Bupa Care Services NZ Ltd

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01941)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman during her short stay at a rest home in 2018. The woman stayed for eight days while awaiting a definitive care plan to manage fractures in her upper arm.

2. On day eight of her admission, the woman was transferred to the public hospital via ambulance, as her condition had deteriorated, and she had severe pain and dehydration. Sadly, four days later she passed away from intra-abdominal sepsis.

Findings

3. The Deputy Commissioner found that Bupa Care Services NZ Limited breached Right 4(1) of the Code for the lack of assessment and care planning by a registered nurse at the time of the woman's admission; the lack of direction and clear documentation to allow care workers to provide safe, effective care for the woman's fractures; the failure to undertake a pain assessment during the woman's stay, despite her uncontrolled pain; the inconsistent and inappropriate use of pain relief and anti-emetics despite uncontrolled pain and nausea throughout the woman's stay, as well as a failure to administer laxative medications; the failure to undertake a formal nursing assessment, develop a relevant short-term care plan, or seek medical review after the woman was noted to have a UTI, or after she demonstrated a clear deterioration in her condition; the management of her continence; and the call bell being left out of her reach on a number of occasions.

Recommendations

4. The Deputy Commissioner recommended that Bupa Care Services NZ Limited undertake a three-month audit of patient records to confirm the inclusion and correct use of the Bristol Stool Chart for every resident; undertake a three-month audit of all new admissions to confirm that the relevant admission assessments have been completed by a registered nurse; use the findings of this complaint as a basis for training staff at its facilities; schedule education sessions for all the rest home nursing staff on the topics of short-term care plans, the use of assessment tools such as the Iowa pain assessment, clinical review and transfer of patients to hospital, documentation, and management of a deteriorating condition; provide a written apology to the woman's family for the breach of the Code identified in this report; and review and update its "Short Stay — Residents" policy for accepting a patient from hospital, and the discharge summary information required from the DHB at the time of transfer.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint regarding the services provided to the late Mrs A while she was a resident at a rest home. The following issue was identified for investigation:

- *Whether the rest home (BUPA Care Services NZ Limited) provided Mrs A with an appropriate standard of care in 2018.*

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

7. The parties directly involved in the investigation were:

Mr B	Complainant/son
Mrs A (dec)	Consumer
Bupa Care Services NZ Ltd	Provider/rest home

8. Information was also received from:

District Health Board	
Mr C	Grandson
Mr D	Grandson
Ms E	Granddaughter-in-law
Ms F	Support person to family

9. Also mentioned in this report:

Dr G	General practitioner

10. Independent expert advice was obtained from Registered Nurse (RN) Jan Grant (Appendix A).

Information gathered during investigation

Introduction

11. This report concerns the care provided to the late Mrs A, in her eighties at the time of events, during her short stay at the rest home[1] while she awaited a definitive care plan for the management of her fractured humerus.[2]

[1] The rest home is owned and operated by Bupa Care Services NZ Ltd and provides rest-home level and hospital-level care.
[2] The bone in the upper arm.

12. Mrs A stayed at the rest home for eight days. On Day 8,[3] she was transferred via ambulance to the public hospital as her condition had deteriorated and she had severe pain and dehydration. Sadly, she passed away on Day 12. Mrs A's cause of death was intra-abdominal sepsis in the context of severe constipation and *E. coli* and *Proteus*[4] urosepsis.[5]

Background

13. Mrs A was previously well and living independently in a flat attached to the house of her son, Mr B. She managed independently with help three times a week for showering. She walked independently with a walking frame or walking stick.

14. In 2018, Mrs A was admitted to the public hospital following a fall at home that resulted in two fractures to her left humerus, and a skin wound to her left elbow. She also had lacerations to her head. Due to the wound on her elbow, the fractures were treated conservatively.

15. On Day 1, Mrs A was discharged from the public hospital to the rest home for interim care under a 23-day [residential respite agreement] until a "definitive plan for treatment of the humerus" could be made. The plan for discharge, as stated on the [agreement], was for Mrs A "to return to the public hospital for surgery. Date to be advised." In response to the first provisional opinion, Mr B said that the public hospital's plan was always to operate.

Admission to the rest home — Day 1

Discharge instructions and medications from the public hospital

16. The discharge summary from the public hospital included details of Mrs A's primary diagnosis, the mechanism of injury and investigation results, her past medical history, current medications, the progress she had made in hospital, and the current management plan. The stated "plan on discharge" was for a cast change and wound review in one week's time (booked for Day 6) and clinic review booked for the following week for "[p]lan to be made at [this] clinic for ? definitive fixation vs non-op management".

17. Mrs A's usual medications were listed on the discharge summary, together with her additional prescribed medications. She was provided with prescriptions for the following medications:

- Paracetamol[6] two-week supply — 1g four times a day when needed for pain.
- Lactulose[7] two-week supply — 2 tabs twice daily when needed for constipation.
- Ondansetron[8] three-day supply — 4mg eight hourly when needed for nausea.

[3] Relevant dates are referred to as Days 1–18 to protect privacy.
[4] *Escherichia coli* (*E.coli*) and *Proteus mirabilis* are bacteria that can cause illness.
[5] A severe bacterial infection of the urinary tract.
[6] A medication used to treat pain and fever.
[7] Used to treat constipation.
[8] An anti-emetic (a medication used to treat nausea).

18. In addition, a controlled drug prescription was given for a four-day supply of oxycodone (OxyNorm)[9] immediate release — 5mg orally every four hours when needed for pain.

19. The DHB told HDC that a verbal handover was provided to the rest home by a hospital registered nurse. This was followed by a nursing transfer letter that was sent with Mrs A at the time of her transfer to the rest home.

20. The nursing transfer letter lists "assistance with personal care" as the key nursing intervention. It was documented that Mrs A was able to weight bear, could be transferred with the assistance of one person, and walked with a walking frame with assistance/supervision of one person. It was also noted that she required assistance with meals but was independent with fluids. She was also noted to be continent.

21. Bupa told HDC that it questions whether the discharge information provided by the public hospital was sufficient. Bupa stated:

> "We note that [the public hospital's] discharge paperwork sent to [the rest home] did not contain the following information that could be seen as critical to ongoing care:
>
> - The fact that Mrs A's admission was delayed by a day due to her pain and nausea not being under control. It is unclear the extent to which this was under control at the time of transfer.
> - Use of and recent removal of indwelling catheter (IDC): This would have resulted in an increased risk of developing a urine infection, and the need for increased mobility that could have led to a higher risk of increased pain.
> - Change of arm plaster cast to an arm back slab, and how this was impacting on her pain levels and ability to use a walking frame."

22. In response to the first provisional opinion, Mr B stated that on Day 3 the family informed rest-home staff that Mrs A had had a catheter while at the public hospital.

Admission assessments

23. Bupa told HDC that Mrs A's admission assessments and paperwork were completed by a "student enrolled nurse" using the discharge documentation from the public hospital. However, it said that a registered nurse did review and sign the care plan.

24. On admission to the rest home, a "Short Stay Support Plan" was completed. In this, Mrs A was recorded as being mobile with a walking frame and the assistance of one person using a transfer belt. She was noted to be continent and to have pain relief medications charted as required. Under nutrition, she was noted to eat well but needed her meals to be cut up.

25. A "Short term care plan for fracture" was also completed. Under "Pain", "Ensure pain levels are regularly assessed and appropriate pain relief provided" is ticked, and "can

[9] An opioid medication used to treat moderate to severe pain (OxyNorm is the brand name).

communicate" is recorded. Under "Documentation", "Ensure regular entries are made in progress notes regarding — pain and mobility" is ticked.

26. A "Transfer plan" was also completed. On this it is noted that Mrs A needed the assistance of one person for turning in bed, and her "[a]rm to be supported on pillows". She was also noted to need the assistance of one person, using a transfer belt and walking frame, for moving in and out of bed and chairs and for mobilising.

27. An Iowa pain assessment[10] (a formal pain assessment) was not commenced. Further, it does not appear that multidisciplinary input for care planning, such as from a physiotherapist or a nurse practitioner, occurred at that time.

28. In relation to the adequacy of the initial assessments completed at the time of admission, Bupa noted that there was no specific information in the public hospital paperwork regarding positioning of the arm. Bupa stated:

> "On arrival at the rest home, [Mrs A] was assessed as being able to verbally express when and if her arm/shoulder was comfortable or not. We submit that if the care of [Mrs A's] fractures required more specific positioning and a specific number of pillows, this would have been sent by the public hospital to the rest home in writing."

29. In addition, Bupa noted that there was no evidence that an assessment by a physiotherapist was undertaken whilst Mrs A was at the public hospital, or that she needed any specialised equipment such as a monkey bar, and "it was the [rest home's] senior clinical staff experience that the public hospital would have informed them prior to discharge if any such specific specialised equipment would have been required".

30. The first entry in the progress notes, documented at 10.15pm on the evening of Day 1, stated: "Arrived approximately [2.30pm], [observations] completed, nutritional chart completed, GP faxed, [short-term care plan for fracture]. Cast check monitoring in place." Mrs A was noted to have been visited by her family and had declined pain relief and had settled in bed.

31. In response to the first provisional opinion, Mr B noted that the admission assessments and care plan were not discussed with the family. He said that his mother was left alone with her food, which was not cut up, or was still wrapped, and food and water were out of reach on more than one occasion. He also witnessed that owing to her fractures, she was able to turn in bed only with the assistance of two people.

Days 2–4

32. Mrs A's family stated that over the following days, Mrs A reported experiencing a lot of pain in her arm, and said that she was administered her prescribed pain relief inconsistently, and also experienced nausea and vomiting due to her medications.

[10] The Iowa pain assessment is a tool used to assess pain levels and needs.

Saturday Day 2

33. On Day 2, Mrs A was given ondansetron at 6.45am, followed by oxycodone at 7.30am, with "good effect". Nothing specific about her pain levels was documented at that time.

34. In statements from Mrs A's grandson, Mr D, and his partner, Ms E, they said that they arrived to find Mrs A uncovered in bed and cold, having slipped down the bed. They stated that they called for someone to move Mrs A back up the bed, and that the nurse who came to assist kept grabbing her by her left shoulder and had to be reminded that it was fractured.

Sunday Day 3

35. On Day 3, the medication chart records that Mrs A was given both ondansetron and oxycodone at 7.30am. In the evening, in response to a request by her family, who reported that she was experiencing "lots of pain", at 7.05pm she was given oxycodone, but immediately vomited. She was then given a further dose of oxycodone at 7.20pm, and ondansetron at 7.30pm.

36. In response to the first provisional opinion, Mr B stated that the times documented are incorrect, as he arrived at the rest home at around 8pm. He said that again he found his mother uncovered and cold, and she was in pain, distressed, needing to urinate, and crying. He said that they raised concerns with staff at the time.

37. In a statement from Ms F, she recalled that in the evening, two people assisted Mrs A to stand so that she could be made more comfortable in bed, and when Mrs A asked to go to the bathroom, an enrolled nurse told her to pee in the pad she was wearing, but Mrs A was embarrassed and concerned that her bladder was too full for the pad, and asked again for a pan.

38. Bupa said that it was "very concerned to read in the complaint that [Mrs A] had been given a pad and been told to 'pee into pad', and this was addressed with staff after the complaint was received". Bupa told HDC that it believes that the staff member was a "student enrolled nurse". Bupa said that the matter was addressed with the staff member following receipt of the complaint, and that the person is no longer employed by Bupa. Bupa acknowledged that this was an inappropriate comment for an individual staff member to make.

Monday Day 4

39. In the progress notes for Day 4, it is noted that Mr B raised concerns that Mrs A was not receiving sufficient pain relief and anti-nausea medications before her pain relief. In addition, he was concerned that staff were touching her shoulder too much when doing cares. According to the clinical records, a plan was discussed with Mr B and a note placed in Mrs A's room requesting that her shoulder not be touched. In addition, she was put on 30-minute checks, and was to be given oxycodone every four hours and anti-nausea medication three times a day with each dose of oxycodone.

40. In response to the first provisional opinion, Mr B noted that he had to insist that a sign be put on the wall stating that his mother had fractures and was not to be lifted by her shoulder. He noted that the clipboard for 30-minute checks was placed outside the room, and he requested that it be placed in the room.

41. At 7.30am, Mrs A was given ondansetron and oxycodone together. At 11.30am, she was given ondansetron, and at 11.40am she was given oxycodone. At 1.20pm, it was noted that Mrs A had received all her cares, was dressed and transferred into a chair, was toileted after breakfast and lunch, and was "eating [and] drinking well".

42. Mrs A was given further doses of oxycodone at 3.30pm and 9pm, and ondansetron at 9.15pm.

43. At 8pm, Mrs A was noted to have a temperature of 38.6°C, and she reported pain when passing urine. A dipstick urine test[11] was done which was positive, indicating a urinary tract infection (UTI).

44. No referral for clinical review was made at that time, nor was the matter escalated to the Clinical Manager. However, according to Bupa's complaint review report, a note was made in the Facility Manager's book. No further action was taken at that time, including sending a urine sample for testing, which Bupa acknowledged would have been "best practice" prior to antibiotics being prescribed.

45. A short-term care plan for the UTI was also not developed. Bupa's complaint review report identified that although several interventions on the care plan template were initiated, not all of them were implemented.

Tuesday Day 5

46. At 9am, Mrs A was given ondansetron and paracetamol. In the clinical records it is noted that Mrs A was unable to stand or "help herself with anything".

47. A fax marked "urgent" was sent to Mrs A's GP, Dr G, requesting a new prescription for oxycodone. The fax stated:

> "[Mrs A] has been having [oxycodone] regularly for pain as per script [and] is still requiring it. Her script was for 4 days so I am unable to give her pain relief this morning. Could you please fax me a script."

48. According to the progress notes, Dr G telephoned the rest home at 10.20am and agreed to write a further prescription for oxycodone. At that time, Dr G was advised about the positive dipstick test. The clinical notes state:

> "[Dr G] phoned, he will write a script for [oxycodone] PRN, to be collected at lunch. Informed about positive [urine] test, he will chart [antibiotics]. [Mr B] phoned & informed, he will bring her script in later today."

49. At 12.30pm, Mr B brought in the medications prescribed by Dr G for Mrs A. In response to the first provisional opinion, Mr B noted that he had been contacted by Bupa and asked to

[11] A test using a special strip of paper dipped into a urine sample to check for urinary tract infections and other conditions.

collect an "urgent" prescription, but there was some confusion at the pharmacy, and the pharmacist had to contact Mrs A's GP to obtain a copy of the prescription.

50. At 1pm, Mrs A was given paracetamol, and at 1.50pm she was given oxycodone.

51. At approximately 2pm, the antibiotic was administered. Bupa noted that while there was a two-hour delay between the antibiotic being brought in by Mr B and when it was administered, the antibiotic was prescribed on a once-daily regimen.

52. In a statement dated Day 17, Ms E said that she visited Mrs A at approximately 3.15pm that afternoon, and during the visit Mrs A told her that she had been vomiting and had not been able to eat all day. Ms E said that Mrs A also told her that she had been put in an incontinence pad at night time, and that it made her feel humiliated.

53. At 4pm, Mrs A was given paracetamol and ondansetron, and noted to have declined pain relief at 10.30pm.

Wednesday Day 6

54. On the morning of Day 6, Mrs A was noted to be experiencing nausea and dry retching. At 4.45am, she was given ondansetron and paracetamol, and at 4.55am she was given oxycodone for severe pain in her arm. Further doses of paracetamol and oxycodone were administered at 9am. Mrs A's temperature was recorded as 38.8°C, but it reduced to 37.8°C after the administration of paracetamol.

Hospital review

55. That morning, Mrs A was taken to the public hospital for her scheduled appointment. On arrival at 10.05am, Mrs A was triaged and placed in a waiting room for review by the Orthopaedics team. A second nursing assessment was completed while Mrs A was waiting. The clinical records from this review state: "Reports having trouble [with] pain at home → on [oxycodone] [and] paracetamol. Also trouble [with] nausea → on ondansetron."

56. Mr C, Mrs A's grandson, met Mrs A in the waiting area at approximately 10.30am. However, because there was a delay in Mrs A being seen, and Mr C had to leave to return to work, he asked the Bupa caregiver who had accompanied Mrs A to contact him when the doctor arrived. However, Mr C was not contacted until after Mrs A had been seen by the Orthopaedics team.

57. At 1pm, Mrs A was seen by an Orthopaedics registrar and an Orthopaedics house officer. On assessment, Mrs A was noted to have "[s]evere pain in arm, tearful. Nausea with it. Pain the same since the injury." Mrs A reported having regular paracetamol and oxycodone two to three times a day, but that this was not helping. The clinical records also note: "[Mrs A is] [h]aving 'attacks/spasms', makes her jump. At night she says she feels she's experiencing the accident again." An anti-emetic medication, metoclopramide, was prescribed for Mrs A's ongoing nausea.

58. At 1.10pm, Mrs A was given intravenous fentanyl 50mg[12] and the cast was removed. The wound was noted to be "clean and dry" and was re-dressed. The plan was to continue oxycodone as required, for Mrs A to be seen in clinic on Day 12, and to await operation for fixation of the fracture.

59. Mrs A was then transferred back to the rest home. It appears that she was given paracetamol at 5pm. At 9pm, it was noted that she had refused dinner as she was nauseated, and that ondansetron had been given at 5.30pm with some effect, but that Mrs A refused pain relief.

Thursday Day 7

60. Mrs A was administered oxycodone at 12.30am. At 9am, she was given metoclopramide, and at 10.40am she was given a further dose of oxycodone.

61. Mrs A refused her morning shower because she was feeling nauseated and unwell. She was noted to have "urinated on floor twice due to UTI", and had pain in her abdomen.

62. Over the day, Mrs A was noted not to be eating, to be feeling unwell, and to be "very tired and frail". A fluid balance chart was commenced, and by 8.30pm she was noted to have consumed 375ml. No urine output was recorded. At 12.30pm, she was administered metoclopramide, at 5.40pm she was given ondansetron, and at 7.03pm she was given oxycodone.

63. A fax was sent to Dr G outlining that Mrs A had had her hospital appointment the previous day and had been charted metoclopramide as she was very nauseated. The fax noted that Mrs A was not eating well as she was afraid of vomiting, and that the hospital had advised: "[Arrange a] psych referral, [as Mrs A] appears anxious and [is] feeling tired." A review by the GP was not requested in the fax.

64. In response to the first provisional opinion, Mr B recalled visiting that evening and finding his mother noticeably unwell. He said that no senior staff were on site to speak with, so he planned to return in the morning to resolve his concerns.

Friday Day 8

65. On Day 8, Mrs A was noted to have had a "[r]apid decline in condition [with] [s]evere pain [and] dehydration". She was recorded as having consumed 428ml during the day. No urine output was recorded.

66. Bupa stated that Mrs A's condition was discussed at the clinical review meeting, which is held twice weekly, and it was agreed that she should be transferred back to the public hospital. Bupa said that Mr B was called and advised of the plan, and he agreed that an ambulance should be called.

[12] Fentanyl is an opioid medication used to treat severe pain.

67. In response to the first provisional opinion, Mr B said that he was not called, and rather returned out of concern and requested that an ambulance be called immediately.

68. The ambulance was called at 11am, and it arrived at 2.20pm. In relation to the delay in the ambulance arriving, Bupa stated:

> "[W]hen the ambulance was phoned in order to have [Mrs A] transferred to hospital, the ambulance service needed to triage the response time to calls, apparently due to high ambulance demand. At that point, [Mrs A's] condition did not appear life threatening (wording used by the ambulance service at the point of triage) to staff and so the ambulance arrival was delayed."

69. However, Bupa noted that "on reflection, and given [Mrs A's] subsequent rapid deterioration", clinical staff did not recognise the seriousness of her condition at the point of the call to request an ambulance. In response to the first provisional opinion, Mr B said that the family could see her deterioration and did raise concerns, but that at no stage did Bupa staff recognise the seriousness of her condition.

Subsequent events

70. Mrs A was transferred and admitted to the public hospital.

71. There, a chest X-ray reportedly showed no perforation, and an abdominal X-ray showed no obstruction, but Mrs A was found to be faecally impacted[13] with a lot of air. There were no bowel sounds and it was thought that she had an ileus[14] due to the impaction. She developed atrial fibrillation[15] likely related to urinary tract sepsis,[16] and was diagnosed with acute on chronic renal failure.

72. Mrs A was admitted to the High Dependency Unit but, sadly, despite treatment, she passed away on Day 12.

Bupa review of care provided

73. Initially, Mrs A's family complained directly to Bupa about the care Mrs A received while at the rest home, and a family meeting occurred in 2018.

74. In response to the family's complaint, Bupa also undertook a review of the care, and issued a report in 2018. The review identified a number of areas of concern, including:

- Non-escalation of concerns.
- Inadequate handover process prior to admission.
- Incomplete documentation.
- Lack of pain and nausea management.

[13] A hardened mass of stool becomes stuck in the colon or rectum from chronic constipation.
[14] An obstruction of the bowel.
[15] An irregular and often rapid heartbeat.
[16] A toxic condition resulting from an infection of the urinary tract.

— Lack of bowel management in regard to the impact of oxycodone and ondansetron.

75. A further family meeting occurred in 2018.

Additional comment from Bupa

Pain relief

76. A formal assessment of pain was not conducted for Mrs A. There was also inconsistent administration of pain relief for Mrs A.

77. Bupa told HDC that communication with Mrs A's GP occurred on Day 1, Day 5, and Day 7. Bupa stated:

> "While the communications from staff did not expressly ask the GP to come and assess [Mrs A], we believe that there would be a shared responsibility with the GP in the GP response to the information staff had provided."

78. Further, Bupa noted that Mrs A was prescribed "as required" (PRN) pain relief, and that the family subsequently advised that pain had been an issue while Mrs A was in hospital. Bupa stated:

> "If this was the case, Bupa would question why [the public hospital] had prescribed pain relief [as required] … It is reasonable to expect that a care home would follow discharge information from the Hospital in the initial period."

79. However, Bupa acknowledged that "formal regular pain assessments would have been beneficial".

Anti-emetics

80. There appears to have been inconsistent administration of anti-emetic medication during Mrs A's admission to the rest home.

81. In relation to Mrs A's nausea, Bupa said that it has since been advised that nausea was also an issue while Mrs A was in hospital. Bupa stated:

> "Given that the anti-emetic medication was prescribed [as required] per [the public hospital's] discharge form, and the GP subsequent prescription, and the later further prescription from the [DHB] orthopaedic outpatient staff, and given that [Mrs A] was able to express when she felt nause[ated], the anti-emetic was not given on a regular prevention basis."

Laxatives

82. Despite having been prescribed lactulose and Laxsol "as required", it appears that Mrs A was not administered any laxatives during her admission at the rest home.

83. Bupa stated that there was no information in the public hospital's discharge paperwork regarding when Mrs A had last had a bowel motion. Bupa noted that while Mrs A was at the rest home, she was recorded to have had bowel motions on Day 2, Day 3, and Day 6, and

that according to Bupa guidelines, further assessments and interventions should occur after three days of no or inadequate bowel movements.

84. Further, Bupa noted that Mrs A was discharged on "as required" laxatives, and that there was no record that laxatives were part of her regular medication. Bupa stated:

> "Given laxatives were not charted to be given as a regular medication, and given the regularity and amount of bowel motions, [rest home] staff did not administer laxatives."

85. However, Bupa's complaint review acknowledged:

> "[There appears to have been] no consideration given to the fact she was having regular oxynorm and ondansetron, both of which can cause constipation. Her overall clinical picture of a poor appetite, reduced fluid intake, reduced mobility and medications should have alerted staff. There appears to have been no consideration to administer prophylactic laxatives despite these having been prescribed by the GP."

Medical input

86. Rest home staff did not request a medical review of Mrs A during her admission.

87. In relation to whether there was a delay in seeking medical review during her admission, Bupa noted that "in hindsight", sending documentation to the Orthopaedics team at the public hospital at the time of [Mrs A's] [Day 6] orthopaedic review would have "had some benefits". However, Bupa stated: "[W]e would suggest that it would not be common practice to send that type of documentation to an orthopaedic outpatient's appointment."

88. However, Bupa acknowledged that there was a missed opportunity to escalate concerns on Day 7. Bupa stated:

> "We agree that there was a missed opportunity on [Day 7], where the nursing staff should have escalated their concerns more urgently, and at the least, consulted with the Clinical Manager on that date."

Call bell

89. Mrs A's family told HDC that on numerous occasions they noted that the call bell was out of Mrs A's reach. In response to this, Bupa stated:

> "We deeply regret that there were several occasions where [Mrs A's] call bell was not within her reach, and this was not acceptable. An apology was given at the time to the family, and subsequently. As a corrective action at the time, and at the family request, [Mrs A] was placed on a 30 minute observation by staff."

Documentation

90. In relation to the adequacy of the clinical documentation, Bupa agreed that a short-term care plan should have been initiated in relation to the management of Mrs A's UTI. Further, it stated:

> "The registered nurses did not undertake/document a full nursing assessment or appear to consult with the Clinical Manager regarding [Mrs A's] care, as would be expected when a resident's health condition appeared to be deteriorating."

91. Bupa also said that some dates of communication with Mrs A's family were not recorded on the family/whānau record sheet. While it noted that there is an expectation that this would have been done, it stated:

> "[T]his record is only intended to be brief, as longer and more detailed accounts should be, and were, documented in the clinical file. Communication with the family was written in more detail within the progress notes, as required within the Bupa work instructions and policies at the time."

Relevant Bupa policies

"Short Stay — Residents" policy

92. The "Short Stay — Residents" (2015) policy states:

> "'Clinical Risks — Continuity of care and safe handover'
>
> We identify that the key risk areas around short stay admissions are
>
> - Failure to recognise acute decline
> - Inadequate handover of care
> - Safe management of medications …
>
> It is up to the admitting qualified nurse to consider and complete any additional relevant clinical assessments based on risks, needs or issues identified at admission …
>
> If any additional clinical risks, needs or issues are identified, the required intervention must be documented in the short stay support plan, or a specific care plan if more complex."

93. Under "Nursing assessment", the policy states: "Completed by Registered Nurse on day of admission … Additional care plans completed as appropriate to manage any identified risk or specialised care/interventions."

"Bowel Record" policy

94. The "Bowel Record" policy states that all residents should have a bowel record maintained and recorded at the end of every shift.

95. When a resident's bowels have not opened "within three days (or there have been no recordings made on the bowel chart) it is the responsibility of the RN to ensure that appropriate assessment and intervention occurs and is documented".

"Pain Assessment and Management" policy

96. The "Pain Assessment and Management" policy states that a formal pain assessment — the Iowa assessment tool for residents who are verbal — is to be completed by a registered nurse within 12 hours of admission for any resident where:

- Pain has been identified as an issue in the transfer documents
- Resident or family confirm that pain is an issue at admission
- Resident is admitted on analgesia/pain relief

Changes made by Bupa

97. Bupa outlined a number of actions it has taken since receiving this complaint, including:

- Any hospital respite patients are visited in hospital prior to transfer, and a pre-admission assessment is undertaken.
- Incontinence pads are not allocated to short-stay residents routinely.
- The Bristol Stool Chart is now included with every resident's bowel chart.
- Education sessions have been provided on:
  - Person centered continence;
  - Pain management;
  - Use of the ISBAR[17] template; and
  - Escalation of concerns.

98. In addition, Bupa advised that it has been implementing "The Bupa Care Journey", which it explained as follows:

> "The Care Journey is Bupa's philosophy that guides how we run our care homes to provide quality of care and quality of life for our residents, to make sure our residents are front and centre of everything we do, to consistently deliver best practice care and services, and to minimise instances of missed care and complaints …"

99. Bupa also told HDC that as part of the corrective action plan to address Mr B's concerns, a memo was sent out to staff stating that short stay residents do not get pads allocated. The memo stated:

> "I would like to remind you all that all short stay residents do not receive continence product unless they are provided by family or made an arrangement with the facility manager. I am sure that this has been mentioned multiple times. It was b[r]ought up by a family member that staff are providing pads when they don't need it. Please remember to treat our residents with respect and dignity …"

[17] ISBAR (Identify, Situation, Background, Assessment, Recommendation) is a tool used for communication/handover of a patient's condition.

Responses to first provisional opinion

Mr B

100. Mr B was given an opportunity to comment on the "information gathered" section of my first provisional report. Where relevant, his comments have been incorporated into this report.

Bupa Care Services NZ Ltd

101. Bupa was given an opportunity to comment on the provisional decision. Bupa stated:

> "Bupa acknowledges that the care provided to [Mrs A] did not, at many times, meet our own organisational expectations. We would again offer our sincerest apologies to the whānau of [Mrs A] for these instances."

102. Bupa reiterated its submission that the transfer information provided by the public hospital at admission did not contain certain information, and considers that responsibility cannot rest solely with Bupa. It submitted that had sufficient information been provided at the time of admission, this may have allowed medical and nursing staff to identify and plan care more appropriately, in reflection of Mrs A's recent needs.

Management of continence — response to provisional opinion and further information gathered

103. With respect to the management of Mrs A's continence, Bupa provided HDC with new evidence at the provisional opinion stage, which had previously not been provided to HDC. In relation to the "pee into pad" comment, Bupa advised that it had located an interview with the relevant staff member, and submitted that it appeared that this staff member was discussing the use of a "wrap" as an alternative supportive option, and this was in the context of Mrs A having had two episodes of incontinence (i.e., on Day 7) and difficulty managing a bedpan. Bupa stated that this was an attempt to reassure Mrs A and not intended in a negative or disrespectful way, and apologised that the attempt to reassure was taken in a negative way by Mrs A or her whānau.

104. In response to this, Mr B submitted that this information, in addition to the family's recollections, therefore indicates that there was more than one incident of Mrs A being told to use incontinence products instead of a pan, commode, or toilet, and/or being unable to call for assistance.

105. Bupa also submitted that:

a) Mrs A was able to communicate her needs and give consent to treatment, and while she may have informed Ms E that she had felt humiliated about being put in an incontinence pad at night time, there is no record that this was communicated to Bupa.

b) After being diagnosed with a UTI, there were two episodes of urinary incontinence, and, in this context, it would be deemed more disrespectful not to offer continence products as a supportive management option, and it disagrees that incontinence pads were not clinically indicated.

106. Further information was requested from Bupa in relation to when Mrs A was provided with pads, wraps, or pull-ups. Bupa advised that it was unable to establish a date on which Mrs A was first provided with continence products, as it had no entries in its electronic system of any allocation of products to Mrs A. Bupa believes that any provision of continence products would have occurred after the episodes of incontinence, i.e., on Day 7.

Response to second provisional opinion

Bupa Care Services NZ Ltd

107. As a result of the new information received in response to the first provisional opinion, Bupa was provided with a copy of the second provisional opinion. Bupa acknowledged the findings and accepted the recommendations.

Opinion: Bupa Care Services NZ Ltd — breach

Introduction

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

109. Mrs A was transferred from the public hospital to the rest home on a short respite stay while she awaited a decision about the management of a double fracture of her humerus. Guided by advice from my nursing expert, RN Jan Grant, I have identified a number of deficiencies in the care provided to Mrs A during her eight-day stay at the rest home, as set out below. I consider that Bupa holds primary responsibility at a systems level for these deficiencies.

Admission information

110. At the time of Mrs A's admission to the rest home, the transfer documentation provided by the public hospital included a clinical discharge summary with details of Mrs A's primary diagnosis, the mechanism of injury and investigation results, her past medical history, current medications, the progress she had made in hospital, and the current management plan.

111. Mrs A was provided with a prescription for paracetamol, lactulose, and ondansetron. She was also provided with a prescription for the controlled drug oxycodone.

112. A verbal handover, followed by a nursing transfer letter that included relevant observations and nursing interventions, was also provided.

113. RN Grant advised:

> "The discharge information [provided by the public hospital] is in keeping with what is common practice and, in my opinion, would be viewed as acceptable practice by my peers."

114. I note Bupa's submission that the information provided by the public hospital did not include information regarding issues with pain and nausea, which had delayed Mrs A's discharge from hospital, or that an IDC had been removed recently, or that her arm cast had been changed recently, and how this was impacting on her pain levels.

115. While RN Grant acknowledged that this information was not provided in the transfer information, she advised that this information should have been identified by the rest home during the admission assessments.

116. I accept RN Grant's advice. I am satisfied that the information available to the rest home at the time of Mrs A's admission to the rest home was consistent with accepted standards. While there was information that may have aided the rest home staff with its subsequent management of Mrs A, as noted by RN Grant:

> "An informative discharge letter is helpful, but it remains the responsibility of the facility admitting the patient to do its own assessments. If there are discrepancies then a phone call is often able to clear up any issues."

117. I agree. In my opinion, it is the responsibility of the receiving facility to ensure that a full and comprehensive assessment is carried out at the time of admission. I discuss the adequacy of the admission assessment in more detail below.

Admission assessment

118. I am concerned about the adequacy of the admission assessments and documentation following Mrs A's transfer to the rest home.

119. At the time of Mrs A's admission to the rest home, a "Short Stay Support Plan", a "Short term care plan for fracture", a nutritional chart, and transfer plan were completed. Bupa told HDC that these assessments and paperwork were completed by a "student enrolled nurse" using the discharge documentation from the public hospital. However, Bupa stated that a registered nurse did review and sign the care plan.

120. The Bupa "Short Stay — Residents" (2015) policy states that the admission nursing assessment is "[c]ompleted by Registered Nurse on day of admission [and] [a]dditional care plans completed as appropriate to manage any identified risk or specialised care/interventions".

121. RN Grant advised that the assessment carried out at the time of Mrs A's admission was inadequate. RN Grant advised:

> "I am of the view that the documentation is brief, limited, and lacks the details that would allow care workers to provide safe, effective care for [Mrs A]. It is noted that care workers may not have had previous experience with this type of injury. Hence it is my view that it is the responsibility of the registered nurse to ensure that clear direction is demonstrated and documented in a way that is easy for care staff to follow. I do not believe this was done."

122. In particular, RN Grant noted that there is no documentation regarding the care and support needed for Mrs A's fractured arm and shoulder, with the exception of the "Transfer Plan", which states: "[A]rm to be supported on pillow." RN Grant noted that there is no positioning diagram or instructions for staff on how to position and support the arm with pillows. Furthermore, RN Grant noted that there were no further details in the progress notes regarding arm positioning or support required for transfers or moving Mrs A, nor was there any referral for multidisciplinary support such as physiotherapy input.

123. RN Grant advised that this would be viewed as a moderate departure from accepted practice.

124. In response to RN Grant's advice, Bupa noted that this information was not contained in the transfer documentation from the public hospital. Bupa stated:

> "On arrival at the rest home, [Mrs A] was assessed as being able to verbally express when and if her arm/shoulder was comfortable or not. We submit that if the care of [Mrs A's] fractures required more specific positioning and a specific number of pillows, this would have been sent by [the public hospital] to [the rest home] in writing."

125. Further to this, Bupa noted that there was no evidence that an assessment by a physiotherapist was undertaken while Mrs A was at the public hospital, and there was no evidence that she needed any specialised equipment.

126. Having considered Bupa's submission, RN Grant remained of the view that the admission assessment was inadequate and should have been carried out by a registered nurse. She stated:

> "I believe that any competent Registered Nurse would have identified the issues of positioning, and the equipment needed to assist [Mrs A]. The Registered Nurse's care plan would, in my opinion, have identified all the care issues and the need for ongoing evaluations to review cares [if] the need arose."

127. I accept RN Grant's advice. In my opinion, the assessment and documentation completed at the time of Mrs A's admission was inadequate. It was inappropriate, and a deviation from Bupa's own policy, for this task to be delegated to a student enrolled nurse. The failure to ensure that a comprehensive assessment was carried out at the time of admission meant that specific and detailed information was not available for care staff to follow, and this had a significant impact on the ongoing care provided to Mrs A.

Pain and medication management

128. I am concerned at the failure of staff to carry out a formal pain assessment, and the inconsistent administration of Mrs A's medications, particularly for pain and nausea management.

129. At the time of discharge from the public hospital, Mrs A was provided prescriptions for paracetamol, lactulose, ondansetron, and oxycodone. All these medications were charted to be administered PRN (as required).

130. The Bupa "Pain Assessment and Management" policy requires a formal pain assessment to be completed by a registered nurse within 12 hours of admission for any resident who is admitted on analgesia medications, or who reports pain as an issue on admission.

131. The Competencies for Registered Nurses (Nursing Council of New Zealand, 2007) Domain Two: Management of Nursing Care; Competency 2.1 states: "Provides planned nursing care to achieve identified outcomes." Indicator 4 states: "Administers intervention, treatments and medications within legislation, codes and scope of practice; and according to authorised prescription, established policy and guidelines."

132. Following Mrs A's admission, she experienced ongoing issues with pain and nausea. Despite this, she was not given regular pain relief or regular anti-emetic medications. On Day 4 — day three of Mrs A's stay — Mr B raised concerns about this, and subsequently a plan was implemented for Mrs A to be placed on 30-minute checks, to be given oxycodone every four hours, and to be given anti-nausea medication three times a day with each dose of oxycodone. However, Mrs A's medications continued to be given inconsistently, and her pain and nausea were uncontrolled.

133. Mrs A's ongoing issues with pain and nausea were noted by the Orthopaedics staff at her clinic visit to the public hospital on Day 6, and a second anti-emetic medication — metoclopramide — was prescribed. Following this clinic visit, at no stage was a pain assessment completed, nor was Mrs A's nausea formally assessed and documented.

134. RN Grant noted the inconsistency in the administration of regular pain relief. She advised that it is common practice to use regular paracetamol as background analgesia, and to add the stronger analgesia as required. In addition, she advised that it would have been reasonable to use oxycodone prior to cares that were likely to cause pain, and for "the Registered Nurse to seek clarification of the pain management regime from the general practitioner early in the admission".

135. RN Grant also considered that an Iowa pain assessment should have been commenced on admission, as per Bupa policy.

136. RN Grant noted that there was also inconsistency with the use of anti-emetic medications, and advised that common practice is for an anti-emetic to be administered prior to opioid pain relief. RN Grant advised:

> "It is my view that when a patient is admitted with Oxycodone charted for pain relief and an anti-emetic charted for relief of nausea, then this should have red-flagged Registered Staff that pain and nausea would be an ongoing issue."

137. In its statement to HDC, Bupa noted that Mrs A's GP was made aware of her ongoing issues with pain and nausea. Bupa stated:

> "While the communications from staff did not expressly ask the GP to come and assess [Mrs A], we believe that there would be a shared responsibility with the GP in the GP response to the information staff had provided."

138. Further, Bupa noted that Mrs A was prescribed "as required" pain relief and anti-emetic medication. Bupa submitted that because Mrs A was able to express when she felt pain and nausea, these medications were not given on a regular basis. Bupa also noted that the family has subsequently advised that pain had been an issue while Mrs A was in hospital. Bupa stated:

> "If this was the case, Bupa would question why the public hospital had prescribed pain relief [as required] … It is reasonable to expect that a care home would follow discharge information from the Hospital in the initial period."

139. Having considered Bupa's submission, RN Grant reiterated her view that a pain assessment should still have been completed following Mrs A's admission. RN Grant stated:

> "Had adequate pain assessments been undertaken, then staff would have had a better understanding of the severity of [Mrs A's] pain and frequency of it. This in turn would have clarified the need for a specific pain management regime."

140. Further to this, RN Grant stated:

> "I believe the clinical notes show that there are inconsistencies in pain assessment and a lack of detailed individualised assessment expected of a registered nurse and certainly expected of a senior registered nurse."

141. I agree. Despite Mrs A having ongoing issues with pain and nausea throughout her stay, this was not appropriately assessed and managed by staff, resulting in Mrs A's family having to flag this to staff.

142. I do not accept Bupa's submission that staff were following discharge instructions from the hospital, and that the GP shared responsibility for the lack of assessment. In my opinion, as noted in the previous section, Bupa had a responsibility to ensure that its nursing staff carried out their own assessments, in accordance with Bupa policy and the standards expected of a registered nurse.

Laxatives

143. Mrs A was also charted lactulose and Laxsol to treat constipation. However, it does not appear that these were given during Mrs A's stay.

144. Bupa's "Bowel Management" policy states that all residents should have a bowel record maintained and recorded at the end of every shift. When a resident's bowels have not opened "within three days (or there have been no recordings made on the bowel chart) it is the responsibility of the RN to ensure that appropriate assessment and intervention occurs and is documented".

145. According to the clinical records, Mrs A's bowels opened on Days 2, 3 and 6. Bupa stated:

> "Given laxatives were not charted to be given as a regular medication, and given the regularity and amount of bowel motions, the rest home staff did not administer laxatives."

146. RN Grant advised that constipation is one of the side effects of oxycodone, "so laxatives should have been administered regularly as a preventive measure". RN Grant stated that all registered nurses should be aware of this. I note that Bupa's complaint review report acknowledged this.

147. While RN Grant noted that Mrs A's bowels opened while at the rest home, there is no evidence that constipation was considered as a side effect of the medication. RN Grant stated: "In my view this should have been detailed in a short term care plan to ensure it was identified and appropriately managed."

148. I note that when Mrs A was admitted to the public hospital, faecal impaction was identified.

Conclusion

149. RN Grant advised: "Overall, my opinion is that [Mrs A's] pain management, anti-emetic usage and bowel management medications were poorly managed." I note RN Grant's view that these failings would be viewed as a moderate departure from accepted standards.

150. I accept RN Grant's advice. It appears that staff were reliant solely on the information provided by the public hospital. In my opinion, the lack of assessment and evaluation demonstrates a lack of critical thinking by the nursing staff at the rest home.

Delay in obtaining clinical review and transfer to hospital

151. I am concerned by the failure of staff to undertake any formal nursing assessments or care plans throughout Mrs A's stay, or to request clinical review at any stage, despite clear indications to do so.

152. At 8pm on Day 4, Mrs A was noted to have a temperature (38.6°C), and she reported pain on passing urine. A dipstick urine sample was subsequently taken, which was positive, indicating a UTI. However, a specimen was not sent for testing, nor was a clinical review requested at that time.

153. The following day, on Day 5, Mrs A's GP was asked to write a prescription for antibiotics, which Mr B collected from the pharmacy.

154. On Day 6, Mrs A was seen at the public hospital for review of her wound and cast; however, her UTI was not communicated to staff.

155. Bupa noted that "in hindsight", sending documentation to the Orthopaedics team at the time of Mrs A's Day 6 orthopaedic review would have "had some benefits". However, Bupa stated: "[W]e would suggest that it would not be common practice to send that type of documentation to an orthopaedic outpatient's appointment."

156. Over the following days, Mrs A continued to experience pain and nausea. She also had two episodes of incontinence, passing urine on the floor, and she reported abdominal pain. She also had decreased activity, and refused food and water.

157. On Day 7, a fluid balance chart was commenced, but limited entries are recorded, with no urine output recorded. That day, Mrs A was reported to appear very tired and frail. On Day 8, she was noted to be dehydrated and in severe pain and, following a clinical review meeting, the decision was made to admit her to hospital.

158. At no time was a full nursing assessment carried out, nor was a short-term care plan documented in order to identify Mrs A's needs, nor was Mrs A referred for medical review. Further, as noted by RN Grant, senior nursing management did not appear to be involved in any decision-making.

159. RN Grant considers that Mrs A's GP or the hospital doctor should have been asked to review Mrs A's pain relief and the management of her nausea and constipation soon after her admission. There is no evidence that this was done.

160. Further to this, RN Grant advised that clinical review should have been requested after Mrs A was noted to have a UTI and continued to deteriorate. However, despite staff requesting a prescription for antibiotics to treat the UTI, no request for clinical review was ever made.

161. RN Grant stated:

> "There was clinical indication that [Mrs A] was acutely unwell on [Day 7] and consideration to contacting medical input or transfer to the DHB should have been made at this time. If one considers abdominal pain as well as shoulder pain, inability to eat and drink and the presence of nausea despite medications, then these are all good clinical reasons to request a medical opinion. In my opinion staff should have been alerted to seek medical attention as soon as possible."

162. RN Grant advised that the delay in transferring Mrs A to hospital would be viewed as a moderate to severe departure from accepted standards.

163. I accept RN Grant's advice. It is concerning that despite pain and nausea being ongoing issues, no formal nursing assessments were undertaken, nor was a clinical review requested despite a UTI being identified on Day 5 and further deterioration noted on Day 7.

164. I note that Bupa acknowledged that there was a missed opportunity to escalate concerns on Day 7, or "at the least, [consult] with the Clinical Manager on that date".

Continence

165. It is not disputed that at the time of her admission to the rest home, Mrs A was continent and therefore did not require continence products.

166. On the evening of Day 4, Mrs A was diagnosed with a UTI, and her two episodes of incontinence occurred on Day 7, the day before her transfer to the public hospital.

167. In a statement dated Day 18, Ms F recalled Mrs A wearing a pad in the evening of Day 3. Similarly, in a statement dated Day 17, Ms E recalled Mrs A telling her on Day 5 that she had been put in a pad at night time.

168. The family were concerned that Mrs A was given pads despite being continent and was at one stage told to "pee into the pad".

169. Bupa initially told HDC that it was very concerned to read in the complaint that Mrs A had been given a pad and had been told to "pee into pad". It believed that this staff member was a "student enrolled nurse" and had addressed the matter with the staff member following receipt of the complaint. Bupa advised of a number of actions taken, including that incontinence pads are no longer allocated to short-stay residents routinely, education sessions had been provided to staff on person-centred continence, and a memo had been sent to all staff reminding them that short-stay residents do not get pads allocated.

170. In response to the provisional opinion, Bupa provided new information with respect to the "pee into pad" comment, stating that Mrs A had not communicated to staff that she felt humiliated, and that in the context of being diagnosed with a UTI and two episodes of urinary incontinence, it would be deemed more disrespectful to not offer continence products as a supportive management option. Bupa therefore disagreed that incontinence pads were not clinically indicated.

171. When asked to clarify the dates on which pads were provided to Mrs A, Bupa was unable to clearly establish the dates on which this occurred. It advised that there were no entries in its electronic system of any allocation of products to Mrs A. Bupa believes that any products would have been provided after Mrs A's episodes of incontinence.

172. RN Grant advised:

> "Evidence presented at admission indicated that [Mrs A] was continent. It must be a nursing objective to maintain continence throughout her stay. …
>
> I would question why pads were provided to [Mrs A] as there is no indication in the clinical notes that she was incontinent on admission. There is no documentation that the choice to wear pads or not was discussed with [Mrs A] at any time.
>
> The clinical notes stated that she was incontinent twice on the morning of [Day 7]. By this time a urinary tract infection had been identified and [Mrs A] was acutely unwell. There is nothing documented to show that she was incontinent before this time. …
>
> I am of the opinion that there was assistance given to [Mrs A] to assist her to walk to the toilet, but that at times she was unable to call for assistance. The use of pads, in my view, was not clinically indicated and the comments to 'pee into pad' as opposed to toileting is unprofessional and not indicative of individualised nursing care.

> In my opinion this would be viewed as a moderate departure from acceptable standards. I believe my peers would also view this as a moderate departure from acceptable standards."

173. Having considered the new information and submissions, I reach the following conclusions.

Comment made by staff member

174. The evidence outlined above about the comment to "pee into [the] pad" has highlighted the importance of being respectful and considerate when providing such cares. Mrs A was an elderly consumer who was previously living independently, was competent, and on admission was continent (and was so for the majority of her admission). In this context, sensitivity must be shown when discussing matters that could cause a consumer distress or embarrassment.

175. Bupa submitted that the comment for Mrs A to "pee into [the] pad" was made in the context (and timing) of episodes of incontinence and difficulty managing with a bedpan, and was intended to reassure her, whereas Mrs A's family recall such comments being made prior to those events.

176. In my view, even where the use of pads is clinically indicated, it is important that staff members be mindful of their communication and the manner in which they broach such topics. It is appropriate that Bupa has provided education to staff about person-centred continence.

Use of incontinence products

177. With respect to the timing of when Mrs A was provided with pads and whether this was clinically indicated, I note that Mrs A was diagnosed with a UTI in the evening of Day 4, and her two episodes of incontinence occurred on Day 7, the day before her transfer to the public hospital.

178. Bupa advised that it has been unable to clearly establish a date when Mrs A was first provided continence products, but believes that any products would have been provided after the episodes of incontinence.

179. However, both Ms F and Ms E recall that Mrs A was provided with pads prior to her episodes of incontinence on Day 7.

180. On the evidence available to me, namely the recollections of Ms E and Ms F, and the absence of any documentation to the contrary from Bupa, I consider that it is more likely than not that Mrs A was provided with pads prior to her episodes of incontinence on Day 7. In addition, as outlined above, RN Grant took into account the episodes of incontinence and the diagnosis of a UTI, and nevertheless advised that the use of pads was not clinically indicated. I accept this advice.

181. While I accept that it would have been reasonable to consider the use of continence products after the episodes of incontinence, I am critical that these were provided to Mrs A prior to this when she was continent.

Call bell

182. The family noted that on numerous occasions the call bell was left out of Mrs A's reach. I note that Bupa acknowledged that this occurred and considered it unacceptable.

183. RN Grant advised that the failure to ensure that the call bell was within Mrs A's reach at all times was a "departure from acceptable nursing care". I agree, and am critical that this occurred.

Conclusion

184. Rest-home residents are a vulnerable population, and short-stay residents are particularly at risk. As noted in Bupa's "Short Stay — Residents" policy, the key risk areas around short-stay admissions include a failure to recognise acute decline, inadequate handover of care, and safe management of medications. It is disappointing that despite being cognisant of these risks, there were multiple failings in the care provided to Mrs A during her short stay at the rest home. Those failings resulted in Mrs A suffering with significant pain, nausea, and discomfort during her stay at the rest home, which, sadly, were some of her final days.

185. In my view, it was the responsibility of Bupa to have in place adequate systems to ensure that Mrs A was provided with care of an appropriate standard. Overall, I consider that the failures of staff demonstrate a pattern of suboptimal care, and Bupa is responsible for the service provided by its staff. In particular, I am critical of the following:

a) The lack of assessment and care planning by a registered nurse at the time of Mrs A's admission, in accordance with Bupa policy. I note that RN Grant considered the failure to have registered nurse input as a central issue.

b) Directions were insufficiently clear, and the documentation was brief, limited, and lacked the details that would allow care workers to provide safe, effective care for Mrs A's fractured arm and shoulder.

c) The failure to undertake a pain assessment during Mrs A's stay, in accordance with Bupa policy and nursing standards, despite Mrs A's uncontrolled pain.

d) Inconsistent and inappropriate use of pain relief and anti-emetics despite uncontrolled pain and nausea throughout Mrs A's stay, as well as a failure to administer laxative medications.

e) The failure to undertake a formal nursing assessment, develop a relevant short-term care plan, or seek medical review after Mrs A was noted to have a UTI, or after she demonstrated a clear deterioration in her condition by Day 7.

f) The management of Mrs A's continence.

g) The call bell being left out of her reach on a number of occasions.

186. In conclusion, for the reasons set out above, I consider that Bupa failed to provide services to Mrs A with reasonable care and skill, and therefore breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

Recommendations

187. I recommend that Bupa Care Services NZ Ltd:

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

b) Undertake an audit of patient records over the preceding three-month period to confirm the inclusion and correct use of the Bristol Stool Chart for every resident. This information should be provided to HDC within three months of the date of this report.

c) Undertake an audit of all new admissions over the preceding three-month period to confirm that the relevant admission assessments (including pain assessments, where indicated) have been completed by a registered nurse. This information should be provided to HDC within three months of the date of this report.

d) Use the findings of this complaint as a basis for training staff at its facilities, in a way that maintains the anonymity of all parties involved, and provide evidence of that training within three months of the date of this report.

e) Schedule refresher education for all the rest home nursing staff on the following topics, to be provided within the coming three months, and schedule regular and ongoing education sessions every two years for pain management and care planning, and provide evidence of this, within three months of the date of this report:

   i. Short-term care plans.
   ii. Use of assessment tools such as the Iowa pain assessment.
   iii. Clinical review and transfer of patients to hospital.
   iv. Documentation.
   v. Management of a deteriorating condition.

f) Review and update, with reference to current best practice, its "Short Stay — Residents" policy for accepting a patient from hospital, and the discharge summary information required from the DHB at the time of transfer. Evidence of this should be provided to HDC within three months of the date of this report.

Follow-up actions

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

189. A copy of this report with details identifying the parties removed, except Bupa Care Services NZ Limited and the expert who advised on this case, will be sent to 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 Jan Grant:

"I have been asked to provide an opinion on the care provided to [Mrs A] by [the rest home] …

I have no personal or professional conflict of interest in the case. My advice is based on a review of the documentation provided.

I have read and agreed to the Commissioner's guidelines.

I am a Registered Nurse with over 30 years of experience in Aged and Community Care. In that time, I have had a variety of roles. I have been Manager and Director of Nursing of an aged care facility and in community care for 17 years. I have represented the NZNO and the Aged Care Sector on several national working parties. I have been involved in setting standards for Practice for Gerontology Standards. I have been a clinical tutor and guest speaker both here in New Zealand and overseas. I have had international papers published. My immediate past role was as Clinical Advisor/ Rehabilitation Coordinator in the community. I am a designated assessor for ACC. I have post graduate qualifications in nursing and a Masters degree in management, with nursing ethics and research as a focus.

Questions

…

1. The handover documentation to [the rest home]

Handover documentation included a medical discharge letter dated [Day 1], timed at 11.43am. The discharge letter included primary diagnoses and long-term medical diagnoses. Clinical information includes medical diagnoses and regular medications. It states the injury and the cause of injury, as well as social living arrangements. The results of the examination and XRay are listed. The letter goes on to describe the progress [Mrs A] made in hospital and the plan for her on discharge. It states in the plan that she is to have a follow up visit at clinic, at which time arrangements would be made for internal fixation vs non-operative management. It states that [Mrs A] is to be discharged to [rest home] care under [residential respite agreement] until a definitive plan for the management of her fractured humerus is decided.

The letter states that *'if you experience increased swelling, severe pain, any numbness or tingling, please seek medical attention'*.

Discharge prescriptions included:

Paracetamol 1 g PO QID PRN for pain, 2 weeks supply

Lactulose 2 tabs PO BD PRN for constipation, 2 weeks supply

Ondansetron 4mg po 8hrly PRN for nausea, 3 days supply.

A controlled drug prescription was supplied for oxycodone immediate release, 5mg orally every four hours as needed for pain. The prescription was for 4 days supply.

A nursing transfer letter was included in the discharge information. This was a two page document, listing relevant observations and key nursing interventions. It outlines [Mrs A's] activities of daily living. Under the heading of pain management the notes state: *'refer to copy of meds chart'.*

The discharge information is in keeping with what is common practice and, in my opinion, would be viewed as acceptable practice by my peers.

2. The management of [Mrs A's] fractured shoulder

The nursing management of [Mrs A's] cares while in [the public hospital] would, in my opinion, meet professional standards.

In relation to the medical management of [Mrs A's] fractured shoulder, I believe this opinion should be sought by medical staff.

[Rest home]

Background

[Mrs A] was admitted on [Day 1] from [the DHB] under the [residential respite agreement] for a duration of 23 days. She had a review pre-booked to return to [the DHB] on [Day 6], with a second review scheduled for [Day 13]. [Mrs A] returned on [Day 6] but was later admitted back to [the DHB] on [Day 8] due to acute illness.

Admission information and clinical notes include:

- Convalescent care on discharge from DHB summary
- Medical discharge letter
- Nursing transfer letter (DHB)
- Prescription form (DHB)
- Medication signing sheets (Bupa)
- Short stay admission checklist (Bupa)
- Family/whānau contact record (Bupa)
- Short stay admission information (Bupa) 2 pages
- Short stay support plan (Bupa) 2 pages
- Short term care plan — fracture (Bupa) one page
- Transfer plan (Bupa) 2 pages
- Progress notes (Bupa) 7 pages
- Nutritional requirements (Bupa) one page

- Bowel record (Bupa) one page
- Short stay admission record (Bupa) one page
- TPR/blood pressure chart (Bupa) one page
- Plaster/fiberglass cast record (Bupa) one page
- Physical check (Bupa) two pages
- Fluid Balance chart — two pages
- Resident van outing consent

The management of [Mrs A's] fractured shoulder at [the rest home]

The Medical discharge summary from [the DHB] clearly outlines [Mrs A's] diagnoses as well as her other pre-existing medical conditions. The nursing transfer letter gives baseline recordings taken at 7.30am on the day of discharge.

It states that assistance is required for personal cares. The assistance required for daily living is noted as*: Mobility — walking frame; walking — assistance of one person.*

Skin is listed as: *Wound on L elbow, to be seen in clinic in one week's time.*

Washing, grooming, bathing, showering and dressing all state that: *assistance of one person is required.*

Diet is listed as: *Needs assistance to set up and needs assistance with meals.*

No information is documented in the Bupa clinical notes as to the verbal handover information given by the registered nurse at [the public hospital] at 1210hrs on [Day 1]. Clinical progress notes written by the RN at 2215hrs on [Day 1] state that *'obs (observations*) *completed'*, as were the nutritional chart and the STCP (short term care plan) for # (fracture). Cast monitoring was commenced. Family visited. Medications were available in the treatment room. [Mrs A] was settled in bed and had declined pain relief.

There is no documentation as to the care and support of [Mrs A's] arm and shoulder, except for a comment in the transfer plan: '*arm to be supported on pillow'.* There is no positioning diagram or instructions to show care staff the number of pillows to use and how to position the arm on the pillows.

The progress notes throughout [Mrs A's] stay do not expand on positioning or support required in relation to shoulder/arm care. Neither progress notes nor the short-term care plan explains how to transfer and/or mobilise the patient, apart from this statement in the short term care plan: *'1 x assist with walking frame and transfer belt'.* The 'transfer plan' notes that the sling is to be used to support the arm, but there is limited information in the nursing progress notes to indicate if this was followed through in her care. No evaluation was documented.

Family have commented that staff attempted to lift [Mrs A] up the bed by having care staff place their arms underneath her in order to move her. This was noted to be painful and so staff then used a 'slippery sam' to re-position her further up the bed.

There is no evidence that multidisciplinary support, such as physiotherapy input, was sought to assist staff with positioning and thus prevent excessive pain during movement and mobilising. In the event that staff did not have the appropriate knowledge then it would be an expectation that they would access this knowledge by contacting various specialists. Examples are: phone calls to [the public hospital], the general practitioner, physiotherapist or nurse practitioner. There is no evidence available to show if senior clinical staff at [the rest home] were involved in her care in relation to shoulder positioning.

I am of the view that the documentation is brief, limited, and lacks the details that would allow care workers to provide safe, effective care for [Mrs A]. It is noted that care workers may not have had previous experience with this type of injury. Hence it is my view that it is the responsibility of the registered nurse to ensure that clear direction is demonstrated and documented in a way that is easy for care staff to follow. I do not believe this was done.

It is noted that in the complaint review undertaken by Bupa of [2018] (page7), *'the morning RN had asked a student enrolled nurse to complete the care plan and the nursing transfer letter from the hospital was used to complete it. The RN did review the care plan and sign it. The RN stated that they are often too busy to complete the care plan with the residents but will check it with them if possible'*.

The lack of detail in the care plan may have been firstly due to unqualified staff completing it, and secondly to a lack of a full, individualised review of [Mrs A] and the care plan by a registered nurse prior to signing it.

Assessments and care plans should, in my opinion, be completed by a Registered Nurse. This requirement was stated in the policy for short term residents used at the time of [Mrs A's] stay. Competent nursing care would have included a thorough assessment and management plan, with specific and detailed information to allow untrained staff to provide care and meet [Mrs A's] needs. There is no record of any equipment utilised to support [Mrs A's] needs. An example would be a monkey bar to assist her to support herself when sitting up in bed. No assessment appears to have been carried out. As previously stated, no physiotherapy input was requested.

It is also noted that the nutritional requirement form which was completed on admission indicates that [Mrs A] does not require assistance with feeding. This conflicts with the nursing transfer letter from [the DHB]. The short stay support plan notes that [Mrs A] eats well and needs her meals to be cut up. Family noted that several times they arrived and that the call bell was not within reach, fluids were also not within reach and at times food was presented in such a manner that [Mrs A] was unable to manage by herself. I believe that [Mrs A] would have required assistance with meals, certainly

cutting up the food into bite-sized pieces, as well as the correct positioning of fluids in order to feed herself.

Summary

In my opinion the management of [Mrs A's] fractured humerus was poorly assessed and poorly documented and this would be viewed as a moderate departure from acceptable professional standards by my peers.

[Mrs A] was admitted to Bupa [the rest home] on [Day 1]. She had sustained a fractured L humerus and a wound to the L elbow. She was awaiting a decision as to how this fracture was to be managed. It would be reasonable to expect this injury to be painful, especially on movement.

The medication list in the medical discharge letter lists her usual medications as well as the discharge prescriptions. These included Paracetamol, Lactulose and Ondansetron. A controlled drug prescription was also provided for Oxycodone 5 mg orally every four hours as needed for pain up to a maximum daily dose of 30mg. There was limited information in the nursing discharge letter with the only note around pain management as being '*refer copy of meds chart.'*

No information was documented by the staff at [the rest home] about the detail given at the verbal handover by [public hospital] staff. No pain assessment — IOWA — was undertaken, despite this being a documented policy.

The table of medications [below] shows that there was inconsistency with regular pain relief. Paracetamol was not administered until [Day 4] at 2100hrs. Oxycodone which was charted 4hrly PRN was not given consistently, except for [Day 4] when it was administered 4 times over a 24hr period. It is common practice to use regular paracetamol, eg 1G qid, to provide a background level of analgesia and to add in the stronger analgesic (in this case oxycodone) on an as required basis. In [Mrs A's] case this did not happen. It would have been reasonable to use the oxycodone 30–60 minutes prior to cares that were likely to cause pain, such as showering and dressing. It would also have been reasonable for the Registered Nurse to seek clarification of the pain management regime from the general practitioner early in the admission.

The pain relief and anti-emetics provided to [Mrs A]

Date	Metoclopramide 10mg	Paracetamol 1 g QID PRN	Ondansetron 4mg Q8h	Oxycodone 5mg 4hrly PRN
[Day 1]			-	-
[Day 2]			0645	0730
[Day 2]				1835
[Day 3]			0730	0730

[Day 3]			1930	1905
[Day 3]				1920
[Day 4]		2100	0730	0730
[Day 4]			1130	1140
[Day 4]				1530
[Day 4]			21.15	2100
[Day 5]		0900, 1300, 1600	0900, 1600	1350
[Day 6]		0445, 0900	0445, 1730	04.5
[Day 6]				0900
[Day 7]	09.00, 12.30		1740	0030
[Day 7]	16.10			1040
[Day 7]				1903
[Day 8]	08.00	1000		

There is also inconsistency with administration of the anti-emetic medication. Nausea is an unpleasant symptom and is often associated with the use of opioid analgesics such as oxycodone. It can also be secondary to constipation and infections, both of which affected [Mrs A] during her stay at [the rest home]. Common practice is to administer the anti-emetic 1 hour to 30 min before administering opioid pain relief. This practice appears not to have been followed. Family brought this to the attention of staff on [Day 4]. Clinical progress notes indicate that [Mrs A] experienced pain and nausea. No pain assessment was completed during her stay despite identifying the presence of pain and family discussing this with staff. Similarly, the presence of nausea was not formally assessed and documented.

[Mrs A] was charted the anti-emetic, ondansetron, on her admission to [the rest home], to be used on a prn basis. A second anti-emetic, metoclopramide, was prescribed by [the public hospital] after a clinic visit on [Day 5]. On [Day 7] both anti-emetics were used at different times on the same day. In my opinion the choice of which drug to use would have been potentially confusing to nursing staff. It would have been helpful to clarify this with the general practitioner, particularly as [Mrs A's] condition was deteriorating by this time.

It is my view that when a patient is admitted with Oxycodone charted for pain relief and an anti-emetic charted for relief of nausea, then this should have red-flagged Registered Staff that pain and nausea would be an ongoing issue.

An IOWA pain assessment should have been commenced on admission and used as per policy. A short-term care plan was documented on [Day 1]. The plan stated: '*ensure pain levels are regularly assessed and appropriate pain relief provided*'. However, this was not carried through. This part of the short-term care plan had a tick beside it and written '*can communicate'.* The other comment under pain management was '*may need to commence pain monitoring chart'* but this was not completed.

Competencies for Registered Nurses (Nursing Council of New Zealand 2007) Domain Two: Management of Nursing Care; Competency 2.1 states: *Provides planned nursing care to achieve identified outcomes. Indicator 4 states: 'Administers intervention, treatments and medications within legislation, codes and scope of practice; and according to authorised prescription, established policy and guidelines*. I am of the view that this competency was not met.

A fax was sent to [Dr G] on [Day 5] requesting a prescription for oxynorm. The fax states that [Mrs A] was still requiring this and staff were unable to give pain relief as the original prescription from [the public hospital] was for a 4 day supply only. It is noted that paracetamol was given regularly on [Day 5] but nevertheless the delay in the request for further prescription of oxycodone meant that [Mrs A] was not provided with adequate pain relief. Staff should have been aware of this issue and planned accordingly.

[Mrs A] was charted Lactulose10–20 mls OD PRN and Laxsol 2 tbs BD PRN. Both medications are for management of existing constipation and to prevent constipation. There is nothing in the documentation viewed by me to show that these were given. The drug regime charted for [Mrs A] in relation to her pain (oxycodone) has the side effect of constipation and so laxatives should have been administered regularly as a preventive measure. I am of the view that this side effect should have been generally known to registered nurses. There is no evidence in the clinical notes to show that [Mrs A] refused this medication. There is also no evidence that constipation was considered as a side effect. In my view this should have been detailed in a short term care plan to ensure it was identified and appropriately managed.

[Mrs A] had been having bowel medications while in [the public hospital]. The [rest home] bowel chart shows [Mrs A's] bowels opening on [Day 2], [Day 3] and on [Day 6].

Summary

Overall, my opinion is that [Mrs A's] pain management, anti-emetic usage and bowel management medications were poorly managed. This relates to pain assessment and pain medication administration, the random use of anti-emetic medication, and the lack of use of laxatives. I believe the clinical notes show that there are inconsistencies in pain assessment and a lack of detailed individualised assessment expected of a registered

nurse and certainly expected of a senior registered nurse. I am also of the opinion that the likelihood of constipation in this patient was not recognised by the registered nurses, and as a result bowel activity was not adequately monitored or managed. Medical input to clarify medication usage should have been requested early in the admission.

I am of the view that my peers would view this as a moderate departure from acceptable standards.

The management of [Mrs A's] toileting when she was not incontinent

Evidence presented at admission indicated that [Mrs A] was continent. It must be a nursing objective to maintain continence throughout her stay. Family have noted that there were many times when they arrived for a visit that the call bell was not within reach or was not plugged into the wall. This is a departure from acceptable nursing care. At all times call bells must be within a patient's reach. It is acknowledged [Mrs A] needed the assistance and support of one caregiver to go to the toilet. It would have been unsafe for her to attempt this on her own.

I would question why pads were provided to [Mrs A] as there is no indication in the clinical notes that she was incontinent on admission. There is no documentation that the choice to wear pads or not was discussed with [Mrs A] at any time.

The clinical notes stated that she was incontinent twice on the morning of [Day 7]. By this time a urinary tract infection had been identified and [Mrs A] was acutely unwell. There is nothing documented to show that she was incontinent before this time.

In my opinion the urinary tract infection was identified in a timely manner but there was a delay in administration of antibiotics. No short-term care plan was documented for this event. In addition, she continued to deteriorate after the antibiotics were commenced and there seems to be no assessment or examination as to the reason for this. A urine specimen was not sent to the laboratory and the general practitioner was not contacted to review the situation.

I am of the opinion that there was assistance given to [Mrs A] to assist her to walk to the toilet, but that at times she was unable to call for assistance. The use of pads, in my view, was not clinically indicated and the comments to 'pee into pad' as opposed to toileting is unprofessional and not indicative of individualised nursing care.

In my opinion this would be viewed as a moderate departure from acceptable standards. I believe my peers would also view this as a moderate departure from acceptable standards.

The delay in transferring [Mrs A] to [the public hospital] on [Day 8]

The clinical notes show that [Mrs A's] health deteriorated throughout her stay. This related to the presence of ongoing pain and nausea and the development of an acute

urinary tract infection. Family identified this to staff although there is very limited evidence of this in the Family/Whānau contact record. There are only two entries documented. One was to state that the son was informed on [Mrs A's] arrival at [the rest home] and the other, not dated, was to say that the son, [Mr B], was informed of the urinary tract infection and that he would bring the Controlled Drug prescription from the general practitioner.

Clinical notes on [Day 4] show that the son spoke to staff in relation to pain relief and checks on his mother. The progress notes written at 2330hrs by a registered nurse show that pain relief was given twice on that shift, with moderate effect. [Mrs A's] temperature was checked at 2000hrs and was recorded as 38.6°C. [Mrs A] stated she had pain on passing urine. A urine specimen was checked and showed evidence of infection. The Doctor was contacted on [Day 5] at 1020hrs and notes indicate that he was completing a script for antibiotics. [Mr B] ([Mrs A's] son) was asked to pick medications up from pharmacy.

Clinical notes documented by the Health Care Assistant at 1045hrs on [Day 5] state that she spent more than an hour with [Mrs A] as she was unable to stand up or help herself with anything. [Mrs A] requested to go back to bed but could not stand up and was settled in the chair. At 1320hrs progress notes indicate that she was able to get up from bed to chair and walk with the assistance of one person when she wanted to go to the toilet. Later that day the registered nurse documented at 2230hrs that [Mrs A] refused pain relief as she was pain free.

Overnight [Mrs A] was nauseated and was dry retching. Her temperature was 38.8°C and she was described as being in severe pain. Pain medications were given. Her temperature at 0600hrs on [Day 6] was recorded as 37.6°C. No formal assessment of her pain was made. No physical examination was undertaken.

On [Day 6] at 0930hrs she was transferred to [the DHB] to have the dressing on her elbow wound changed. She was accompanied by a caregiver. It would seem that there was no letter to inform [the DHB] staff of the presence of UTI.

Notes from [the DHB] indicate that when [Mrs A] was seen there on [Day 6] she was in severe pain, nauseated and tearful. She required IV Fentanyl to allow the cast to be removed. The plan was to continue with oxynorm PRN. A prescription for the anti-emetic, metoclopramide, was provided.

The clinical notes of [Day 7] indicate that [Mrs A] was unwell that day. The progress notes state that [Mrs A] refused a shower as she was feeling nauseated and unwell. Staff administered pain relief. [Mrs A] had two episodes of incontinence, passing urine on the floor. She continued to complain of pain in her abdomen. No registered nurse assessment was carried out in relation to complaints of a painful abdomen.

It appears that [Mrs A] stayed in bed all day on [Day 7]. Notes from the afternoon shift state that she refused to have dinner and was drinking minimally. The registered nurse

has described her as appearing very tired and frail. Recordings of temperature, pulse, respirations and oxygen saturations were taken, but blood pressure was not recorded. A fluid balance chart was commenced at 1530hrs and lists 375mls consumed by 2030hrs. No other entries are noted that day. The fluid balance is documented again on [Day 8] with a total input of 428 mls from 0800hrs until 1407hrs. No urine output is listed on the fluid balance charts for either [Day 7] or [Day 8]. The final entry by the registered nurse states that *'If she is continuing to not drink then may need to send back to hospital Pls discuss with CNM'.*

On the night of [Day 7], the registered nurse has documented that checks continued, she was toileted overnight and declined any pain relief and to have anything to drink. No recordings were taken.

The clinical notes of [Day 8] documented at 1330hrs show that [Mrs A's] condition had deteriorated. She was described as being in severe pain and dehydrated. This was discussed with the Clinical Nurse Manager and the son. It was decided to admit [Mrs A] to [the public hospital]. An ambulance was called at 11am.

Summary

Family, in their complaint, state that they could see the deterioration in [Mrs A's] health from the time she was admitted to [the rest home]. I believe that the clinical notes support that view. Clinical notes are brief and at no time was a full and thorough assessment undertaken. Short-term care plans were not documented to identify care needs; this includes a short-term care plan for the management of the urinary tract infection.

It is also noted that following family concern a physical check sheet was implemented. There was no other supporting documentation relating to this. No short-term care plan outlined the reason for 30 min checks being done, what parameters were being looked at during these checks and that there was any evaluation of this.

Senior nursing management did not appear to have been involved in decision making in relation to [Mrs A's] care. Communication with family was poorly documented.

It is my view that [Mrs A's] own GP or the hospital doctor should have been asked to see her soon after her admission to clarify pain relief and management of nausea and constipation. It is noted that this was never considered by staff. [Mrs A's] GP was contacted re medications and UTI but this appears to have been only to request prescriptions for medications.

Medical input should also have been requested when [Mrs A's] condition continued to deteriorate following the diagnosis of UTI and the commencement of antibiotics. The acute abdominal pain she was experiencing was not properly evaluated.

I believe that the answer to the question of delay in transferring [Mrs A] to [the DHB] was not just a delay on [Day 8]. There was clinical indication that [Mrs A] was acutely unwell on [Day 7] and consideration to contacting medical input or transfer to [the DHB]

should have been made at this time. If one considers abdominal pain as well as shoulder pain, inability to eat and drink and the presence of nausea despite medications, then these are all good clinical reasons to request a medical opinion. In my opinion staff should have been alerted to seek medical attention as soon as possible.

I consider the delay in transferring the patient to an acute hospital setting as a moderate to severe departure from acceptable standards. I believe this would also be viewed as a moderate to severe departure by my peers.

The appropriateness of the changes made by [the rest home] following the review of [Mrs A's] care.

In my opinion a thorough investigation was carried out concerning [Mrs A's] care.

Following the investigation, several changes have been made. One important decision that I believe will improve care is that senior staff will visit patients in [the public hospital] before their admission under the short term stay program. This, in my opinion, is a positive move and will allow staff to carry out assessments and to get to know and understand the level of care the patients coming to the facility will require.

As many of the short stay clients can be on bedrest it is vital that the facility know that they can provide safe, competent care before accepting patients. It also provides the opportunity to acquire any special equipment needed for that patient's care.

In addition, I recommend that a structured form, such as ISBAR, is used in the case of a handover from the public system. Generic questions are answered and documented and become part of the patient's file if staff do not get to see patients before they arrive. When patients are required to return to [the DHB] for evaluation, it is important that documentation goes with them. In this way, information on progress, concerns and changes in health status may be passed on to ensure good continuity of care.

Education on pain management is acknowledged. Policies in relation to short stay patients need to clearly define who is responsible for medication management, collection and delivery of medication from the pharmacy and re-charting if required.

The updated short-term care policy clearly states:

1.47 Doctor's visits — you will need to remain under the care of your current GP.

Although it appears that patients can keep their own GP for short stay admissions, it must be acknowledged that many of the patients have multiple medical needs and it may be beneficial to have a GP visit to document medical assessment in the clinical file and to prescribe all medications on the approved drug sheets.

Overall I believe the changes will improve the services offered to short term patients.

Summary

Overall, I believe the care delivered to [Mrs A] was not of an acceptable professional standard.

I believe that this was due to a lack of registered nursing input. Clinical assessments were lacking or inaccurate at times and this affected the development of appropriate care plans. There appeared to be gaps in clinical knowledge in the following areas:

- understanding the effects and side effects of medication used relatively frequently in long term care facilities,
- recognising clinical red flags, particularly when the patient's condition continues to deteriorate,
- taking the initiative to seek medical, or other multidisciplinary team, input where appropriate.

The above discrepancies all contributed to inadequate pain management, poor management of bowel function and a failure to recognise the rapid decline in the patient's general condition.

I would recommend that some additional education be offered to the registered nurses to improve their clinical assessment skills.

Jan Grant RN"

The following further advice was received from RN Grant:

"I have been asked to review the response from Bupa with respect to my opinion on the care provided to [Mrs A].

1. The assessment of and documentation pertaining to [Mrs A's] fractured humerus.

Bupa's response to my opinion was that [the DHB's] information did not contain any specific information regarding the care of [Mrs A's] fracture nor was there any specific positioning advice given. I acknowledge that this information was not supplied by [the DHB], but again state that in my opinion the assessment on admission should have been undertaken by a Registered Nurse. [Mrs A's] assessment was documented by a student Enrolled Nurse and the information that was used was the transfer letter.

I believe that any competent Registered Nurse would have identified the issues of positioning, and the equipment needed to assist [Mrs A]. The Registered Nurse's care plan would, in my opinion, have identified all the care issues and the need for ongoing evaluations to review cares if the need arose.

An informative discharge letter is helpful, but it remains the responsibility of the facility admitting the patient to do its own assessments. If there are discrepancies then a phone call is often able to clear up any issues.

I have not changed my opinion in relation to the assessment and documentation. I view this as a moderate departure from acceptable standards.

2. Pain Management, anti-emetic usage and bowel management.

Bupa has stated that [Mrs A] was charted medication on a PRN basis in the prescription provided at discharge from [the public hospital], and because of this that inadequate information was sent from [the public hospital].

As previously stated no pain assessment was completed during [Mrs A's] stay. Bupa policies clearly state what was expected and their policies were not followed. Had adequate pain assessments been undertaken, then staff would have had a better understanding of the severity of [Mrs A's] pain and frequency of it. This in turn would have clarified the need for a more specific pain management regime. I believe my initial advice covers the medication and administration adequately. I do not wish to change my original advice.

3. Continence

I believe my initial advice covers this area and I do not wish to make any changes to it.

4. Timeliness of commencing antibiotics in relation to UTI

I accept that the antibiotics were charted once a day and that they were administered on the day they were received. I find there is no departure from acceptable standards.

5. Delay in seeking medical attention and transfer to hospital

I believe the clinical notes showed a deterioration in [Mrs A's] condition throughout her stay, as stated in my original advice. I believe that her clinical picture demonstrated that earlier medical intervention was indicated and should have been requested. I do not change my original opinion.

Jan Grant"