HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate escalation of care provided to resident in care home

1. On 14 December 2021, the Health and Disability Commissioner (HDC) received a complaint from Ms B and Ms C about the care provided to their father, Mr A, by a care home provider prior to his death from urosepsis[1] in late September 2021. At the outset, I extend my sincere condolences to Mr A's family.

Information gathered

2. Mr A was admitted to hospital on 1 April 2021, as he was experiencing confusion and had attempted to self-harm. On 6 April, he was transferred to another hospital. During his time in hospital, Mr A was reported to have experienced recurrent urinary tract infections (UTIs)[2]. He had an indwelling catheter (IDC)[3] and was being treated with antibiotics when he became symptomatic.

3. Mr A was assessed as requiring hospital-level care and was discharged to a care home provider on 17 September 2021. The care home contracted a general practitioner (GP), Dr D, who provided care to its residents. At the time of his admission to the care home, Mr A was still registered with his community GP. On 19 September, Mr A's IDC was noted to be blocked and draining blood-coloured urine. Mr A's community GP was unreachable, so Dr D provided general advice to the nursing staff to flush the catheter. The catheter blocked a second time that day and was replaced by the clinical nurse manager, as it could not be flushed successfully. Dr D was updated on this. The clinical notes contain no reference to Mr A appearing unwell or complaining of urinary symptoms at this time.

4. On 21 September, a support worker noted that Mr A was feeling unwell. His vital signs were taken at 8.15am and showed low blood pressure, a high pulse, an elevated temperature, an increased respiration rate, and low oxygen saturation. There is no evidence that Dr D was informed of Mr A's abnormal observations that day.

5. On the morning of 22 September, Dr D was at the care home for his weekly rounds and was asked by the practice nurse to review Mr A and consider enrolling him as a patient. Dr D said that he was told that Mr A had had a fever, which had settled, and that he had a UTI. Dr D said that he recalls being given a paper copy of Mr A's clinical records, and that due to time constraints, he scanned the page quickly. Dr D stated that Mr A's temperature was normal and his urine was clear. He said that he did not notice the abnormal blood pressure reading from the previous day.

6. Dr D told HDC that he did not conduct a detailed examination as Mr A was asleep, and he did not wish to disturb him. He said that instead, he relied on the nursing observations. He

[1] A serious condition in which sepsis, a life-threatening inflammatory response to infection, originates from the urinary tract.
[2] A bacterial infection in the urinary system, commonly affecting the bladder or urethra.
[3] A flexible tube inserted into the bladder through the urethra or abdominal wall to drain urine.

cannot recall what information was provided to him by nursing staff regarding Mr A's condition or vital signs, but he said that usually the nurses would give him a verbal account of the patient's condition and pass on any vital signs. He stated that he relies on the nurses at the care home to inform him of any issues or observations with residents, and he does not specifically document in the notes that nurses need to keep him informed and updated, as 'this is standard practice'. Dr D said that he would have noticed if Mr A had had increased work of breathing,[4] which he did not.

7. Dr D cannot recall whether he asked nursing staff to take further vital signs but said that his usual practice is to advise staff to continue to monitor vital signs if they are concerned about a patient. Dr D said that he considered the likely diagnosis to be a UTI, as Mr A was an 83-year-old man with several predisposing factors for UTIs, [5] as well as long-term catheterisation for benign prostatic hyperplasia (BPH)[6] and a history of UTIs and blocked catheters requiring bladder washouts. Dr D said that he also noted that Mr A had a slight fever that had settled and some haematuria,[7] all of which were symptoms consistent with a UTI.

8. Dr D advised nursing staff to continue oral fluids, request a urine sample, and commence antibiotics for a UTI. He said that the plan included that Mr A would receive ongoing monitoring as per care home policies. Dr D said that he expected nursing staff to contact him if there were any concerns, but this did not occur when Mr A's observations worsened following his review. Dr D said that he made a retrospective note of his assessment of Mr A in the clinical records, as Mr A had yet to be set up as a patient in the patient management system (PMS) because formal appointment as Mr A's GP had yet to occur.

9. The care home progress notes refer to Mr A shivering in bed on 22 September and having a reduced food and fluid intake, but no vital signs were recorded. He was noted to be very sleepy in the afternoon and evening, and staff were unable to obtain a urine sample. Dr D assessed Mr A and prescribed subcutaneous fluids,[8] which were charted and commenced at 3.30pm. No vital signs were recorded on 22 September. Antibiotics were prescribed by Dr D that evening at 9.30pm, but the first dose was not administered until 1.23pm the following day (23 September), with the second dose administered at 9am on 24 September. Dr D told HDC that the decision to chart antibiotics was made around 12.30pm, following a discussion with Mr A's daughter. He advised that the delay in charting the antibiotics was due to an oversight, as he was rushed for time. The care home told HDC that Mr A refused all other

[4] Increased work of breathing refers to an increase in the number of breaths per minute. This may mean that a person is having trouble breathing or not getting enough oxygen.
[5] Including that Mr A was on immunosuppressive prednisone, and he had chronic malnutrition and chronic iron deficiency.
[6] A condition in which the prostate gland enlarges but is not cancerous. The enlargement can cause problems with urination due to the prostate's location near the urethra.
[7] Blood in the urine.
[8] A method of rehydrating or providing nutrition to individuals who cannot consume adequate fluids or food orally.

doses of antibiotics. However, the care home acknowledged that Dr D was not informed that Mr A was intermittently refusing his medications, including the antibiotics.

10. Progress notes from 23 to 25 September record Mr A's deteriorating condition, reduced responsiveness, reduced urine output, and difficulty with oral intake. From the information available, it appears that Dr D was not contacted by care home staff between 23 and 25 September regarding Mr A's declining condition, and there is no record of regular monitoring of Mr A's vital signs over this period.

11. Mr A was transferred to his local hospital's Emergency Department (ED) via ambulance on 25 September. Blood tests were consistent with sepsis[9] and acute kidney injury due to likely urosepsis. Mr A was admitted to the Intensive Care Unit (ICU) but, sadly, he failed to respond to treatment and died in late September 2021.

Further information

Care home provider

12. The care home told HDC that it extends its heartfelt apologies for the distress Ms B and Ms C experienced while Mr A was in the care home's care. The care home provider told HDC:

> 'We appreciate that nothing can change the outcome of Mr A's time with [the care home], but we thank them for giving us the opportunity to respond to their complaint and review our practi[c]es.'

13. The care home told HDC that it undertook a review of the care it provided to Mr A and identified that best practice would have been to commence a food diary on the second day that Mr A had not eaten (which was not done). The care home noted that its policy is to commence a short-term care plan when an infection is noted and antibiotics are started, and this would have captured that Mr A was refusing his antibiotics intermittently. However, a short-term care plan was not commenced.

Dr D

14. Dr D noted the impact of COVID-19 on the provision of primary care at the time of the events. He apologised to Mr A's family for failing to appreciate the significance of Mr A's low blood pressure on 22 September and said that had he done so, he would have referred Mr A to hospital.

Responses to provisional opinion

Ms B and Ms C

15. Ms B and Ms C were given an opportunity to comment on the 'Information gathered' section of the provisional report. Ms B told HDC:

> 'My sister and I still feel very strongly about what happened and extremely disappointed [in] how our father and ourselves were treated by the rest home, during the days before

[9] A life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.

his death. We also believe that with adequate care during those days, our father's death would have been prevented.'

Care home provider

16. The care home accepted the findings of the provisional opinion and stated: 'We have committed to improvements and already commenced meeting the recommendations outlined in your finding.' The care home also stated: '[P]lease do pass on that I am sincerely sad and apologise for the distress they experienced whilst their father was in our care.'

Dr D

17. Dr D was given the opportunity to respond to relevant sections of the provisional opinion. However, despite follow-up by HDC, Dr D did not provide a response.

Changes made

Care home provider

18. The care home told HDC that it has taken on board the advice of registered nurse (RN) Hilda Johnson-Bogaerts (see Appendix B) and has implemented changes to its procedures and training. The care home said that it has ensured that the relevant staff received the necessary feedback and training to ensure that a similar event does not occur again. The care home said that it requires that all RNs are familiar with its policies, and the policies are now included in its orientation for new nurses. The care home stated that it has conducted training[10] with its nurses, specifically referencing the details of Mr A's case, and, in addition to formal education, it undertakes learning circles with staff. The care home said that admissions are no longer accepted on a Friday,[11] and it has improved access to accurate real-time data for its clinical team and GPs (which includes digital clinical notes).

19. The care home advised that it now has a mobile line to allow direct communication with the RN whenever the nurse is on site; it has updated its vitals monitoring equipment; and a new clinical nurse manager has been appointed, as well as a new position of senior RN. The care home said that the two staff members' workdays are split to ensure that a member of the clinical leadership team is on site seven days per week.

Dr D

20. Dr D told HDC that he has reviewed the Best Practice Advocacy Centre New Zealand (BPAC) and Health Pathways information on urosepsis and intends to present an anonymised version of Mr A's case to his peer group.

21. Dr D said that he has taken this case very seriously and has since refreshed his knowledge of urosepsis and amended his practice. He stated that he now routinely asks care-home

[10] The topics of its training include the Code of Health and Disability Services Consumers' Rights (the Code); Health NZ lessons; identifying changes in health; identifying sepsis; vitals monitoring; short-term care plans; long-term care plans; food and fluid intake and monitoring; SBAR tool; catheter care and changes; communicating health changes; communicating with family/next of kin/enduring power of attorney. In addition, RNs are participating in Health Learn.

[11] Or Thursday if prior to a Friday public holiday.

nurses for patients' observations, and all rest-home patient notes are now available electronically, so they are easier to read and more accessible.

Opinion

22. As part of my investigation into this complaint, I sought in-house clinical advice from GP Dr David Maplesden (Appendix A) and RN Hilda Johnson-Bogaerts (Appendix B).

Dr D

23. With respect to the care provided by Dr D on 22 September, Dr Maplesden advised that if nursing staff did not provide Dr D with information regarding their observations of Mr A on 21 September and concerns about his condition that day, Dr D's management of Mr A would constitute a mild to moderate departure from accepted standards, as Dr D had a responsibility to ensure that there was no reason to suspect urosepsis at that time. Dr Maplesden said that this should have included an assessment of Mr A's vital signs, especially as Mr A was noted to be asleep at that time. On the other hand, if nursing staff did report to Dr D concerns and details of Mr A's condition from the previous day, including his vital signs, Dr Maplesden advised that he would be moderately critical that Dr D did not assess for other red flags for urosepsis on the morning of 22 September.

24. Dr D told HDC that he reviewed the hospital notes and progress notes prior to seeing Mr A. However, Dr D said that he may not have reviewed the notes in detail, and he does not recall whether or not he asked staff to continue monitoring vital signs, but his usual practice was to do so if nursing staff were concerned about a patient. Dr D said that he did not conduct a detailed examination as Mr A was asleep. Instead, he relied on the nursing observations. Dr D cannot recall what information was provided to him by nursing staff regarding Mr A's condition or vital signs, but he said that usually the nurses would give him a verbal account of a patient's condition and pass on any vital signs.

25. Given that Mr A's abnormal vital signs from the morning of 21 September were recorded in the clinical records, which Dr D said he reviewed, I consider it more likely than not that Dr D was at least somewhat aware that Mr A's condition was deteriorating. Accordingly, I accept Dr Maplesden's advice that the failure to assess Mr A for other 'red flags' of urosepsis constitutes a mild to moderate departure from accepted practice.

26. On 22 September, Mr A was noted to be shivering, and his food and fluid intake had reduced. Dr D said that the decision to chart antibiotics was made at around 12.30pm, following a discussion with Mr A's daughter, but the medication was not charted until 9.30pm, with the first dose not being administered until 1.23pm the following day. Dr D told HDC that the delay in charting the antibiotics was due to an oversight as he was rushed for time. Dr Maplesden advised that the delay in charting antibiotics was not consistent with accepted practice. However, he acknowledged the disruptive effects of the COVID-19 pandemic and the fact that Mr A's details had yet to be entered in the PMS due to delays in formalising his transfer of care. Dr Maplesden considered that the delay constituted a mild departure from an appropriate standard of care, and I agree.

27. I am critical that Dr D failed to assess Mr A for other 'red flags' of urosepsis, and for the delay in charting Mr A's antibiotics after Dr D had concluded that Mr A was suffering from a UTI. However, I also acknowledge that Mr A's details had yet to be entered into the PMS due to delays outside Dr D's control, and that the COVID-19 pandemic at the time had disruptive effects, and it is unclear what information was provided to Dr D by nursing staff about Mr A's condition. Accordingly, I encourage Dr D to reflect on my comments and those of Dr Maplesden.

Care home provider

28. At 8.15am on 21 September, Mr A was assessed by an RN following concerns raised by a support worker that Mr A was feeling unwell. Mr A's vital signs were taken and showed low blood pressure, a high pulse, an elevated temperature, an increased respiration rate, and low oxygen saturation. RN Johnson-Bogaerts advised that the nurse who assessed Mr A failed to recognise the signs of potential urosepsis. RN Johnson-Bogaerts said that Mr A's vital signs indicated acute clinical deterioration and met the moderate- to high-risk criteria for sepsis (under the Health Quality & Safety Commission (HQSC) Frailty Care Guidelines — Acute Deterioration including sepsis pathway) and required urgent medical attention.

29. RN Johnson-Bogaerts advised that the missed signs and symptoms of sepsis by the nurses, coupled with the delayed follow-up and incomplete documentation, suggests a lack of clinical reasoning. She said that the lack of clear communication between the nurses and Dr D, as well as the failure by nursing staff to convey the full clinical picture to Dr D on 22 September, may have contributed to the inadequate response to Mr A's acute deterioration. RN Johnson-Bogaerts considered these failures to constitute a moderate to significant departure from accepted standards. I agree, and I acknowledge the comments from the care home that it has taken on board RN Johnson-Bogaerts's advice.

30. I have also taken into account RN Johnson-Bogaerts's advice that the care home's review of Mr A's care 'also failed to address these critical issues, which underscores the need for improved clinical oversight, training and communication protocols'. I agree and encourage the care home to reflect on these comments.

31. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) provides that every consumer has the right to have services provided with reasonable care and skill. Several registered nurses involved in Mr A's care failed to identify and escalate the signs and symptoms of urosepsis from 21 to 25 September. In addition, there was a clear lack of communication between the nurses and Dr D. In my view, these failures collectively point to a systems issue at the care home, and, as such, I find the care home responsible for the failures in the care provided to Mr A. Accordingly, for the reasons outlined above, I find the care home in breach of Right 4(1) of the Code.

Recommendations

32. In my provisional report, I recommended that the care home provide a written apology to Mr A's family for the failings outlined in this report. The apology has been provided to HDC for forwarding to Mr A's family.

33. I recommend that the care home use an anonymised version of this report to provide targeted education on recognising symptoms of sepsis, managing acute deterioration, and using communication tools such as SBAR.[12] Evidence of this training is to be provided to HDC within six months of the date of this report.

34. I recommend that the care home amend its clinical policies and procedures to include guidance on how to recognise symptoms of sepsis, manage acute deterioration, and use SBAR to ensure that these practices are applied consistently. Evidence of the updated policies and procedures are to be provided to HDC within three months of the date of this report.

Follow-up actions

35. A copy of this report with details identifying the parties removed, except my in-house clinical advisors, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

[12] ISBAR stands for Situation-Background-Assessment-Recommendation. It is an easy-to-remember, concrete communication mechanism for framing any conversation, especially critical ones, requiring a clinician's immediate attention and action and can be used as a tool to foster a culture of patient safety.

Appendix A: In-house clinical advice to the Commissioner

The following in-house clinical advice was obtained from GP Dr David Maplesden:

'**FROM** : David Maplesden

CONSUMER : Mr [A] (dec)

PROVIDER : Dr [D]

FILE NUMBER : C21HDC03183

DATE : 19 September 2023; **Addendum 25 June 2024 (section 15 & 16)**

1. My name is David Maplesden. I am a graduate of Auckland University Medical School, and I am a vocationally registered general practitioner holding a current APC. My qualifications are MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the care provided to the late Mr [A] by Dr [D]. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Internal file review dated 12 April 2023
- Response and care documentation [care home provider]
- Response from practice manager Doctors […] [GP]
- Clinical notes former […] DHB ([…] DHB)

3. This advice relates to the care provided to Mr [A] by Dr [D]of [GP's] following Mr [A]'s admission to [the care home provider] on Friday 17 September 2021. The […] DHB discharge summary indicates Mr [A] was for long-term placement hospital-level care, but I understand Mr [A]'s family indicated to [the care home] staff that the admission was for short-term placement with a view to Mr [A] returning home once he was sufficiently recovered.

4. There is a very detailed […] DHB discharge summary on file dated 17 September 2021. This notes Mr [A]'s co-morbidities of probable psychotic depression, suspected giant cell arteritis with loss of vision right eye, cachexia, malnutrition and self-neglect, chronic low-grade iron deficiency anaemia, COPD [chronic obstructive pulmonary disease], seropositive rheumatoid arthritis, frailty, benign prostatic hypertrophy with outflow obstruction requiring long-term indwelling urinary catheter (associated recurrent catheter blockages and urinary tract infection (UTI) with regular catheter irrigation and three-weekly catheter change advised). Mr [A] had been admitted to […] [h]ospital on 6 April 2021 with psychotic depression and catatonia and had a prolonged and complex hospital admission. The discharge summary and prior progress letters were sent to Mr [A]'s usual GP, Dr [E], and were not available to Dr [D] at the time of the events in question (see below). However, a nursing acute care plan was included in the discharge

information provided to [the care home], and this covered most of Mr [A]'s admission issues and current management, including catheter care. Catheter was last replaced on 16 September 2021. Vital signs just prior to discharge were BP 154/78, P 78, resps 16, O2 sats 96%, temp 36.4. Notes include: *BP usually 130/80 but can be low — needs encouragement with fluids …*

5. Mr [A] was discharged to [the care home] on Friday 17 September 2021. [Care home] staff contacted Dr [E] on that date to inform him of the admission, but it does not appear a reply was received from Dr [E]. Vital signs recorded on admission to [the care home] were BP 150/78, P 78, resps 16, O2 sats 95%, temp 36.5. On 19 September 2021 (Sunday), Mr [A] was noted to have a blocked urinary catheter and discoloured urine. Apparently attempts to contact Dr [E] for advice were unsuccessful, and Dr [D], the facility GP, was contacted and gave general advice regarding flushing the catheter and need for replacement if this was unsuccessful. The catheter was successfully replaced by the clinical nurse manager (CNM) and Dr [D] updated. There is no reference to Mr [A] appearing unwell or complaining of urinary symptoms at this point and there is no record of vital signs being taken.

6. Comment: Note is made in the [GP clinic] response that at this stage there had been no formal handover of Mr [A]'s GP care from Dr [E] to Dr [D], and Dr [D] was not aware of Mr [A]'s medical history. Nevertheless, I believe it was reasonable for Dr [D] to provide general advice regarding management of a blocked catheter and, in the absence of any concerns expressed by nursing staff regarding Mr [A]'s overall condition, I do not believe there was any requirement for prophylactic antibiotics, and management in this regard was consistent with accepted practice[1]. I note [care home] staff sought further advice on catheter management from the […] DHB urology service on 20 September 2021 (daily irrigation, use 18F catheter at next scheduled change). At some stage, Dr [E] apparently discussed with [care home] staff that he would be unable to visit Mr [A] and requested that Mr [A]'s care be transferred to Dr [D], although the details of this communication are unclear.

7. Mr [A]'s catheter appeared to function well initially. At 1630hrs on 21 September 2021 progress notes record: *Carer reported that [Mr A] was feeling unwell. Obs done at 0815 BP 90/44, pulse 107, temp 39.2, resp 26, O2 91% …* paracetamol administered and oral fluids encouraged. Temperature repeated at 1000hrs (38.4) and 1300hrs (37.4) but no record of GP being notified. Vital signs were repeated in the evening: temp 37.1, P 82, O2 sats 95%, resps 22, BP 85/46. Mr [A] remained in bed and was noted to be very sleepy. Note is made: *On list for GP in morning.* Concerns might be raised at the adequacy of monitoring of Mr [A]'s vital signs and adequacy of escalation of care (nursing issues). Mr [A] was at increased risk of UTI (history of recurrent UTI associated with indwelling catheter, recent catheter change), and his vital signs and drowsiness

[1] National Institute for Health and Care Excellence (NICE) guideline. Urinary tract infection (catheter-associated): antimicrobial prescribing. Published: 23 November 2018. https://www.nice.org.uk/guidance/ng113/resources/urinary-tract-infection-catheterassociated-antimicrobial-prescribing-pdf-66141596739013 Accessed 19 September 2023

were concerning for possible sepsis (using accepted sepsis risk assessment tools[2], Mr [A] initially had three high-risk criteria for sepsis with two high-risk criteria persisting).

8. Around 0630hrs on 22 September 2021 Mr [A]'s catheter was noted to be draining clear urine and temperature recorded as 36.5. Dr [D] was in attendance for his usual weekly rounds of the facility and (per [GP clinic's] response) *he was asked by the rest home nurse to review* [Mr [A] *and consider enrolling under him … Dr [D] reviewed the hospital notes and the rest home progress notes … Dr [D] was asked to review Mr [A] for urine retention and recurrent UTI.* The response notes Dr [D] advised pushing oral fluids, requested a urine sample and *prescribe antibiotics if clinically required.* Following the assessment, Dr [D] apparently phoned Mr [A]'s daughter *and discussed the management plan for Mr [A].* Transfer of care from Dr [E] to Dr [D] was formalized.

9. Dr [D]'s notes dated 22 September 2021 read: *Hospital-level admission 17/9/2021 after 5 m [specialist hospital] admission, seen with RN […] not responding — asleep Depression: psychotic with catatonia, urine retention recurrent UTI, blocked catheter — awaiting urology appt in dec, seropostive RA, fe def anaemia normocytic anaemia persisting thrombocytosis awaiting further investigations if clinically indicated, frailty phoned and discussed mgt with daughter [Ms B] EPOA in […] — has been activated. She gave verbal consent for change in GP as Dr [E] not able to visit also would like Dad rx for UTI which is a likely scenario.*

10. [The care home] progress notes dated 1230hrs 22 September 2023 note Mr [A]'s assessment by Dr [D] and *Commence on antibiotics re reoccurrence of UTI history …* Progress notes completed at 1350hrs 22 September 2021 refer to Mr [A] *shivering in bed* on first review that morning and reduced food and fluid intake during the day (Dr [D] apparently notified and subcut fluids charted (see below)). Mr [A] was noted to be *very sleepy* during the later afternoon and evening, and inability to obtain a urine sample is noted in an entry at 2223hrs. The entry includes: *GP said will chart oral abs … still waiting.* There is no record of any vital signs being recorded on 22 September 2021.

11. Medimap records show Dr [D] charted Mr [A]'s regular medications at 1120hrs on 22 September 2021 and his notes record *MEDIMAP UPDATED.* There are subsequent notes the same day: *4pm ph call from RN […]: not drinking: sc fluids charted* (subcut fluids commenced at 1530hrs) *9pm text from RN […] ? urosepsis* [no record of text presented] *reply — start abs Augmentin charted, for Urine sample.* Medimap records show Dr [D] charted Augmentin 500mg TDS at 2129hrs. This was not available until the following day with first dose administered at 1323hrs on 23 September 2021 and a second dose at 0908hrs on 24 September 2021. Mr [A] apparently refused other doses although Dr [D] was not notified of this situation. On 23 September 2021 a [GP clinic] staff member has noted contact with the laboratory indicating they have received a

[2] https://www.nice.org.uk/guidance/ng51/resources/algorithm-for-managing-suspected-sepsis-in-adults-and-young-people-aged-18-years-and-over-outside-an-acute-hospital-setting-2551485716 referred to in: BPAC. Sepsis: recognition, diagnosis and early management. Published June 2018. https://bpac.org.nz/guidelines/4/ Accessed 19 September 2023

urine sample but no accompanying lab request form. A request form was then generated and sent electronically. The urine result (available 24 September 2021) was consistent with a contaminated sample.

12. Progress notes on 23 and 24 September 2021 note Mr [A]'s ongoing unwellness and reduced responsiveness, reduced urine output and difficulty with oral intake (SC fluids continued). Temperature is noted as "normal" on 24 September 2021. Progress notes on 25 September 2021 (1605hrs) refer to Mr [A]'s reduced urinary output (*oliguria ++*) and vital signs at this time of temp 36.5, resps 38–40, P 58–59, O2 sats 79–80% (no BP recorded). An ambulance was apparently called around 1300hrs and Mr [A] transferred to […] ED. It does not appear there was any contact made with Dr [D] between 23 and 25 September 2021 regarding Mr [A]'s condition and there is no record of regular monitoring of vital signs over this period. I assume these issues will be addressed in any nursing advice sought.

13. In […] ED Mr [A] was noted to be hypotensive and tachycardic with new-onset atrial fibrillation (successful electro-conversion undertaken). Blood tests were consistent with sepsis and acute kidney injury felt to be due to *likely urosepsis with multiorgan failure … possibly concurrent aspiration pneumonia.* Mr [A] was admitted to ICU and treated with IV antibiotics, IV fluids and vasopressors. Despite this he failed to respond and developed signs of agitated delirium and progressive aspiration pneumonia and on […] September 2021 Mr [A] sadly succumbed to his illness.

14. As far as I can ascertain, there was no communication between [care home] staff and Dr [D] after 22 September 2021 to enable Dr [D] to consider an escalation of Mr [A]'s care. My focus is therefore on the management of Mr [A] by Dr [D] on 22 September 2021 which may be deficient in that the presentation may have represented early urosepsis (see discussion in section 7) the severity of which may not have been adequately considered by Dr [D]. However, the precise sequence of events currently lacks clarity, and I recommend further information is obtained (ideally directly from Dr [D]) before I finalise my advice.

15. Addendum 25 June 2024: Further advice was received in response to specific questions as outlined below.

(i) **What information was provided to Dr [D] by [the care home provider] nursing staff regarding Mr [A]'s condition, including vital signs, prior to his assessment of Mr [A] on 22 September 2022.**

Dr [D] states: *I cannot recall exactly the details of the events. I am usually given a verbal account by the nurse prior to seeing a patient who would have told me his vital signs.*

(ii) **Your response indicates Dr [D] reviewed progress notes prior to his assessment of Mr [A]. Can I confirm Dr [D] was aware of Mr [A]'s abnormal vital signs on 21 September 2021 and were any more current vital signs reviewed or requested on 22 September 2021?**

Dr [D] responds that he would have been given access to Mr [A]'s notes on 22 September 2021 but he may not have reviewed these in detail. He does not recall whether he specifically requested further vital signs, but it is his standard practice to ask nurses to continue monitoring of vital signs if there are concerns about the patient. Dr [D] states: *In hindsight, I can clearly see the blood pressure is low and this was not appreciated at the time. I may have been falsely reassured by the normal temperature and pulse at the time.*

(iii) **The clinical notes entered by Dr [D] on 22 September 2021 do not give much indication as to the extent of his physical assessment of Mr [A] other than noting not responding, asleep. Is Dr [D] able to provide more detail regarding the extent of his assessment, diagnostic formulation, intended management plan and any follow-up or safety netting advice provided to nursing staff.**

Dr [D] notes this was a retrospective entry made later in the day as [Mr A] was yet to be set up as a patient in the PMS. There was no detailed examination as Mr [A] *was asleep and I did not wish to disturb him. I relied on nurses obs and their account of his symptoms and physical state. I would have noticed if he had any increased work of breathing, which I did not.* The diagnosis was likely urinary tract infection with plan for antibiotics, ongoing monitoring per rest home protocols and an expectation he would be contacted by nursing staff if there were any concerns.

(iv) **Please provide details of the discussion that took place between Mr [A]'s daughter and Dr [D] on 22 September 2021, particularly in relation to Mr [A]'s current condition and likely diagnosis and any agreed management plan or ceiling of care.**

The discussion was primarily to seek consent for transfer of care (to Dr [D] from the previous GP) to enable access to Mr [A]'s full medical file. Dr [D] notes: *We also discussed his current condition and the likelihood of a urinary tract infection. We did not discuss a detailed management plan or ceiling of care as this was an initial consultation. I did intend to do this later as a routine matter once I had received his file.*

(v) **Please confirm when the decision to prescribe antibiotics was made and why there was a delay between making this decision and completing the prescription on Medimap (if this was the case). Was it Dr [D]'s impression that the antibiotic would be commenced on 22 September 2021?**

The decision to chart antibiotics was made around 1230hrs following the discussion with Mr [A]'s daughter, but the medication was not charted until 2130hrs. Dr [D] states *the delay was due to oversight and related to being rushed for time.*

(vi) **Please provide any further details or comments not covered in your initial response that you feel might be relevant to Mr [A]'s management on 22 September 2021.**

Dr [D] notes the impact of Covid 19 on provision of primary care at this time. He apologises to the family of Mr [A] for failing to appreciate the significance of Mr [A]'s low blood pressure on 22 September 2021 and notes he would have referred Mr [A] to hospital had he appreciated the blood pressure. Dr [D] has since reviewed BPAC and Health Pathways information on urosepsis and intends to present Mr [A]'s case (anonymised) to his peer group.

16. Comments

(i) I believe Dr [D]'s assessment of Mr [A] on 22 September 2021 was inadequate given the diagnosis made of urinary tract infection. It is not clear from the notes on what basis the diagnosis was made (urine reported that morning as clear, temperature normal) but, taking into account the observations from the previous day, the diagnosis was not unreasonable. It remains unclear to what degree the vital signs from 21 September 2021 were discussed or reviewed. It might be expected that nursing staff would have proactively presented these observations to Dr [D] given they were abnormal and Mr [A] had been unwell, but noting there was no escalation of care at the time the observations were first noted such an action cannot be assumed (although if it was not done this might be regarded as a mitigating factor). Nevertheless, I believe Dr [D] had a responsibility to ensure there was no reason to suspect urosepsis at the time he reviewed Mr [A], and this involves an assessment of vital signs particularly as Mr [A] was "unresponsive" or asleep. Had vital signs normalised, Dr [D]'s plan to commence Mr [A] on antibiotics and maintain observations was probably reasonable provided Mr [A] did not evidence any other "red flags" for suspected sepsis. If nursing staff did not provide Dr [D] with information regarding their observations of Mr [A] undertaken on 21 September and concerns regarding his condition that day, I would regard Dr [D]'s management of Mr [A] on 22 September 2021 as departing from accepted practice to a mild to moderate degree taking into account the normal temperature and report of clear urine on the morning of 22 September 2021. If nursing staff did report concerns and details of Mr [A]'s condition from the previous day (including vital signs) I would be moderately critical that Dr [D] did not confirm Mr [A]'s current haemodynamic status or assess for other red or amber flags suspicious for sepsis on the morning of 22 September 2021.

(ii) The delay in charting of antibiotics was not consistent with accepted practice although I acknowledge the disruptive effect of the COVID pandemic at this time, and the fact Mr [A]'s details had yet to be entered into the PMS because of delays in formalising transfer of care (out of Dr [D]'s control). This is a mild criticism under the circumstances. I note Dr [D] remained under the impression the antibiotics would be started on 22 September 2021.

(iii) The remedial actions outlined in Dr [D]'s response are appropriate and I have no further recommendations in this regard.'

Appendix B: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from RN Hilda Johnson-Bogaerts:

'CLINICAL ADVICE — AGED CARE

CONSUMER : Mr [A]

PROVIDER : [Care home provider]

FILE NUMBER : C21HDC03183

DATE : 17 December 2023

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [care home provider]. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Specifically, I am asked to review the provided clinical documentation and comment on:
   a. the adequacy of the management of Mr [A]'s acute deterioration (21 September 2021)
   b. the adequacy of care planning regarding the management of his urinary catheter

3. **Documents reviewed**

- Provider letters of response dated 14 February 2022 and 28 July 2023
- Initial assessment and care plan
- Nursing progress notes

4. **Review of clinical records and clinical advice**

Mr [A] was admitted to [a care home] on 17 September 2021 to recover after having been in hospital since 6 April 2021. He lived with multiple co-morbidities, including general frailty and benign prostatic obstructive hypertrophy requiring a long-term indwelling urinary catheter.

His initial assessment and care plan relating to the urinary catheter included "*haematuri and debri potential"* and that he would use incontinence product for leakage bypassing his urinary catheter. The long-term care plan included the issue of "*Potential for blockage"* of the catheter with as nursing intervention the need for bladder irrigations and a change of catheter every 3 weeks. On 20 September this was changed on the care plan to daily bladder irrigations.

The clinical notes show good nursing intake notes including observations and getting to know Mr [A]'s preferences. His catheter was reported to be draining well until the evening of 19 September 2021, when it was found to be blocked and unresponsive to flushing attempts. His catheter was replaced at that time, and blood clots were noted in the urine. The following day, further haematuria was documented in the care notes, and his daughter was updated of the recent catheter issues.

On 21 September the notes indicate that a carer had reported that Mr [A] was feeling unwell. At 8.15 hrs, the registered nurse took his vital signs, which showed low blood pressure (90/44), pulse high (107), an elevated temperature (39.2°C), an increased respiration rate (26), and a relative low oxygen saturation (91%). As intervention, the nurse administered Panadol with some water. The notes further include that at 10.00hrs his temperature was taken again showing a slight decrease (38.4°C) and that he was sleeping. Later that day, he was transferred with a full body hoist into a chair to repair his faulty bed. It was noted that he was scheduled for a GP review in the morning for a potential urinary tract infection.

I am concerned that the registered nurse who assessed Mr [A] at 08.15hrs, and later that day, did not recognise the signs of potential urosepsis when taking his vital signs and making observations. The vital signs and observation indicated an acute deterioration and met the moderate to high-risk criteria for sepsis[1], which required urgent medical attention.

On the morning of 22 September 2021, Mr [A] was reported by the caregiver to be shivering in his bed, and a heat pack was provided. Shivering is an additional symptom that may indicate sepsis. The notes include that the GP reviewed Mr [A] as a new admission and prescribed antibiotics. However, it is not clear what information was communicated by the nurses to the GP, what questions the GP asked, or what assessments were completed as part of the medical intake and diagnosis.

In the situation of an acute deterioration, it is recommended that nurses use the SBAR tool (Situation, Background, Assessment, Recommendation) or similar structured communication method when handing over health concerns. The lack of documented communication is concerning, as it may have impacted the medical response to Mr [A]'s condition at the time.

The notes of the following days describe Mr [A] being cared for in bed, showing signs of sleepiness, minimal verbal responsiveness, and refusing to eat or drink. Vital signs were not documented (?taken) until 25 September 2021, when he showed further signs of deterioration, including breathlessness.

The care home provided their review on what went wrong; however, I am concerned that this review did not identify that signs and symptoms of sepsis were missed at various times by the registered nurses, and that Mr [A]'s deterioration was not escalated with the urgency it required. Additionally, I am concerned that the clinical information provided to the GP might not have conveyed the full clinical picture. These oversights highlighting gaps in recognition and management of sepsis.

[1] See HQSC frailty care guides — Acute Deterioration including Sepsis pathway

In conclusion:

a. The care provided to Mr [A] raises several concerns, particularly regarding the recognition and management of potential sepsis. The missed signs and symptoms of sepsis by the registered nurses, coupled with the delayed follow up and incomplete documentation, suggests a lack of clinical reasoning. Furthermore, the lack of clear communication between the nursing staff and the GP, as well as the failure to convey the full clinical picture during this critical moment, may have contributed to the inadequate response to Mr [A]'s acute deterioration. My peers would consider in the circumstances the management of the acute deterioration to have been a moderate to significant deviation from accepted practice.
b. The care home's review of the situation also failed to address these critical issues, which underscores the need for improved clinical oversight, training, and communication protocols.
c. I consider the care plan for management of Mr [A]'s urinary catheter in the circumstances to have been adequate as an initial care plan until a long-term care plan would be developed.

It is my recommendation that the care home provides targeted education on recognising symptoms of sepsis, managing acute deterioration, and using communication tools such as SBAR. To ensure these practices are consistently applied, it is essential that the protocols and communication tools are embedded into the care home's clinical policies and procedures.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Nurse Advisor (Aged Care)
Health and Disability Commissioner'