not right and was very confused". RN K told HDC that Mrs A's confusion was "no more than her typical behavior that [RN K] was used to dealing with before".

35. RN K said that she renewed the wound dressings on Mrs A's left lower leg, and observed that it had not improved nor significantly deteriorated since the last time she had seen the wounds (18 days previously). RN K said that she did not update the details on the wound evaluation form because of feeling "utterly under pressure to complete [her] other nursing jobs on that shift". However, she documented in the progress notes, "Wound dressing on [left] lower leg renewed," and signed on the wound evaluation form that she had assessed the wound.

36. RN K documented the following plan: "To continue to monitor and to do urine collection — send to lab if confusion continue[s]." RN K told HDC that she handed over to the

[7] Temperature 37.1°C, pulse 64 beats per minute, respirations 21 breaths per minute, oxygen saturation 96%.

afternoon nurse, RN E, that Mrs A had been confused and anxious, and made RN E aware of the plan to collect a urine sample. RN K also said that she advised RN E that she had commenced a fluid balance chart for Mrs A, and asked RN E to monitor Mrs A closely and check on her regularly.

37. RN K said that as Mrs A's vital signs were stable and she appeared to be comfortable with no more signs of confusion that shift, she decided not to request a visit from the GP.

38. RN E worked the afternoon shift on Day 4. She said that at the beginning of the shift, she greeted Mrs A, who was "like her usual self". RN E said that she informed Mrs A that she needed to take a urine sample, but Mrs A was not ready to go to the toilet. RN E said that when she left Mrs A's room, her call bell was in reach, and she reminded Mrs A to ring it if she needed assistance.

39. RN D was the duty leader at the rest home on the afternoon of Day 4. RN D said that at around 4–4.30pm she received a telephone call from RN E updating her that she had a resident, Mrs A, who was confused and wanted to go home. However, RN D said that RN E reported to her that Mrs A's vital signs were stable, she was afebrile, and she was alert and sitting up in a recliner chair.

40. At around 5.20pm, Mrs A was found semi-conscious by a caregiver. RN E said that the caregiver came to her and stated that Mrs A was not responding well. RN E said that as she was doing the medication round, she locked the medication trolley, then ran to Mrs A's room. She said that she found Mrs A sitting on her recliner chair, "head down towards her chest with a small amount of vomit and drooling saliva from her mouth".

41. RN E stated that she left the caregiver with Mrs A while she went to the staff room to get equipment to check Mrs A's vital signs. RN E documented these as: blood pressure 194/83mmHg, temperature 36.8°C, pulse 63 beats per minute, oxygen saturation 96% with oxygen, and respiratory rate 22 breaths per minute.

42. RN E recorded in the progress notes that at 5.28pm, she left a voice message for Dr C, and that Mrs A was unconscious. RN E told HDC that she had contacted the GP clinic, but was advised that Dr C was unavailable and should be contacted on his mobile. Therefore, RN E rang Dr C's mobile and left a message stating that Mrs A was "almost unconscious and reported her vital signs".

43. Ms B told HDC that she arrived to visit her mother at around 5.20pm, and her mother was unconscious in her chair with a caregiver standing next to her holding a sick bowl. Ms B stated:

> "I asked her what was wrong with Mum and where was the nurse. I immediately rang all the family and told them to get there as fast as they could as I thought she wasn't good … The carer told me the doctor had been rung shortly before."

44. RN E stated that she returned to Mrs A's room and spoke to Ms B. RN E said that she updated Ms B to let her know that staff would transfer Mrs A to her bed to make her more

comfortable, and that the GP had been contacted. Dr C told HDC that he received RN E's voice message just as he was about to drive home, and he attended the rest home immediately. In response to the provisional opinion, Ms B said that her mother was not placed on the bed until after Dr C arrived (detailed further below).

45. RN D said that RN E telephoned her again sometime around or after 5.30pm to advise that Mrs A had deteriorated and was not responding, and that she had left a message for the doctor, and he had called back and was on his way. RN D told RN E that she would come up to assist, but RN E said that she was "okay, they had put [Mrs A] back to bed and that another registered nurse [RN G] … was with her".

46. RN E said that she asked RN D whether Ms B should inform her relatives, and on RN D's advice RN E said that Ms B could do this. RN E stated that "within minutes the relatives all came and gathered in [Mrs A's] room".

47. RN E said that Mrs A tried to vomit a small amount, so she gave her a subcutaneous injection of metoclopramide (an anti-emetic) and Mrs A settled. RN E stated:

> "It was apparent from the family, that they were saying goodbye to their mother and at this point I felt like they wanted me to leave … I sent the carer back and left, leaving almost 10 family members with [Mrs A]. Before leaving the room, I definitely made sure [Mrs A's] airway was not obstructed. I regret now that I didn't immediately call 111."

48. RN E then attended another resident in the rest home who required controlled pain medication.

49. At around 5.50pm, Dr C arrived at the rest home and went to Mrs A's room. Dr C stated that he found Mrs A unconscious, unresponsive, and with rapid respirations. He said:

> "There was no [nursing] staff member present and over the next few minutes multiple family members began to arrive. I pushed the call bell and then in frustration used the emergency bell … [It] took far too long to obtain a nurse … finally after perhaps 10 minutes or maybe a little less I had an RN in the room … the RN was very competent once present and was of great help filling in the gaps."

50. RN E said that at about 6pm she was told by a caregiver that Dr C was looking for her, and she went to Mrs A's room to assist with the vital signs and blood sugar monitoring equipment. RN E documented that Mrs A's blood sugar level was 17.8mmol/L.[8]

51. Dr C said that a temperature recording confirmed that Mrs A had a fever, and he checked her legs and discovered advanced cellulitis. Dr C diagnosed septic shock and, after discussion with the family, decided to admit Mrs A to hospital.

[8] There are no other blood sugar levels documented for Mrs A between Day 1 and Day 4.

52. At 6.04pm, Dr C made an electronic clinical note at the nurses station. RN G said that he helped to prepare the papers to transfer Mrs A to hospital. RN G told HDC that Dr C instructed RN E to call the ambulance (which she did at 6.05pm) and to show the paramedics his written instruction to start an intravenous line and give Mrs A a bolus of saline solution.

53. At around 6.20pm, the ambulance arrived. RN D said that she met the paramedics to show them the way to Mrs A's room. RN D stated that she saw RN E in the hallway, and asked where she had been, and RN E responded that she had been assisting a healthcare assistant with a hoist transfer. RN D said that she told RN E that she should not have left Mrs A or the nurses station when there was an ongoing emergency.

54. At 6.45pm, the paramedics transferred Mrs A to the public hospital.

Further events

55. Mrs A was treated palliatively in hospital and, sadly, she died a few days later. Mrs A's death certificate lists the causes of death as: "Sepsis Days, Right Leg Cellulitis Days, Rectal Adenocarcinoma Years, Congestive Heart Failure Years."

Further information

Guidelines

56. The Bupa document "Clinical Emergencies Residents — Guidelines for Staff"[9] supports staff to ensure that appropriate actions are taken in the event of a clinical emergency involving a resident. The guideline states that when a resident suddenly becomes unresponsive or a resident's condition changes or deteriorates suddenly, this would be considered a clinical emergency. It states:

> "Residents who are suddenly unresponsive should receive emergency care unless clearly documented otherwise …
>
> If a Doctor is unable to attend the resident or cannot be contacted and the Registered Nurse has significant concerns for the patient's safety or health status then don't hesitate in calling an ambulance."

57. Bupa has in place a "STOP AND WATCH" early warning tool[10] for assessing and reporting deterioration in a resident's condition. This acronym stands for: seems different than usual; talks or communicates less than usual; overall needs more help than usual; participated in activities less than usual; ate less than usual; drank less than usual; weight change; agitated or nervous more than usual; tired, weak, confused or drowsy; change in skin colour or condition; help with walking, transferring, toileting more than usual.

[9] Implemented September 2006.
[10] Implemented in 2015.

Training

58. Bupa told HDC that an education session was delivered on the "STOP AND WATCH" tool. This was attended by, among others, the Care Home Manager, the Clinical Manager, the Duty Leader, and several nurses.

Changes made since these events

59. Bupa told HDC that since these events, the rest home has facilitated education sessions on the following topics:

- Palliative care
- Emergency procedures
- Neurological assessment
- Wound care
- Quality and critical thinking
- ISBAR[11]
- Recognising and reporting changes in condition
- Medication management
- Diabetes management

60. RN K told HDC that since this event she has read further literature on sepsis in an attempt to understand where she may have overlooked the symptoms of an upcoming event.

61. RN D said that since this incident, she has raised with clinical management that nurses should be able to contact the ambulance or after-hours surgery if the after-hours doctor is not available immediately.

Responses to provisional opinion

62. Ms B, Bupa, and RN E were given an opportunity to comment on relevant sections of the provisional opinion. Where appropriate, changes have been incorporated above.

63. Bupa submitted that Mrs A did not have an ongoing decline between Day 1 and Day 4, rather, it considers that she had an acute deterioration at 5.20pm on Day 4. Bupa submitted that the only clinical issues its staff observed, prior to Mrs A's acute deterioration on the evening of Day 4, were minor or transient, and that appropriate actions were taken by Bupa staff at the time. In particular, Bupa submitted the following:

a) There is no evidence that Ms B or Mrs A informed Bupa staff prior to or on Day 1 that Mrs A was "not feeling right".

[11] A framework for clinical conversations between health professionals. ISBAR stands for: identify/ introduction; situation; background; assessment; request/recommendation.

b) There is no evidence that Ms B shared with Bupa staff Mrs A's wish to see her GP. Bupa stated that within contemporaneous documentation, there are examples that show that staff did act on Ms B's requests and feedback.

c) Prior to the incident on Day 3, Mrs A had an episode of urinary incontinence that did not appear to relate to any associated decline in health. Bupa stated that constipation can be a contributing factor for incontinence.

d) Management of Mrs A's bowel movements was appropriate given her history of rectal cancer and bowel movements at long intervals up to five days.

e) Bupa nursing staff were responsive to Mrs A's reports of pain, and when prescribed analgesia was not sufficient, they informed the GP.

f) Prior to Day 1, Mrs A had had intermittent periods of confusion, which were transient in nature and did not appear to relate to any associated decline in health. Any confusion or disorientation prior to Day 1 was attributed to Mrs A's morphine medication, and confusion between Day 3 and Day 4 was attributed to anxiety.

g) Mrs A's status did not warrant GP review prior to 5.20pm on Day 4.

h) If hyperglycaemia or hypoglycaemia were causing Mrs A's confused state, such episodes would not have resolved without intervention or with only psychological support such as speaking with Ms B or staff.

64. Bupa acknowledged that there were areas of service delivery that could have been improved, and offered its apologies to Ms B for the lack of timely action following Mrs A's deterioration at 5.20pm on Day 4. However, Bupa disputed that there was an overall lack of response by multiple staff to Mrs A's declining condition, and stated that there were no systemic or organisational shortcomings that could sustain a finding of direct liability against Bupa.

65. RN E accepts that she should not have left Mrs A's family in the room on Day 4, and should have stayed nearby in order to communicate with the family what was happening and provide information so that the family could understand the events that were taking place.

66. RN E submitted that throughout the critical time period after 5.20pm, she was in contact with her team leader, RN D, to update her and receive advice, and at no time did RN D instruct her to ring an ambulance immediately. RN E stated that she regrets waiting for RN D's advice, and that she could have called an ambulance instead of calling RN D multiple times. RN E said that she wishes to convey her apologies to Mrs A's family and loved ones.

67. RN E also advised that since these events she has attended more than 64 hours of educational sessions to develop professionally.

Opinion: Bupa Care Services NZ Limited — breach

68. Bupa had a duty to provide Mrs A services with reasonable care and skill. This included responsibility for the actions of its staff at the rest home, and an organisational duty to facilitate continuity of care. Bupa also has a duty to comply with the New Zealand Health and Disability Services (Core) Standards, which state:

> "**Service Management 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."

69. Notwithstanding that Mrs A was noted to be cognitively intact and communicated effectively and appropriately with staff, her medical history would suggest that she was likely to experience a progressive decline in her general function. As such, in my view, the various nursing staff involved in her care should have been alert to changes in her condition, and should have reacted more rapidly to new symptoms as they manifested. There were deficiencies in the care provided to Mrs A by multiple staff at the rest home, which, in my view, were overall systemic issues for which Bupa bears responsibility. These are outlined below.

Failure to recognise and manage Mrs A's deteriorating condition appropriately

70. Over the period of Days 1–4, Mrs A's condition was changing — in particular, Ms B reported that Mrs A told her that she was "not feeling right" on Day 1; Mrs A was found wet with urine on Day 3 despite usually being continent and able to use the call bell for assistance; she did not open her bowels over this period; she experienced intermittent pain that was managed by regular and PRN medication; and she had episodes of confusion and deterioration prior to losing consciousness on the evening of Day 4. In response to the provisional opinion, Bupa submitted that there is no evidence that Ms B or Mrs A told staff that Mrs A was "not feeling right". Bupa stated that previously Mrs A had had an episode of urinary incontinence and intermittent periods of confusion that did not appear to relate to any associated decline in health, and she had a history of multiple days without bowel movements.

71. My expert advisor, RN Megan Sendall, advised that the care provided to Mrs A at the rest home between Days 1–4 failed to meet required standards. RN Sendall stated:

> "[Bupa] staff were provided with appropriate up to date policy, procedure and guidelines and were able to access additional RN support and guidance where and when required. However, prior to and during this event, identified staff failed to seek appropriate and timely medical care over several days prior to [Mrs A's] loss of consciousness. There was a departure from expected practice to complete comprehensive nursing assessments and prioritise tasks effectively to maximise an appropriate and timely clinical response."

72. RN Sendall was concerned that staff did not identify symptoms that indicated deterioration, including cellulitis and sepsis. She stated:

> "I believe my peers would identify the need for staff to recognise a change in a resident's cognition … and complete timely comprehensive assessments, acknowledge, respond to and act on family concern and seek medical review as soon as possible."

73. I acknowledge Bupa's submissions outlined above that suggest that some of Mrs A's symptoms were not new to her. However, I consider that the combination of symptoms that Mrs A was experiencing in a similar timeframe warranted greater attention by multiple Bupa staff. I also note that RN Sendall reviewed and considered Bupa's submissions but these did not cause her to amend her advice. I therefore accept RN Sendall's advice, and I am concerned at the overall lack of response to Mrs A's declining condition by multiple rest-home nursing staff.

Blood sugar levels not monitored

74. Mrs A was a diabetic. On Days 3 and 4 it was documented that Mrs A experienced episodes of confusion, and then on the afternoon of Day 4 her level of consciousness reduced. Mrs A's blood sugar levels were recorded only once Dr C arrived on Day 4.

75. RN Sendall advised:

> "It would be expected that the attending RN would arrange to measure the resident's blood sugar alongside baseline recordings to ascertain/rule out hyperglycaemia or hypoglycaemia."

76. I note Bupa's submission that Mrs A's confusion would not have resolved without intervention or with psychological support only if she was experiencing hyperglycaemia or hypoglycaemia. Regardless of the cause of the confusion, I maintain that it would be expected practice for the attending nurse to arrange to measure Mrs A's blood sugar. I note that RN Sendall also did not change her advice after reviewing this submission. I remain concerned that the nursing staff who noted Mrs A's confusion did not assess her blood sugar levels to rule out hypoglycaemia or hyperglycaemia in light of her diabetic history.

GP not notified earlier

77. Dr C was not contacted in response to Mrs A's confusion or disorientation noted on Day 3 or Day 4. He was called only later on Day 4, once Mrs A was found to be almost unconscious. RN Sendall advised:

> "Changes in cognition can indicate serious health events. It is accepted practice to notify a resident's GP if they had previously not shown symptoms of cognitive change and then present with confusion and/or disorientation. In this case staff report [Mrs A] had shown symptoms of anxiety and confusion previously however this time [Mrs A] and family indicated it was 'different'. Her rapid decline indicated it was indeed different. It is my belie[f] that staff should have acknowledged this 'different feeling' reported by [Mrs A] and acted upon family concern therefore I believe this was a major departure from accepted practice."

78. While Bupa has submitted that Mrs A's status did not warrant GP review prior to 5.20pm on Day 4, I disagree. I maintain that the combination of symptoms that Mrs A was experiencing in addition to her confusion (constipation, pain, and urinary incontinence) warranted earlier consultation with a GP. I also note that RN Sendall's advice remained unchanged after she reviewed Bupa's submission on this point. I accept RN Sendall's advice, and I am critical that nursing staff did not contact Dr C earlier in response to Mrs A's confusion and disorientation.

Family communication

79. Ms B was in regular contact with her mother and visited her regularly. She was the EPoA (not activated) for her mother's care and welfare. In my opinion, it is important for rest-home facilities to consider the views of family members.

80. Ms B told HDC that she reported to staff that she was concerned about her mother on Days 2 and 4, and that she requested her mother be seen by the GP. However, there are minimal records of communication between staff and Ms B, and there is no documentation in the GP's notebook that staff had requested that Mrs A be seen by the GP. The staff involved do not recall a request for Mrs A to be seen by the GP, and staff accounts were generally that Mrs A's condition was in line with her "typical behavior".

81. I am unable to make a finding exactly what concerns Ms B raised with staff, based on the differing versions of events and lack of supporting documentation, but it is clear that Ms B was worried about her mother's well-being. In my view, there were missed opportunities for nursing staff to take into account Ms B's concerns (when she was visiting her mother or speaking to staff) in addition to the changes in Mrs A's condition.

Conclusion

82. In my view, Bupa had the ultimate responsibility to ensure that Mrs A received care that was of an appropriate standard and complied with the Code of Health and Disability Services Consumers' Rights (the Code). Overall, there were serious issues with the care Mrs A received at the rest home, which I consider contributed to a delay in Mrs A receiving appropriate medical care in a timely manner. In particular:

a) There was an overall lack of response to Mrs A's declining condition.

b) Nursing staff who noted Mrs A's confusion did not assess her blood sugar levels to rule out hypoglycaemia or hyperglycaemia in light of her diabetic history.

c) Nursing staff did not contact Dr C earlier in response to Mrs A's confusion and disorientation.

d) There were missed opportunities for nursing staff to take into account Ms B's concerns.

83. In light of these issues, Mrs A's deteriorating condition was not identified appropriately, and she did not receive treatment of an appropriate standard. I consider that the care

provided to Mrs A by Bupa was inadequate. Accordingly, I find that Bupa did not provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[12]

Opinion: RN E — adverse comment

Failure to manage emergency situation appropriately

84. At 5.20pm on Day 4, Mrs A was found semi-conscious by a caregiver, who then informed RN E. RN E took Mrs A's vital signs, then left to contact Dr C. She was unable to get through to Dr C, so left a voicemail on his mobile. Once Dr C received the message, he made his way to the rest home. During that time, RN E gave Mrs A an anti-emetic and her family members arrived. RN E left the family and a caregiver with Mrs A, and attended to another resident. Dr C reported that it took close to 10 minutes for RN E to come to assist once he arrived at the rest home.

85. Regarding this situation, my expert advisor, RN Sendall, advised:

> "Loss of consciousness is a serious clinical event requiring immediate clinical attention. Staying with the resident and sending a care assistant to call for internal and external assistance, collect equipment, and contact family would be prioritised in that order. [RN E] had access to a phone. Managing and monitoring the resident's airway and breathing until emergency support arrived would be expected."

86. RN Sendall also noted that when direct contact with Dr C could not be made, RN E departed from Bupa policy. The "Clinical Emergencies Residents — Guidelines for Staff" document specifies that residents who are suddenly unresponsive should receive emergency care, and that if the doctor cannot be contacted then not to hesitate in calling an ambulance. RN E submitted that throughout the critical time period, she was in contact with and updating her team leader, RN D, and was taking advice from her, and at no time did RN D instruct her to ring an ambulance immediately. I note that RN Sendall reviewed and considered this submission but it did not cause her to amend her advice.

87. RN E was the registered nurse physically present with Mrs A at the time her condition was deteriorating, and was the person best placed to respond appropriately. In my view, it was inappropriate for RN E to leave Mrs A alone with a caregiver and family, and I consider that RN E should have called an ambulance when she could not contact Dr C immediately. I do not consider that she required instruction from her team leader to do this. I am also critical that RN E was not present when Dr C arrived at the rest home, and I accept RN Sendall's advice that this fell short of expected practice.

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

Family communication

88. Mrs A's family arrived at the rest home on the evening of Day 4 after her condition deteriorated. RN E administered an anti-emetic, and then left the room. RN Sendall was critical that RN E left the room, and stated:

> "Supporting family to understand [Mrs A's] declining condition as they arrived and providing information … at that time was vital to the family's understanding of the events taking place."

89. RN Sendall said that RN E failed to provide the support the family needed. I agree, and I consider that RN E should not have left Mrs A and her family at that time.

Conclusion

90. Overall, there were some deficiencies in Mrs A's care that are attributable to the rest home. However, as outlined above, RN E was directly responsible for some of Mrs A's care. I am critical that RN E failed to manage the emergency situation on Day 4 appropriately, and that she left Mrs A and her family alone with a caregiver.

Recommendations

91. I recommend that Bupa provide a written apology to Ms B and the family of Mrs A for the issues identified in this report. The apology should be sent to HDC within four weeks of the date of this opinion, for forwarding to Ms B.

92. I recommend that Bupa:

a) Schedule further education sessions for all of the rest home's nursing staff on the following topics:

   i. Assessment of the deteriorating resident
   ii. Management of diabetes
   iii. Communication with family
   iv. Direction and delegation during clinical emergencies

b) Use an anonymised version of this report as a case study to encourage reflection and discussion during the above education sessions.

c) Review its "Clinical Emergencies Residents — Guidelines for Staff" to ensure that it provides sufficient guidance on the circumstances under which staff should call an ambulance or after-hours medical surgery.

d) Provide evidence to HDC that the above recommendations have been implemented, within three months of the date of this opinion.

Follow-up actions

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

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Megan Sendall:

"Assessment of care provided to [Mrs A] was conducted through review of documents requested and supplied to the office of the Health and Disability Commissioner by [rest home] staff, [the] District Health Board, [Dr C] General Practitioner (GP), [Bupa New Zealand (NZ)] and [RN E]. *Additional information received July 2019 included statements from [four rest home nurses] and a second statement from [RN E] under advice.*

Two initial areas of advice were requested as follows:

1. Was care provided to [Mrs A] during the period of [Day 1] to [Day 4] appropriate and consistent with her needs?
2. Was input from [Mrs A's] GP, [Dr C] sought in an appropriate time frame?

Additional advice requested July 2019 includes:

1. *Whether the additional documentation reviewed prompted amendment of original advice provided. In particular:*
    a. *Whether the care provided to [Mrs A] during the period of [Day 1] to [Day 4] was appropriate and consistent with her needs?*
    b. *Whether input was sought from [Mrs A's] GP, [Dr C], in an appropriate timeframe?*
2. *The appropriateness of the care provided by [RN E].*
3. *The appropriateness of care provided by any other individual staff member that the expert advisor considers warrants comment.*

The review process included [the rest home's] RN knowledge and skills to provide clinical care. Particular attention was given to [RN E] including her prior nursing experience and length of employment at [the rest home]. Consideration was also given to the RN skill mix at the time of the event and clinical oversight when managing a clinical emergency. Review of [the rest home's] internal organisational resources to support staff in the implementation of their duties included:

- policy, in particular
    1. Clinical Emergencies Residents — Guidelines for staff
    2. ISBAR — Communication tool
- direction and delegation requirements
- [Mrs A's] advanced directives and resuscitation status records/documents
- communication between [rest home] staff and [Mrs A's] Enduring Power of Attorney (EPOA) and family prior to and on the day of [Day 4]

Clinical experience, knowledge and skill mix

[RN E] commenced work at [the rest home] after gaining NZ registration earlier that year. She reports five years of prior nursing experience including positions in medical/surgical and ICU inpatient services [overseas]. She was employed by [the rest home] for less than one year prior to [Mrs A's] transfer to [the DHB].

Although [RN E] was reasonably new to aged residential care nursing in a NZ primary health context, it is considered by the writer that [RN E] had sufficient knowledge and skill to perform her duties.

[The rest home] provides suitable staff access to policy and other key documents alongside established systems and processes for safe service delivery. [RN E] completed orientation to the service and organisation's systems and processes as required. *[RN E] was supported on duty [Day 4] by experienced RNs and a responsive suitably skilled duty leader.*

A [rest home] representative reports that on the afternoon shift of [Day 4], 4 RNs were on duty for a total of 95 residents. Residents comprised of 66 hospital level and 29 rest home level in dual purpose beds. It is considered that adequate RN staffing levels existed alongside additional clinical support through an established on-call process. *Review of RN statements confirms the evening duty of [Day 4] was particularly busy. This may have added to the complexities of the duty and the potential for competing demands for RN attention.*

Policy

The organisation has developed a suite of documents to guide clinical practice including a policy and procedures to manage serious illness and events. 'Clinical Emergencies Residents — Guidelines for Staff' supports staff when serious illness and events requiring emergency management arise. The document is controlled, implemented August 2006 and reviewed May 2011. It provides information to identify various clinical situations that could occur which could be considered a clinical emergency. Situations identified include sudden unresponsiveness, a sudden change in condition or rapid deterioration. Management of these situations is described and includes accessing an ambulance through the 111-call system.

Consideration of the resident's advance directives is also documented. Emergency drugs are listed and include medications to manage diabetic emergencies. It is noted that the process to respond to medical emergencies includes contacting the GP first. *Following the event involving [Mrs A] it is noted that the duty leader on duty [Day 4] requested a review of this process to allow for direct priority dialling to 111 national emergency system.*

A policy titled 'ISBAR — Communication Tool' reviewed in October 2016 is also available to staff. The policy provides information to employees to ensure factual and concise information occurs between clinicians. The ISBAR acronym includes a description of the current situation, background information and requirements for

assessments and request or recommendation. An ISBAR note pad is also available to [rest home] staff when completing clinical communication.

It is considered that [the rest home] provided appropriate and up to date key policy/ procedure documents and tools to guide staff in the case of emergency including the sudden deterioration of a resident. ISBAR policy outlined actions to support clear and concise communication between clinicians in emergency situations.

Advanced directives/Not for Resuscitation order

[Mrs A] completed advanced directives and resuscitation response plan upon entry to [rest-home permanent care]. The documents note her informed decision to decline Cardio Pulmonary Resuscitation (CPR). Advanced directives document [Mrs A's] desire to be transported to hospital in case of a treatable condition.

Bupa New Zealand, [the rest home's] parent organisation, provides a resuscitation treatment flow chart utilised at [the rest home] for the routine management of care. This controlled document was last reviewed August 2015. It outlines a decision-making tree for clinicians and supports navigation of actions following a sudden clinical event. The document is intended for use alongside advanced directives and resuscitation requirements for each resident.

[Mrs A] had multiple co-morbidities and the likelihood of successful resuscitation could be considered to be poor, however she indicated a desire to be transported to hospital should her condition require advanced care for a treatable condition. Her daughter and EPOA was aware of her decision and request for treatment.

EPOA /family communication

[Mrs A's] daughter/EPOA had been her caregiver for over six years prior to her initial respite admission to [the rest home]. She was vigilant and responsive to her mother's care and any change in condition. She was in frequent contact with her mother and visited almost daily.

During the three days prior to [Mrs A's] [DHB] admission, her daughter/EPOA indicated to staff on three separate occasions that she was concerned about her mother. [Mrs A's] other children, a son and daughter, also indicated concern to staff over the same three days. [Mrs A] reported her own concerns about her health to her family and to staff. The concerns included a sense that things were 'different' and not [Mrs A's] usual symptoms.

It is not clear how much detailed clinical information was communicated between [rest home] staff, [Mrs A] and her family during the lead up to [Mrs A's] [DHB] admission. *The details of any discussions were not recorded*.

[RN K] provided clinical care to [Mrs A on] the morning shift [of Day 4]. She reported she responded to a care assistant's concerns regarding [Mrs A] around midday. These included [Mrs A] appearing confused and unsettled at that time. [RN K] completed a

vital sign assessment and found nil of note. She reported she found [Mrs A] more anxious than confused.

She then called [Mrs A's] daughter/EPOA. [Mrs A] was able to talk to her daughter. [RN K] reported the phone call settled her down. [RN K] reported [Mrs A] had been unsettled, confused and anxious in the past. She reported she believed [Mrs A's] confusion, anxiety and change in cognition was 'no more than her typical behaviour'.

However, it was during this telephone call that [Mrs A's] daughter reported she became aware that her mother was unwell and she was concerned. She advised her mother to see the GP. [RN K] did not decide to access medical advice at that time. She did however report that she informed care staff to report any further confusion and updated her shift coordinator.

It is established that concern related to [Mrs A's] constipation was recorded and a request for follow up documented. RN statements provided indicate [Mrs A's] deterioration was not identified throughout the day of her eventual admission to [the DHB] and all symptoms were observed as 'typical' expression of previous symptoms. [Mrs A's] daughter's request for GP examination was not passed on specifically and although the GP book recorded a request for review it indicated constipation as the presenting symptom.

Discussions which include planning for any change in resident condition or sudden clinical events are critical to provide confident and open relationships between all parties and provide stability when events occur. Clinical actions when these changes occur should reflect the family's expectations and wishes coupled with descriptions of probable clinical outcomes. [Mrs A's] family indicated concern that these discussions hadn't occurred and subsequent clinical actions during events prior to [Mrs A's] [DHB] admission were spontaneous.

It is often confusing for parties and clarification required for all parties to establish that a resident may not wish to be resuscitated however they may still wish to receive active treatment for other conditions. It is unclear if these discussions occurred with all parties. Medical discussions with [Mrs A] regarding advanced directives were completed and recorded.

Communication did occur across the day of [Day 4] between staff and family however family members describe feeling worried and unclear that [rest home] staff were responding appropriately to a change in [Mrs A's] reported symptoms. Family report [Mrs A] describing these symptoms as 'different'. In contrast staff record 'no change' in the 'typical' symptoms presented.

Clinical Assessment

Records describe a timeline of progress note entries, events and observations by family and staff leading up to a request for emergency help by [Dr C] at approximately 1755 hours [Day 4] as follows:

- Monday [Day 1] [Mrs A] made a request to phone her son and described 'not feeling right'. Following her daughter's/EPOA visit on the same day and subsequent conversation about her condition the family confirmed things were different. [Mrs A's] situation described again as 'not right' but hard to pin point.

- The following day [Mrs A] again said to family she felt unwell 'not the usual unwell'. [Mrs A's] daughter described her concern and approached staff to request that [Mrs A] was seen by a GP.

- Around the same time staff reported to family that [Mrs A] had received a dose of Morphine. [Mrs A's] daughter described an absence of her mother's normal pain at that time describing a new different experience/expression of pain.

- [Mrs A] was not physically examined by her GP on [Day 3] after the family's request. The request was not passed on directly to [Dr C] however changes to her medication were made following a GP visit which included a prescription for a topical anti-inflammatory and an increased dose of routine aperient. It is believed that *[Dr C] responded appropriately to a request via an established GP visiting booking system in [the rest home]. Information regarding the family's request due to symptomatic changes was not clearly provided to the GP through the booking system and orally by nursing staff on duty.* Progress notes did not record the family's request to have [Mrs A] seen by [Dr C]. Medical notes include an entry by [Dr C] [two weeks earlier] recording a routine medical review and no further entry until [Day 4] describing an acute situation.

- Progress notes [Day 3] document [Mrs A] being found soaked in urine wearing her night pad at 1330 hours that day. No progress notes were completed overnight prior to that entry. There is no entry of family complaining about finding [Mrs A] in urine-soaked clothes in the progress notes other than to report it had occurred however a complaint may have been recorded separately using a complaints system.

- A progress note entry on the morning of [Day 4] described [Mrs A] as 'a bit confused and unsettled'. No clinical assessments were documented in the progress notes in response to this noted change in condition. *[RN K] reported subsequently in a written statement that vital sign assessment was completed at that time.*

- Progress notes 1430 hours the same day, recorded staff queried a urinary tract infection and planned the collection of a urine sample. Several entries over previous days reported [Mrs A] was constipated and actions taken to monitor this.

- 1430 hours progress note entry [Day 4] also states 'wound reviewed' and 'chart updated'. Any consideration of cellulitis or observations of [Mrs A's] lower limbs was not recorded at that time. *[RN K] reported 'On [Day 4], the appearance of the wounds had no significant changes to what I had seen [on a previous occasion]'. She recorded in a later statement she completed a wound assessment however did not record this as required due to feeling 'utterly under pressure to complete other nursing jobs'. She went on to record that* observations were taken. A temperature of 37.1 Celsius and a pulse measurement of 63 beats/minute was recorded however the time the measurements were taken was not documented. The entry also stated [Mrs A] was 'confused and disorientated'. A plan to continue to monitor and collect a urine sample for analyses was recorded. No further observations or actions taken were recorded until the next entry later that day at 1720 hours following [Mrs A's] rapid deterioration. *[Dr C] recorded taking vital signs at that time which indicated fever was present and on examination cellulitis was evident on [Mrs A's] lower legs.*

- [RN E] reported she contacted the duty manager twice during the early evening [Day 4]. *A statement provided by the duty manager reports advice was given at around 1600 or 1630 hours to [RN E]. The advice included guidance to [RN E] to inform [Mrs A's] GP and her family about her change in condition. It is noted that the duty manager reported she did not receive complete information pertaining to [Mrs A's] health history to include Type 2 diabetes. The duty manager requested to be updated. [RN E] was offered support from the duty manager at that time however this was declined.*

- *Somewhere around 1730 hours the duty manager reported she received a second call from [RN E]. [RN E] reported [Mrs A] was unresponsive and [Dr C] had been notified and was on his way. Again, the duty manager offered assistance however it was declined. [RN E] indicated she was receiving support from another RN, [RN G]. The duty manager met [Dr C] at the main entrance. At the same time family arrived and an offer to escort the group to [Mrs A's] room was declined. The duty manager then informed [RN E] of the arrival of [Dr C] and family.*

- *At around 1745 hours [RN G] reported he was alerted to an emerging situation by a care assistant from [Mrs A's] ward (community). The care assistant 'was looking for a RN as [RN E] could not be found and [Dr C] was in [Mrs A's] room'. He unsuccessfully attempted to contact [RN E] by cell phone at that time.*

- *At around 1800 hours the duty leader received a phone call from [RN G] updating her regarding [Mrs A's] condition. He reported he did not know where [RN E] was at that time. The duty manager offered assistance and moved to the area. Upon her arrival she located [RN G] walking with the paramedics who were moving to [Mrs A's] room.*

- *Shortly after the duty leader located [RN E] in a nearby hallway. [RN E] reported she had been assisting/witnessing a care assistant hoisting another resident.*

- *[RN G] reports [RN E] attended the GP 'a few minutes' after the GP arrived.*

- *[RN G] went on to record that he supported the situation by attending [Dr C] at the nurse's station while the Dr organised [Mrs A's] transfer. [RN G] assisted the completion of resident transfer documentation. He then instructed [RN E] to ring 111 and went on to meet the paramedics and guide them to [Mrs A's] room.*

- [Dr C] reported he could not locate [RN E] upon arrival at [the rest home] and [Mrs A's] room. He went on to report a significant delay of '*more than 10 minutes*' in her attending [Mrs A's] room following an emergency bell signal.

Direction and Delegation

Whilst evaluating direction and delegation priorities, consideration was given to the time of day, skill of staff, RN and care assistant cover. Prioritisation of tasks and response to emerging clinical issues was also considered.

[RN E] had completed a medication round when she was called by a care assistant to [Mrs A's] room. She observed [Mrs A's] loss of consciousness, left the room and made an attempt to contact her GP. The attending care assistant was left supporting [Mrs A] in a lazy boy chair. The RN returned and [Mrs A] was moved to her bed. The care assistant left the room sometime later. When additional family and [Dr C] arrived at [Mrs A's] room [RN E] was not in attendance.

At the same time that [Mrs A] was noted unresponsive another resident requested pain relief. [RN E] reported she made the decision to attend another resident and administer pain relief, a controlled drug, and attempted to contact the GP for a second time. *[RN E] reported to the duty manager she was also helping care assistants hoist/move another resident. [RN E] was offered assistance by the duty manager. A care assistant summoned support from another RN.*

Loss of consciousness is a serious clinical event requiring immediate clinical attention. Staying with the resident and sending a care assistant to call for internal and external assistance, collect equipment, and contact family would be prioritised in that order. [RN E] had access to a phone. Managing and monitoring the resident's airway and breathing until emergency support arrived would be expected.

Summary

On admission, [Mrs A] presented as cognitively able with intact cerebral executive function despite multiple morbidities. She reported signs of deteriorating health to both her family and staff over three days prior to her loss of consciousness on [Day 4].

Staff observed changes in her condition however did not note these as out of ordinary.

Family requested an onsite medical review on [Day 3]. Medication changes were made however [Mrs A] was not physically examined *due to incomplete communication*. Information regarding the family's request and the reasons why was not directly passed on to the GP.

Over three days including the morning and early afternoon of [Day 4], [Mrs A's] level of consciousness fluctuated. Staff and family reported and observed her to be confused and disorientated. Staff documented changes in cerebral function. Staff actions recorded at this time included a plan to collect a urine sample although this was not achieved. A set of observations were taken at an unrecorded time.

[Mrs A] was a Type 2 diabetic. During the day she was observed to be suffering from a change in cognition/level of consciousness and described feeling unwell. It would be expected that the attending RN would arrange to measure the resident's blood sugar alongside base line recordings to ascertain/rule out hyperglycaemia or hypoglycaemia. [RN E] reports she took base line clinical observations/recordings at around 1720 hours and sometime later at an unidentified time checked [Mrs A's] blood sugar level. It was recorded as 17.5 mmols/litre. This was most likely taken at a time close to her hospital transfer. There are no other detectable blood sugar recordings documented between [Days 1–4].

[Mrs A] had three lower leg wounds. Her general condition indicated these were difficult to heal. Poor circulation and open wounds, inactivity and poor general health create a high risk of cellulitis. Her lower legs were examined on the morning of [Day 4] by [rest home] staff. Staff recorded her wounds were dressed. There is no mention of any physical change in appearance of [Mrs A's] lower legs however [Dr C] on examination later that day documented that he checked [Mrs A's] legs and found advanced cellulitis.

When [Mrs A] became acutely unwell around 1720 hours [Day 4], attempts were made by [RN E] to access medical support. When direct contact with her GP could not be made [RN E] departed from policy. Staying with the resident, ringing for an ambulance and managing the client's airway whilst taking vital observations and blood sugar levels would be expected in keeping with [the rest home's] policy and procedure. Supporting family to understand [Mrs A's] declining condition as they arrived and providing information and support actions taken at that time was vital to the family's understanding of the events taking place. [RN E] in this instant failed to provide the immediate clinical care required and failed to provide family with the support and information they needed.

Advice for question 1

Was care provided to [Mrs A] during the period of [Day 1] to [Day 4] appropriate and consistent with her needs?

- The standard of accepted practice for care is guided by policy, clinical knowledge and skill and is consistent with current best practice and aligned to resident wishes. In this instance staff did not identify symptoms indicating deterioration to include cellulitis and sepsis.
- There was a major departure from standard practice as staff noted symptoms of decline and had opportunity over three days prior to [Mrs A's] admission to [the DHB] to complete comprehensive nursing assessments and seek medical advice.
- I believe my peers would identify the need for staff to recognise a change in a resident's cognition 'the deterioration resident' and complete timely comprehensive assessments, acknowledge, respond to and act on family concern and seek medical review as soon as possible.

Advice for question 2

Was input from [Mrs A's] GP, [Dr C], sought in an appropriate time frame?

There are 2 elements of response to this question:

a) timely access to medical review following noted change in condition and
b) timely medical contact for assistance in the case of a medical emergency.

- Changes in cognition can indicate serious health events. It is accepted practice to notify a resident's GP if they had previously not shown symptoms of cognitive change and then present with confusion and/or disorientation. *In this case staff report [Mrs A] had shown symptoms of anxiety and confusion previously however this time [Mrs A] and family indicated it was 'different'. Her rapid decline indicated it was indeed different. It is my belief that staff should have acknowledged this 'different feeling' reported by [Mrs A] and acted upon family concern therefore I believe this was a major departure from accepted practice.*

- Loss of consciousness is considered an emergency if not part of a palliative situation therefore urgent nursing and medical attention was required in this case. [Dr C] reported that nursing staff were not present when he arrived and were delayed in responding after he rang the emergency call bell. *This falls short of expected practice.*

- I believe my peers would view this as not meeting organisational policy and best practice requirements alongside failing to acknowledge the concerns of family. In the immediate time prior to [Dr C's] arrival on [Day 4] and immediately following this time, the RN on duty failed to meet a duty of care, policy and procedure related to managing a critical event and direction and delegation responsibilities.

- If the GP was unreachable then following emergency guidelines/policy essential.

  Care provided to [Mrs A] at [the rest home] between [Day 1] and [Day 4] failed to meet required standards. [Rest home] staff were provided with appropriate up to

date policy, procedure and guidelines and were able to access additional RN support and guidance where and when required. However, prior to and during this event, identified staff failed to seek appropriate and timely medical care over several days prior to [Mrs A's] loss of consciousness. There was a departure from expected practice to complete comprehensive nursing assessments and prioritise tasks effectively to maximise an appropriate and timely clinical response.

Recommendations for improvement include:

1. RN Education:
   - clinical assessment — 'The deteriorating resident'
   - management of diabetes — 'The management of Diabetes in the unwell resident'
   - communication with family — 'Critical conversations'
   - direction and delegation — in particular around clinical emergencies

2. Policy review:

This would include clinical emergency policy(s) to reflect the concerns brought forward by the team leader on [Day 4] and ensure access to medical/emergency support was clear and appropriate.

3. RN reflection activities:

To include identifying the deteriorating resident, management of diabetes in the deteriorating/unwell resident and management of clinical emergencies.

4. It would be considered appropriate for the RN(s) concerned to apologise directly to the family.

M. Sendall RN"

RN Sendall was given a copy of the providers' responses to the provisional opinion, and advised that it did not change her advice. She stated:

"**Re [Mrs A] C17HDC01279**

I have reviewed and considered the documents supplied to me electronically yesterday regarding Bupa's response to the Deputy Commissioner and [RN E's] legally supported statement.

In addition I have reviewed my original advice and additional advice provided to the Commissioner's office (2019).

Having reviewed and considered all the documents, and advice previously given, I have come to the position that my original advice remains unchanged for all the reasons previously stated.

The additional documentation does not alter in any way my interpretation of the documents and statements originally supplied to me related to the management of [Mrs A's] deteriorating condition in 2017."