Rest Home

Registered Nurse, RN B

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC00471)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. At around 7am in early 2013, registered nurse (RN) RN B arrived to start her shift at a rest home, and found a resident, Mr A (aged 82 years), lying on the grass outside. He was wearing only a thin pair of pyjamas, which were damp from the dew, and he was cold to touch. He was also barefoot and shivering. Mr A told RN B that he had been there for about half an hour.

2. Other staff members came to assist, and RN B asked them to return Mr A to his room and to get him warm and put him back to bed.

3. At approximately 7.15am, RN B told staff to go to handover. RN B went too, leaving two night shift caregivers to care for Mr A. No registered nurse assessment of Mr A was carried out.

4. Following handover, RN B delegated care of Mr A's observations to enrolled nurse (EN) EN C, and asked her to record Mr A's vital signs.

5. At 7.30am, EN C checked on Mr A and took his vital signs. His temperature was recorded as 34.4°C. EN C updated RN B about Mr A's vital signs. RN B did not assess Mr A herself.

6. At around 8am, Mr A was found dead. The post-mortem report concluded that Mr A had died of hypothermia complicating pre-existing ischaemic heart disease and chronic obstructive respiratory disease.

Findings

7. RN B failed to recognise that Mr A required a comprehensive nursing assessment at 7.15am, and left two caregivers in charge of his care. Following handover, RN B delegated the assessment of Mr A to an enrolled nurse, and decided that it was appropriate for EN C to continue to monitor Mr A, even after EN C had reported vital signs that suggested that Mr A had hypothermia. RN B should have assessed Mr A at that point.

8. Accordingly, it was found that RN B failed to provide services to Mr A with reasonable care and skill and, therefore, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

9. The rest home owner was not found to have breached the Code, and was not found vicariously liable for RN B's breach of the Code.

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

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Complaint and investigation

10. The Commissioner was referred a complaint from the Coroner about the services provided to Mr A by the rest home and RN B. The following issues were identified for investigation:

- *Whether the rest home provided an adequate and appropriate standard of care to Mr A in 2013.*
- *Whether RN B provided an adequate and appropriate standard of care to Mr A in 2013.*

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

12. The parties directly involved in the investigation were:

Rest home	Provider
RN B	Registered nurse

Also mentioned in this report:

EN C	Enrolled nurse
Ms D	Caregiver
Ms E	Caregiver
RN F	Registered nurse
Ms G	Caregiver
Mr H	Caregiver

13. Information was also reviewed from:

The Coroner
HealthCERT
The District Health Board

14. Independent expert advice was obtained from a registered nurse, Dawn Carey (**Appendix A**).

Information gathered during investigation

Background

15. In 2011, Mr A (who was 80 years old at the time) was admitted to a rest home for hospital level care.

16. Mr A's medical history on admission was documented as:

- cerebrovascular accident (stroke);
- atrial fibrillation (abnormal heart rhythm);

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- prostatism (urinary difficulties);
- hereditary haemochromatosis (deficiency of the iron regulatory hormone hepcidin);
- dementia (decline in mental ability, affecting memory);
- previous fracture of femur; and
- postoperative pneumonia.

17. A year later, Mr A's mobility evaluation review (part of his Care Plan and filled out every two months) recorded: "Place sensor mat near bed so that whereabouts can be monitored regularly (esp. at nights)." It is documented in Mr A's progress notes that he would, on occasion, attempt to get out of bed and stand unaided, and that this was to be monitored as he was unsteady on his feet and at risk of falls. The goal for Mr A was documented to be restful sleep, and evidence that this goal had been reached would be a decrease in, or an absence of, wandering at night. The subsequent mobility evaluation review documents that there had been no reports of wandering at night or falls. The mat was no longer placed near his bed.

18. While at the rest home, Mr A was reviewed by doctors every three months. The locum general practitioner (GP) for the rest home advised HDC that while Mr A had advanced stages of dementia, he did not have any mood disorders or behavioural issues. She said that he was "firmly set in his daily routines, not wandering or getting lost or venturing out on his own".

19. In early 2013, Mr A had his three-monthly doctor review with the locum GP. It was recorded in Mr A's Doctor Treatment Notes for this visit that his weight was 56kg, and that he was "doing fine" with no behavioural issues.

20. Approximately one month later, at around 7am, RN B arrived at the rest home to start her shift. RN B told HDC that before she entered the building she heard a mumbled cry. She found Mr A lying on a small patch of grass approximately 15 metres from the building.[2] He was wearing a thin pair of pyjamas and did not have his walking frame with him. Various staff members told HDC that it was very unusual for him to be without his frame.

21. Caregiver Ms D arrived soon after RN B. RN B sent her inside to bring other staff to help. RN B advised HDC that she asked Mr A how long he had been lying on the grass, and he said he had been there for half an hour.

22. RN B said that Mr A was cold to touch, so she put her cardigan over him. His pyjamas were damp from the dew; his feet were bare, and he was cold and shivering. She estimated the temperature that morning to be around 3 or 4°C.

23. RN B said that she "checked [Mr A] quickly", checking his head and gently moving his arms and legs, and did not see any cuts, bruises or injuries, although she noted that

[2] The incident form, filled out soon after Mr A was found, does not expressly state that he was found on the ground, or mention the risk of hypothermia.

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it was only half light as it was early in the morning.[3] She said that Mr A was conscious and talking.

24. Caregivers Ms D and Ms E, and RN F, arrived to assist, bringing a wheelchair. RN B told HDC that she asked them to return Mr A to his room and to get him warm and back into bed. She said that once he was in his room she made sure the heating was on in his room. At approximately 7.15am, RN F gave handover. RN B told staff to go to handover, leaving the night shift caregivers (Ms G and Ms E) to put dry pyjamas on Mr A and to wrap extra bedding around him. RN B also left to attend handover.

25. Ms G and Ms E settled Mr A in bed. Ms E told HDC that initially Mr A was shivering, but that once he was changed into new pyjamas and covered with extra bedding, including a blanket warmed in the tumble dryer, he was talking and answering their questions and had stopped shivering.

26. Following handover, RN B delegated care of Mr A's observations to EN C, and asked her to record Mr A's vital signs.

27. At 7.30am, EN C checked on Mr A and completed his Physical Recordings Chart. His temperature was recorded as 34.4°C (normal ranges are between 36.1°C to 37.2°C). She advised HDC that, although his temperature was low, "on checking on his previous recordings [this] was not out of his range", as his normal temperature was usually about 35°C.[4] She stated: "His temperature wasn't low enough for me to get concerned … Had it got down to 33°C that would have caused alarm."

28. EN C also recorded that Mr A had a pulse of 60 beats per minute (normal being 60–100), and said: "I did not get a reading on the oximeter[5] so did a manual pulse." She stated that she could not get a reading on the oximeter as Mr A was too cold to do so.

29. EN C said that she touched Mr A and his hands were still cold, but "his body was warm", and he was talking and responding to her requests as she took his observations. She stated: "He did not give any cause for immediate concern." She said she then updated RN B about Mr A's vital signs.

30. RN B said that EN C told her that it had been hard to find Mr A's pulse and, when it was found, it was slow, and he had a low temperature. At 7.45am, RN B recorded in Mr A's progress notes the information EN C had passed on to her. RN B documented that he was afebrile[6] with a temperature of 34°C, and that his pulse was not easily palpable. RN B instructed EN C to "continue the observations" at least once an hour.

[3] A small abrasion on Mr A's left elbow is later documented in his progress notes for this day.
[4] HDC was provided with Mr A's Physical Recordings Chart (on which staff recorded Mr A's temperature monthly, or more frequently when unwell). This documented that his temperature fluctuated frequently.
[5] A medical device that indirectly monitors the oxygen saturation of a person's blood.
[6] Did not have a fever.

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31. EN C told HDC that at approximately 7.50am, Mr A was sleeping and so she left him alone. She stated: "I knew he was still alive at this point as he had a good colour and I could see his chest rising as he breathed in. Breakfast would be along in 10 mins or so, so I thought I'd leave him."

32. At around 8am, caregiver Mr H arrived at Mr A's room to give him breakfast and found that, sadly, Mr A had died. Mr H informed RN B, and RN B confirmed that Mr A had died.

33. RN B advised the Clinical Nurse Manager (who arrived at the rest home sometime around 8am), of that morning's events and Mr A's death. The initial incident form (originally filled out by RN F at around 7.25am and left on the Clinical Nurse Manager's desk for her to review when she arrived that morning) was updated to report Mr A's death.

34. The post-mortem report concluded that Mr A had died of hypothermia complicating pre-existing ischaemic heart disease and chronic obstructive respiratory disease.

Further information gathered during the course of this investigation

RN B

35. RN B acknowledged to HDC that a temperature of 34°C is "low, borderline hypothermic". She said she appreciated that Mr A needed prompt treatment and that he was at risk of hypothermia. RN B advised HDC that when she found Mr A, she moved quickly to restore him to a warm and safe environment with the help of other staff members.

36. RN B told HDC that her actions were influenced by time constraints. She said she needed to be present at morning handover to gather information from the registered nurse who had been on night shift (RN F) about any changes in condition of any of the residents. RN B said that it was part of her role as a registered nurse to be present at handover. However, she also said: "I now feel that as an RN I should have taken on the responsibility of assessment and monitoring of [Mr A's] progress once he was back in his room and should not have delegated this to an EN, as I have appreciated that [Mr A] had a variation from a stable health situation."

37. RN B said that she has not undertaken any training in recent years regarding when it is appropriate to delegate care to an enrolled nurse, but stated that since these events she will "become conversant with the up to date scope of practice for other practitioners within the Health Service", and would gladly undertake a professional session covering this.

The rest home

38. The rest home advised HDC that the rest home is not a locked facility, and residents are free to go out at any time, but that security measures mean the doors are locked at night and they are checked by the night staff throughout the night to ensure they remain locked. At around 6.30am on the morning Mr A was found outside the rest home, Ms G unlocked the main entrance to let the morning staff in. She told HDC that at this time she saw Mr A asleep in his bed. Another door was unlocked shortly afterwards but was not opened. It is not known who unlocked this door.

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39. The rest home said that no staff member saw Mr A leave his room or exit the building. It has been unable to establish which door Mr A used to leave the building, or why he went outside. The rest home advised: "[Mr A] had shown no previous signs of wandering out of the building and although he suffered from dementia this was not at a level to need dementia level care. His only movements were between his bed, where he spent much of the day, the toilet, and to and from the dining room."

40. The rest home acknowledged that there were significant departures in the nursing care provided to Mr A in 2013, including a lack of understanding of the delegation of enrolled nurse responsibilities.

41. The rest home said that staff failed to take appropriate action following Mr A suffering from hypothermia. It acknowledged that there was a failure to provide immediate medical assistance to Mr A and, once it was established that Mr A had a very low temperature "because of his exposure to the chilled outside weather climate", further medical assistance should have been sought immediately.

42. Following this event, the rest home developed policies for all its facilities, entitled Direction and Delegation of Care to Enrolled Nurses (issued November 2014) and Treatment of Hypothermia (issued November 2014). It also advised HDC: "Staff have been made aware of this new policy on all sites and further in-service education has commenced on first aid response to elderly residents suffering from hypothermia."

Responses to provisional opinion

43. RN B stated that she now understands more clearly the EN and RN relationship. She submitted that her competence in nursing is to a high standard.

44. The rest home owner and other relevant staff members at the rest home advised they had no further comment to make.

Relevant standards

45. The Nursing Council of New Zealand (NCNZ) publication *Code of Conduct for Nurses* (June 2012) states:

> "6.8 When you delegate nursing activities to enrolled nurses or others ensure they have the appropriate knowledge and skills, and know when to report findings and ask for assistance."

46. The NCNZ publication *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (May 2011) states:

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"**Understanding direction and delegation**

Delegation is the transfer of responsibility for the performance of an activity from one person to another with the former retaining accountability for the outcome.

…

The principles of delegation to enrolled nurses

1 The decision to delegate is a professional judgment made by a registered nurse and should take into account:

(a) the health status of the health consumer
(b) the complexity of the nursing intervention required
(c) the context of care, and
(d) the level of knowledge, skill and experience of the enrolled nurse.

2 The decision to delegate must be consistent with the service provider's policies.
3 The registered nurse must ensure the enrolled nurse understands the nursing interventions required, and knows when to ask for assistance and when to report back to the registered nurse.
4 The registered nurse is responsible for monitoring and evaluating the outcomes of delegated nursing care.

The responsibilities of the registered nurse

…

(a) The health consumer must have a plan of care developed by a registered nurse. This may be developed in collaboration with the enrolled nurse.
(b) The registered nurse must determine if it is appropriate for an enrolled nurse to complete interventions based on the complexity of the health consumer's needs.
(c) The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible.
(d) The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation.
(e) If the registered nurse has made a professional judgment that delegation is inappropriate, she or he must communicate (and document) this to the enrolled nurse and the employer.
(f) It is the registered nurse's responsibility to provide direct or indirect guidance according to the interventions and the competence of the enrolled nurse. He/she must be available for timely advice regarding any nursing needs. If the registered nurse, whose role it is to provide direction, is off the premises and not contactable, another registered nurse must be contactable for such guidance.
(g) Processes for seeking contact with and support from the registered nurse must be clearly documented and communicated within the nursing setting.
(h) An appropriately educated and experienced registered nurse may direct care across more than one setting if health consumer needs are predictable and the requirements for timely response can be met.

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(i) The registered nurse retains accountability for evaluating whether the enrolled nurse maintains the relevant standards and outcomes."

Opinion: RN B — Breach

7am

47. At around 7am, RN B arrived at the rest home to start her shift and found Mr A outside lying on the grass. He was wearing only a thin pair of pyjamas, which were damp from the dew, and he was cold to touch. His feet were bare and he was shivering. RN B estimated the temperature that morning to be around 3 or 4°C, and Mr A told her he had been there for about half an hour.

48. RN B "checked [Mr A] quickly", by checking his head and gently moving his arms and legs. She did not see any cuts, bruises or injuries, but noted that it was only half light.

49. Ms D, Ms E and RN F then arrived to assist, bringing a wheelchair. RN B asked them to return Mr A to his room and to get him warm and back into bed, while she made sure the heating was on in his room.

7.15am

50. At approximately 7.15am, at RN B's direction, RN B and other staff went to handover leaving the night shift caregivers (Ms G and Ms E) to put dry pyjamas on Mr A and to wrap extra bedding around him. No nursing assessment was carried out.

51. RN B said she appreciated that Mr A had a need for prompt treatment, and that he was at risk of hypothermia, but her actions were influenced by time constraints, as it was part of her role as a registered nurse to be present at handover.

52. Hypothermia is defined as a core body temperature of less than 35°C. As part of this investigation I obtained advice from my in-house nursing advisor, RN Dawn Carey. I note her advice:

> "Whilst hypothermia is defined with reference to core temperatures, it is appreciated that concerning symptoms — reduced respiratory rate, dysrhythmias, confusion — can be present even at 'mild' hypothermia temperatures. Therefore a comprehensive nursing assessment of all vital signs including consciousness and motor skills needs to be completed. Also as standard thermometers are less reliable at accurately measuring lower temperatures and subject to 'user' issues, interventions need to be informed by a comprehensive assessment rather than just on a temperature reading."

53. I also note Ms Carey's advice that owing to the normal aging process and conditions impairing thermoregulation, elderly people will routinely display lower core body temperatures than younger people, but that "[i]mpaired thermoregulation processes

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means that the elderly are more at risk of hypothermia and have a reduced or absent fever response to infection".

54. RN Carey advised me that because of the risk of hypothermia Mr A should have had a nursing assessment at approximately 7.15am when he was transferred to his room. She also commented that there was a "total lack of awareness" that Mr A was at risk of hypothermia and needed a comprehensive and prompt assessment. I agree, and am critical that RN B left Mr A with caregivers at this stage without having performed a comprehensive nursing assessment.

Following handover

55. Following handover, RN B delegated Mr A's observations to EN C and asked her to record Mr A's vital signs. RN B said that she knew Mr A was at risk of hypothermia, and she "appreciated that [Mr A] had a variation from a stable health situation".

56. The Nursing Council of New Zealand (NCNZ) standards outlined above state that the decision to delegate care to an enrolled nurse requires the registered nurse to use his or her professional knowledge, judgement and skills to determine whether the enrolled nurse has the necessary level of skill/knowledge, and whether the delegation is in the best interests of the health consumer.[7] I note RN Carey's advice that she is critical of RN B's decision to delegate the care and monitoring of Mr A to EN C.

57. I also note that RN B acknowledged that, as a registered nurse, she should have taken on the responsibility of assessing and monitoring Mr A's progress, and should not have delegated this to an enrolled nurse.

58. I am critical that following handover, RN B failed to assess Mr A herself, and instead delegated the assessment and monitoring of Mr A to an enrolled nurse.

7.30am

59. At 7.30am, EN C checked on Mr A and took his vital signs. His temperature was recorded as 34.4°C.

60. EN C updated RN B about Mr A's vital signs, which I am advised by RN Carey demonstrated hypothermia. EN C told RN B that it had been hard to find Mr A's pulse and, when it was found, it was slow, and he had a low temperature. RN B instructed EN C to "continue the observations" at least once an hour.

61. RN Carey advised me that RN B demonstrated a lack of appreciation that the reported vital signs, as relayed to her by EN C, showed that Mr A was hypothermic and that there were significant risks associated with him being in that condition.

62. I agree with RN Carey's advice and, in my view, when advised of Mr A's vital signs, RN B should have assessed Mr A. This was a further missed opportunity to ascertain his condition and provide appropriate treatment.

[7] Nursing Council of New Zealand (NCNZ), *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (Wellington: NCNZ, 2011).

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Conclusion

63. Overall, I consider that RN B failed to recognise that Mr A required a comprehensive nursing assessment, and she made a number of sub-optimal decisions. I am critical that at 7.15am she failed to assess Mr A, and left two caregivers in charge of his care. While I accept that RN B thought that her attendance at handover was important as part of her role, I consider that she should have first assessed Mr A. I am also critical of her decision following handover, to again delegate the assessment of Mr A to an enrolled nurse. Furthermore, I am very concerned that RN B decided that it was appropriate for EN C to continue to monitor Mr A even after EN C had reported vital signs that suggested that Mr A had hypothermia. In my view, RN B should have assessed Mr A at that point.

64. Accordingly, I find that RN B failed to provide services to Mr A with reasonable care and skill and therefore breached Right 4(1) of the Code.

Opinion: Rest home owner — No breach

65. Under section 72(2) of the Health and Disability Commissioner Act 1994 (the Act), an employing agency may be held vicariously liable for any actions or omissions of its employees and/or agents who have been found to be in breach of the Code, whether or not the actions or omissions occurred with the employing authority's knowledge or approval. Pursuant to section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the acts or omissions leading to an employee's breach of the Code. In addition to vicarious liability, the rest home owner may also be held directly liable for the services it provides.

66. This Office has previously found providers not liable for the acts or omissions of staff, when those acts or omissions clearly relate to an individual clinical failure made by the staff member.[8]

67. The rest home owner has been unable to establish why Mr A went outside, and said that he had shown no previous signs of wandering out of the building. While I consider it concerning that he was able to go outside unnoticed for about half an hour, I note that he was not known for wandering and did not require dementia level care.

68. Following Mr A's death, the rest home owner developed a policy for all its facilities on the Direction and Delegation of Care to Enrolled Nurses (issued November 2014) and produced an updated policy on the Treatment of Hypothermia (issued November 2014). Its staff have been made aware of this new policy at all of its sites, and further in-service education for all staff has commenced on first aid response to elderly residents suffering from hypothermia.

[8] Opinion 12HDC01483 (12 July 2013) available at: www.hdc.org.nz.

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69. Although disappointing that it did not have the above policies in place at the time, in my view the rest home owner has not breached the Code. I consider that RN B should have known the NCNZ's standards regarding delegation and been aware of the signs of hypothermia. I find that RN B's failings were individual clinical errors and therefore, in my view, the rest home owner is also not vicariously liable for RN B's breach of the Code.

Recommendations

70. I recommend that the Nursing Council of New Zealand consider whether a review of RN B's competence is warranted.

71. I recommend that, within six months of the date of this report, RN B undertake further training on recognising the signs of hypothermia.

Follow-up actions

72.
- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the District Health Board, and it will be advised of RN B's name.

- A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent nursing advice to the Commissioner

The following expert advice was obtained from RN Dawn Carey, in-house clinical nursing advisor:

> "Thank you for the request that I provide clinical advice in relation to the complaint forwarded from [the Coroner] … The complaint concerns the care provided by the rest home to the late [Mr A] [in] 2013. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> I have reviewed the documentation available on file: correspondence and copies of evidence forwarded from [the Coroner] including statements to the Police, report from [the rest home] prepared for the Coroner by Facility Manager (FM) including [Mr A's] clinical file, report from [the locum] (GP), [post mortem report]; response from [the rest home owner] on behalf of [the rest home] including Policy on Treatment of Hypothermia (issued May 2014).
>
> [Mr A] was found deceased in his bed at [the rest home] at 8am [in early] 2013. At the time of his death, he was 82 years of age and had dementia. He had initially been admitted to [the rest home] for hospital level care [in] 2011 following repair of a fractured neck of femur.
>
> [At 7am], [Mr A] was found outside by a [rest home] staff member coming to work. He was bare foot, wearing thin pyjamas and lying on the grass. He was shivering and cold but conscious. He was assisted back to his room and put to bed. At 7.35am an Enrolled nurse (EN) took [Mr A's] vital signs. At 7.50am the EN observed [Mr A] to be sleeping. [Mr A] was found dead at 8am by a caregiver who had brought him his breakfast. Post-mortem finding reported combined effects of recent hypothermia and pre-existing ischaemic heart disease and chronic obstructive respiratory disease as cause of death.
>
> I have been asked to review the management of [Mr A's] hypothermia and to comment on whether the risks of hypothermia were recognised and appropriately responded to.
>
> I have reviewed the [report provided to the Coroner]. The report is consistent with the submitted clinical notes and staff statements. For the purposes of brevity I have chosen not to repeat the content of the report here.
>
> I have also reviewed the response provided by [the] Audit & Compliance Manager for [the rest home]. [She] completed an investigation review into the care provided to [Mr A] on [the day of these events]. The review determined that [the rest home] failed to provide immediate medical assistance to [Mr A], by failing to recognise the serious potential consequences following exposure to hypothermia. The development of a policy document on the treatment of hypothermia and relevant

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in-service education were identified remedial actions. The Policy and education have been applied to all facilities owned by [the rest home owner].

Comment: I note that the Policy refers to the Hypothermia Chart — assessment Tool. This chart refers to 'umbles' as a sign of hypothermia. The term was coined by specialists in USA but to the best of my knowledge, is not widespread in New Zealand nursing education. While I acknowledge that in-service education accompanied the roll-out of the policy and that the current staff team will be knowledgeable that 'umbles' refers to the loss of fine motor and thought processes — fumble, stumble, tumble, mumble, grumble etc. — I would suggest that the policy or chart is amended to explain the term in plain English.

Following a review of the submitted documentation I note the following:

(i) Based on the time that the doors were unlocked for morning staff and the last time [Mr A] was sighted, maximum exposure time was approximately 25 minutes.

(ii) Consistent across the documentation is that [Mr A] was found outside lying on the grass at 7am. His pyjamas were damp from the dew; he was bare foot, cold, shivering but conscious. Following assessment for injuries he was assisted into a wheelchair and transferred back to his bed. At approximately 7.15am, registered staff went to take handover leaving night shift caregivers to put dry pyjamas on [Mr A]. He was covered with extra bedding, including a blanket warmed in the dryer … *At that stage he was speaking and answering our questions.* Following handover [EN C] was asked to record [Mr A's] vital signs. After checking some morning medications with [RN B], [EN C] checked on [Mr A] and completed the Physical Recording Sheet (PRS) *07.30 pulse 60 BP 120/62 temp 34.4°C.* [EN C] reports updating [RN B] and another RN of [Mr A's] vital signs.

(iii) Progress notes (PN) by [RN B] *[date] 07:45 Observations — Afebrile*$^{\wedge 34.0}$ *pulse not easily palpable. Resting on his bed.*

It is unclear when the temperature recording '34.0' was added to this entry.

(iv) [EN C] reports … *His temperature wasn't low enough for me to get concerned. It is normal for elderly to record temperatures of 34.8°C, not many get to 36°C. He felt warm other than his hands. Had it got down to 33°C that would have caused alarm…*

(v) [RN B] reports that the plan was to continue the observations at least hourly. … *A temperature of 34°C is low, borderline hypothermic. Elderly can get to 35.5°C and be considered normal but 34°C is low. The normal treatment for low temperature is to monitor and gradually warm them up ….*

(vi) [EN C] reports that [Mr A] was sleeping at approximately 7.50am … *so I left him. I knew he was still alive at this point as he had a good colour and I could see his chest rising as he breathed in. Breakfast would be along in 10 mins or so, so I thought I'd leave him …*

(vii) Caregiver [Mr H] reports … *About just before or just after 8am I arrived at [Mr A's] room to give him his breakfast … I realised at the point he had passed away …*

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(viii) Doctor Treatment Notes (DTN) report [Mr A's] weight as 56kgs in [early] 2013. The [autopsy Medical Report] confirms this weight and reports [Mr A's] body habitus as 'cachectic'. Decreased subcutaneous fat is viewed as a predisposing risk factor for hypothermia[9].

(ix) [Mr A] had regular incidences of low temperature recordings — <34.6°*C* — recorded for [late] 2011 and the early part of 2012. As his vital signs were mainly recorded monthly the low recordings feature prominently on the PRS even though they occurred 12 months prior.

Comments

Hypothermia is defined as core body temperature <35°C. In my opinion, this definition applies across the lifespan. Due to normal aging processes and conditions impairing thermoregulation, elderly people will routinely display lower core body temperatures than younger patient cohorts. Impaired thermoregulation processes means that the elderly are more at risk of hypothermia and have a reduced or absent fever response to infection.[10.]

Whilst hypothermia is defined with reference to core temperatures, it is appreciated that concerning symptoms — reduced respiratory rate, dysrhythmias, confusion — can be present even at 'mild' hypothermia temperatures. Therefore a comprehensive nursing assessment of all vital signs including consciousness and motor skills needs to be completed. Also as standard thermometers are less reliable at accurately measuring lower temperatures and subject to 'user' issues, interventions need to be informed by a comprehensive assessment rather than just on a temperature reading.

In my opinion, [Mr A] should have had a RN assessment at approximately 7.15am when he was transferred to his room.

The scope of practice for enrolled nurses changed on 31 May 2010[11]. Registered nurses who work with Enrolled nurses are responsible for understanding the EN scope of practise. Enrolled nurses are legally required to work under the direction and delegation of a RN and are limited to working with health consumers who have stable and predictable health outcomes. A decision to delegate care to an EN requires the RN to use their professional knowledge, judgement and skills to determine whether the EN has the necessary level of skill/knowledge, and whether the delegation is in the best interests of the health consumer[12]. I disagree with the decision to delegate the care and monitoring of [Mr A] to [EN C].

[9] Epstein, E., Anna, K. Accidental hypothermia. *BMJ 332*, *(*7543): 706–709.
[10] McCance, K. L., & Huether, S. (Eds.) *Pathophysiology: the biologic basis for disease in adults & children* (6th ed.), (Missouri, USA: Mosby Elsevier, 2009).
[11] Nursing Council of New Zealand (NCNZ), *Competencies for the enrolled nurse scope of practice* (Wellington: NCNZ, 2012).
[12] Nursing Council of New Zealand (NCNZ), *Guideline: responsibilities for direction and delegation of care to enrolled nurses* (Wellington: NCNZ, 2011).

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I consider that [Mr A's] reported vital signs at 7.30am demonstrated hypothermia, which should have prompted appropriate action and assessment from the notified RNs.

Clinical advice

I agree with [the rest home owner's] response that there was a failure to recognise the serious potential consequences following exposure to hypothermia. I agree that the identified remedial actions are appropriate and necessary. In my opinion, in-service education on direction and delegation, and the EN scope of practice is required.

In my opinion, there were significant departures in the nursing care provided to [Mr A]. I consider that there was a total lack of awareness that [Mr A] was at risk of hypothermia and needed comprehensive and prompt assessment. I am critical of the failure of the Registered nurses to assess [Mr A] at approximately 7.15am. I disagree with the initial decision to delegate the assessment of [Mr A] to an EN and fundamentally disagree with the decision that it was appropriate for [EN C] to continue to monitor [Mr A]. Had [EN C] not reported [Mr A's] vital signs promptly to a RN, I would have considered her care to have departed from expected standards and the responsibilities under her scope of practice.

In my opinion, the RN response to the reported vital signs was suboptimal and a moderate departure from expected standards. I consider that there was a lack of appreciation that the reported vital signs showed that [Mr A] was hypothermic and that there were significant risks associated with this state.

Dawn Carey (RN PG Dip)

Nursing Advisor

Health and Disability Commissioner

Auckland."

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