**Access Community Health Limited**

**Registered Nurse, RN B**

**A Report by the**

**Deputy Health and Disability Commissioner**

**(Case 18HDC00779)**

## Contents

## Executive summary

1. This report concerns the care provided to a woman by Access Community Health Limited (Access) and the Clinical Nurse Manager in 2018. The woman's general practitioner (GP) also provided care and prescribed her medications. The woman had a number of health conditions, including a history of skin infections. Her primary caregiver was her husband, and she received home and community support from Access, including daily visits from support workers.

2. There were a number of oversights in the woman's care relating to a lack of a reliable escalation system, no feedback loop to support workers, and a lack of oversight of Comprehensive Reports that were started but not finalised. This contributed to a delay in the review of the woman's deteriorating skin condition, and consequently to missed opportunities for her to receive the clinical care she needed.

3. This case highlights the importance of well co-ordinated service provision by all health service providers involved in a consumer's care, such that providers' respective roles and responsibilities are understood clearly, communication channels work effectively, and providers are responsive to the changing needs of the individual. This is particularly important in situations where the consumer has comorbidities and is at risk of becoming seriously unwell over a short timeframe.

### Findings

4. The Deputy Commissioner found Access in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that Access did not have a reliable escalation system for support workers to raise concerns, and that concerns raised were not escalated or actioned, and there was no feedback loop to support workers.

5. The Deputy Commissioner found the Clinical Nurse Manager in breach of Right 4(1) of the Code. The Deputy Commissioner was critical that the Clinical Nurse Manager did not address the health concerns escalated from support workers, and did not make clinical notes in the woman's file.

6. The Deputy Commissioner made adverse comment about the GP. The Deputy Commissioner was critical that the GP provided repeat prescriptions without assessing the woman in person, and was not proactive regarding follow-up arrangements.

### Recommendations

7. The Deputy Commissioner recommended that Access review its system for monitoring Comprehensive Reports; review the training provided on responding to support workers' reports; undertake a nationwide audit against documentation policies and standards; review the training provided on documentation; and provide a written apology to the woman's family.

8. The Deputy Commissioner recommended that the Clinical Nurse Manager report to HDC on her reflections and the changes to her practice as a result of this case; undergo further education on the subject of documentation; and provide a written apology to the woman's family.

9. The Deputy Commissioner recommended that the GP read the Medical Council of New Zealand "Ending a doctor–patient relationship" guidance and report to HDC on his reflections and the changes to his practice as a result of this case.

## Complaint and investigation

10. The Health and Disability Commissioner (HDC) received a complaint from the daughter of Ms A about the services provided to Ms A by Access Community Health Limited. The following issues were identified for investigation:

- *Whether Access Community Health Limited provided Ms A with an appropriate standard of care between Month1[1] and Month3 2018 inclusive.*
- *Whether RN B provided Ms A with an appropriate standard of care between Month1 and Month3 2018 inclusive.*

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

12. The parties directly involved in the investigation were:

| | |
|---|---|
| Ms A's daughter | Complainant |
| Access Community Health Limited | Provider/community residential support service |
| RN B | Provider/Clinical Nurse Manager |
| Dr C | Provider/general practitioner (GP) |

13. Also mentioned in this report:

| | |
|---|---|
| Ms D | Customer service representative (CSR) |
| Ms E | Support worker |
| Ms F | Care coordinator (CC) |
| Ms G | CSR |
| Ms H | CSR |
| Ms I | DHB social worker |
| RN J | Medical centre nurse |
| Ms K | Support worker |

[1] Relevant months are referred to as Months 1–3 to protect privacy.

14. Further information was received from the District Health Board (DHB), the Ministry of Health, the Nursing Council of New Zealand, the medical centre, and Ms A's husband.

15. In-house nursing advice was obtained from Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A), and in-house medical advice was obtained from GP Dr David Maplesden (Appendix B).

## Information gathered during investigation

16. This report concerns the services provided to Ms A by Access Community Health Limited (Access) and RN B between Month1 and Month3. Sadly, Ms A died on 21 Month3 from cellulitis[2] with sepsis.[3]

17. At the time of these events, Ms A was in her early sixties. She suffered from a number of health conditions, including obesity (documented as weighing 198kg in 2018), psoriasis,[4] type two diabetes,[5] and chronic obstructive pulmonary disease (COPD).[6] Her conditions impeded her mobility, and in late 2017 it was noted that she had not left her house independently for about two years.

### Hospital admissions in 2016 and 2017

18. In 2016, Ms A was admitted to the public hospital with fever, cellulitis, and breathlessness. Her clinical summary noted an impression of pneumonia, exacerbation of COPD, and cellulitis on her abdomen and upper thigh. It further stated that she had "skin breaks and ? pressure ulcers around apron folds, and mixed bacterial and fungal infection around tops of thighs". Ms A improved after treatment with antibiotics, and was discharged.

19. In early 2017, Ms A was admitted to hospital with *Streptococcus agalactiae* bacteraemia,[7] apronitis,[8] and type two respiratory failure.[9] Ms A was treated with antibiotics and discharged.

### Arrangements in place for Ms A's care

20. Between 2016 and 2018, Ms A's primary caregiver was her husband, Mr A. At least three organisations provided care to Ms A during this time:

[2] A bacterial skin infection.
[3] A potentially life-threatening condition caused by the body's response to an infection.
[4] A chronic skin disease.
[5] A condition that affects the body's ability to produce or use insulin.
[6] Chronic breathing problems, including shortness of breath and coughing.
[7] A bacterial infection.
[8] Infection of skin on the abdomen that is covered by hanging skin.
[9] Inability of the lungs to perform adequate gas exchange.

- The medical centre was Ms A's medical clinic and primary care service provider. Dr C prescribed various medications to Ms A to treat her health conditions.
- The DHB's District Nursing Service (DNS)[10] provided home-based wound care to Ms A for three months in 2016, while its Adult Community Services (ACS) group provided social work services to Ms A between 2016 and 2018.
- Access provided home support (including personal cares) to Ms A between mid 2016 and 2018.

*Medical centre*

21. The medical centre told HDC that Ms A had been a patient since 2009, but towards the end of her life her decreasing mobility led to "reclusive behaviour", and "unfortunately it was difficult to get her into the practice". To deal with this, the medical centre worked closely with Ms A's husband and lead carer, to provide services remotely to Ms A. Until Dr C's visit to Ms A's house on 6 Month3 (discussed further below), Ms A had not been seen by a doctor from the medical centre since 2016.

*Access*

22. Around the time of Ms A's discharge from hospital in 2016, the DHB referred Ms A to Access for home support, funded under its "Long Term Support, Chronic Health Conditions, Home Based Support" agreement. The referral required Access to send a support worker to Ms A's house twice a day, seven days a week, to help her with personal cares and hygiene. Access developed a support plan for Ms A that required its support workers to help her to shower, dress, and apply ointments to her skin.

23. In 2017, the DHB renewed Ms A's referral to Access. Access updated its support plan to note that its support workers were to "[w]atch [Ms A's] skin for rash spreading or not resolving with cream being used".

24. As Access's services to Ms A were funded under the DHB's "Long Term Support, Chronic Health Conditions, Home Based Support" agreement, Access was required to comply with the Ministry of Health's "Community Services Home Support Services (Personal Care and Household Support) For People with Chronic Health Conditions, Tier Level Two Service Specification"[11]. This service specification obliges providers to ensure that "Support Worker concerns around the wellbeing of a Service user will be reported to the Provider who will, if it is appropriate, discuss further with the Referrer".

*RN B*

25. At the time of these events, RN B[12] was Access's Clinical Nurse Manager in Ms A's area. Furthermore, because the registered nurse who was normally responsible for Ms A's nursing

[10] Typically district nurses provide care to people in their own home.
[11] Service specification May 2011.
[12] RN B had previously worked in other capacities as a nurse for Access.

care had resigned and had not yet been replaced, RN B was temporarily the registered nurse directly responsible for providing nursing services to Ms A.

**Medications prescribed by Dr C (2016–2018)**

26. When Ms A was discharged from hospital in 2016, she was prescribed several medications. Following her discharge, Mr A began a pattern of visiting the medical centre on Ms A's behalf and requesting repeat medications for her. Dr C prescribed the repeat medications. He stated that the "prescriptions were for mainly skin preparations, asthma medication and mild pain relief" based on information from Ms A's 2016 and 2017 hospital admissions. He noted that her "[m]edication was slightly changed" at the 2017 hospital admission, "but in essence stayed the same".

27. The medical centre's "Repeat Prescribing" policy states that "[r]epeat prescriptions may only be given if the patient has been seen within the last 6 months".

28. Dr C said that "[a]ll prescriptions were written on the basis that [Ms A was to] present to the surgery at least twice a year — adhering to [the Clinic's] policy". He stated:

> "[However, Ms A] refused to present to the surgery instead sending [Mr A]. On each occasion he presented I asked him to bring her in. He said he would try but was not successful."

29. Dr C told HDC: "This situation put me in a very difficult situation but I had no choice but to keep trying to get her to come to the surgery." Dr C said that the medical centre's relationship with Ms A was "extremely difficult and concerning for [him]". He stated:

> "Requests from [Mr A] for prescriptions caused much anguish and I told him on 5–6 occasions that I would not care for her any longer as the relationship between doctor and patient had dissolved to dangerous levels and was unsafe. She refused to see me. I asked him to find another doctor to care for her. He refused. I should have ended my contact with her then with a recommendation to another doctor. Every other time he appeared I would refuse his request but he would beg for my help and foolishly I would capitulate."

**Support workers' observations and Access's responses (Month1–Month2)**

30. Access had designated Ms A a "V.1" "Vulnerable client status" — the highest level of vulnerability for a client. Access's process[13] for escalating concerns about vulnerable clients is for the support worker to call either a rostered care coordinator (CC) or a rostered customer service representative (CSR) and report any concerns to them. The CC or CSR then records a summary of the telephone call in the "Client Diary Note Report" system and communicates the support worker's concerns to Access's nurses.

[13] The "Vulnerable Client Monitoring" policy.

*16 Month1*

31. On 16 Month1, a CSR documented that Ms E, a support worker, reported her concern that Ms A's skin was deteriorating and her nails were neglected. The CSR left a note that a nurse was to follow up.

*30 Month1*

32. On 30 Month1, Ms D documented that Ms E reported that Ms A had had a fall in the weekend, which had caused her some bruising around the left side of her body and under her arms. Ms A said that she was somewhat sore and that some of her skin had peeled off. Ms D left a note that a nurse was to follow up.

*6 Month2*

33. On 6 Month2, CC Ms F documented that Ms E reported that she was concerned about Ms A's well-being and skin condition. Ms E felt that Ms A was not improving, and asked for her to be reassessed. Ms F documented that a CC or CSR was to follow up.

*10 Month2*

34. On 10 Month2, a CSR documented that a support worker reported that Ms A had had a fall in the night. The support worker advised that Ms A was "okay", but might need a reassessment. The CSR left a note for a staff member to follow up.

*13 Month2*

35. On 13 Month2, Ms G documented that Ms E reported that she was very concerned about Ms A. Ms G documented that Ms E advised that "she had called numerous times already and feels nothing is being F/U[14]", and that Ms A's family "are not really coping". Ms E advised that Ms A's skin condition was deteriorating, including "all down her back and groin area". Ms G documented that she tried to contact two nurses about this but neither were available, so she left a note for a nurse to follow up.

*20 Month2*

36. On 20 Month2, Ms H documented that Ms E reported that she wanted to speak to a nurse about her concerns regarding Ms A. Ms H documented that she tried to contact three nurses but they were not available, so she left a note for a nurse to follow up.

*Access's responses to Ms E's reports*

37. Concerning the 30 Month1 report, a CSR prepared a "Comprehensive Report"[15] document. The document quoted some of Ms D's diary note about Ms E's report, and stated that a care coordinator was responsible for following up the report. However, most of the text fields in the document have not been filled in; for example, the fields "Is Preventative Action Required?" and "Is Corrective Action Required?" are both marked "No" without further explanation, and the "Date Closed" field is empty.

[14] Followed up.

[15] An automatically generated easy-read version of incidents loaded into the online incident management system.

38. Concerning the 13 Month2 report, Ms H prepared a "Comprehensive Report" document. The document quoted Ms G's diary note about Ms E's report. Most of the text fields in the document have not been filled in; the field "Responsible Person" is empty, the fields "Is Preventative Action Required?" and "Is Corrective Action Required?" are both marked "No" without further explanation, and the field "Date Closed" is marked several months after Ms A's death.

39. Aside from the two abovementioned "Comprehensive Report" documents, Access does not have any record of any actions taken in response to Ms E's 16 Month1, 30 Month1, 6 Month2, 10 Month2, 13 Month2, or 20 Month2 reports.

40. Neither the medical centre nor the DHB have any record of Access communicating with them about these six reports. Regarding the 30 Month1 report, Dr C documented on 9 Month2 that Ms A "[f]ell the other day/4 firemen needed to lift her", but did not document how he received the information.

41. Ms A's support workers recorded notes in a "Client Communication Book", which was kept at her house. On 25 Month2, Ms E signed the following entry in the book: "[Ms A] had a wash on her bed. Her skin is very sore in [left] groin area. Still waiting for Access to initiate a visit and [support worker] will phone them also."

*Statements*

42. Mr A told HDC that he recollects the Access support workers trying to get a nurse to review Ms A, without success until Month3.

43. Access stated:

> "[We are] confident that we responded appropriately in response to [Ms E's] reports, but acknowledge that there is a lack of documentation/clinical notes of the actions and responses taken."

44. Access also stated: "We are confident our escalation process was followed and that this would be corroborated if [the DHB and the medical centre] were asked."[16]

45. RN B told HDC that she found it "difficult to give a detailed outline for each of the diary notes due to the amount of time that has lapsed since the entries". She stated:

> "I do recall having a conversation with [Ms A] re a reassessment and she had advised me that she wanted a reassessment with … the DHB needs assessor. I had sent a request to [the DHB Long Term Services Chronic Health Conditions Service][17] via email[18] and also suggested a joint visit. I cannot recall what timeframe this was. I also recall being

[16] The DHB and the medical centre have no record of Access communicating with them about these six reports.
[17] A funding stream for persons who have chronic health conditions and are under 65 years of age.
[18] As noted at paragraph 39, Access did not have a record of this email.

in contact with district nurses re [Ms A] on one occasion when she had made the request for assistance from District Nurses."

46. The DHB told HDC that its clinical records "mention no involvement by the District Nursing service in the care of Ms A between her discharge [in] 2016 and 16 [Month3]". Moreover, its "Adult Community & Long Term Conditions service [which was responsible for both the District Nursing and Long Term services] does not have documented in the clinical notes any record of contact via phone or otherwise" with Access about Ms A between 2016 and 16 Month3.

**Services provided to Ms A between 21 Month2 and 17 Month3**

*21 Month2*

47. On 21 Month2, the DHB gerontology[19] nurse documented that the DHB social worker, Ms I, telephoned her to ask her to review Ms A. The gerontology nurse advised Ms I that Ms A needed to be reviewed by a GP.

*22 Month2*

48. On 22 Month2, Ms I documented that she met Ms A in person and discussed the prospect of a GP review at her home. Ms A said that she could not afford the cost of a home visit. Ms I advised that she could seek a disability allowance to cover the cost of a visit, and Ms A asked Ms I to apply for an allowance on her behalf.

49. Ms I told HDC that she initiated this visit, and does not recall anyone contacting her about Ms A during this time.

50. On 22 Month2, RN J (a medical centre nurse) documented that Ms I called the medical centre to note that Ms A had rashes on her back and needed to be seen by a doctor. RN J also documented that Mr A visited to request prescriptions for Ms A.

*2 Month3*

51. On 2 Month3, a CSR documented that Ms K, a support worker, reported that Ms A had sores on her body but was not in pain. Ms K advised that she thought it might be cellulitis, as it had come up in a day, and requested a nurse's opinion. The CSR documented that she emailed the nurses about this.

52. RN B told HDC that on 2 Month3 she received an email from Access and spoke with Ms K about Ms A by telephone. RN B said that she tried to call Ms A but was unsuccessful, and then spoke again with Ms K and advised her: "[W]e cannot assume there is infection but given [Ms K's] concern … we need to strongly advise [Ms A] to visit her GP for any medical concerns." Ms K agreed to pass on this message to Ms A.

53. On 2 Month3, a medical centre nurse documented that a social worker was arranging funds to pay for Dr C to visit Ms A at her home.

[19] Aged care.

*6 Month3 review by Dr C*

54. On 6 Month3, Dr C visited Ms A at her house. He documented that there was a rash under her breasts and left groin, and that she had a Staphylococcus infection[20] and cellulitis on her left forearm. He recorded that Ms A had "run out of flixotide[21]", "[n]eeds clomazol[22]", "needs to lose weight", and "refuses to go to hospital". He prescribed her diclofenac[23] tablets, Augmentin[24] tablets, Flixotide, Crystaderm[25] cream, and Clomazol[26] cream.

55. Dr C told HDC that when he saw Ms A, "[s]he was afebrile[27], chest clear and heart sounds normal. She was not in distress but was suffering from a major infected cellulitis and required urgent hospital treatment." Dr C told Ms A that he would order an ambulance to take her to hospital, but she "refused to accept this and begged [him] to let her stay at home". Dr C advised Ms A that this was "not a good decision". Following this exchange, Dr C discussed Ms A's situation with Mr A and "told him to ring an ambulance when she agreed to go to hospital".

56. Ms A's daughter told HDC:

> "If [Dr C] knew my mum needed [an] ambulance why didn't he just ring one for her? … My family has lost someone who could have still been here if [Dr C] did call the ambulance when he know from the[re] that i[t] was bad … [T]here could have been a chance of ambulance was called in regardless of what my mum wanted."

57. Dr C told HDC that he recognised that Ms A "needed IV antibiotics" rather than oral antibiotics and ointment to "treat the extensive area infected", and "told her this". He stated: "When a rational patient ignores a serious plea from me to go to hospital expecting that I can improve their lot by staying at home I believe I can do little more."

58. Dr C commented on the difficulty he had dealing with Ms A, and stated:

> "[T]here was nothing I could do to change her mind or the progress of her condition.[28] I was a distant influence in her treatment and not seeing her every day as were the hospital team."

59. Dr C disagrees that he should have contacted Ms A on a daily basis from 6 Month3, and said that he did not know until 15 Month3 that she had not gone to hospital. He reiterated that he "had strongly recommended she present to hospital for treatment". Dr C told HDC: "I

[20] A bacterial infection.
[21] A steroid medication that is inhaled.
[22] An antifungal cream.
[23] A non-steroid anti-inflammatory medication.
[24] An antibiotic.
[25] An antibacterial cream.
[26] An antifungal cream.
[27] Not feverish.
[28] It is noted that "everyone has the right to refuse to undergo any medical treatment" under The New Zealand Bill of Rights Act 1990, section 11.

planned to visit [Ms A] but was overwhelmed with patients that afternoon and was off sick on [16 Month3]. I had planned to see her ASAP."

60. Access told HDC that it was not aware that Dr C had visited Ms A on 6 Month3.

*13 Month3*

61. RN B told HDC that on 13 Month3 she followed up with Ms K about Ms A, and Ms K told her that she had tried to persuade Ms A to see her GP, but had not been successful. RN B told Ms K to continue to advise Ms A to see her GP, since he would be "the best placed person to assist with this wound and skin condition". RN B also told Ms K that she would follow up the following day.

*14–16 Month3*

62. RN B stated that on 14 Month3 she spoke with Ms A and offered to help her to contact her GP, and Ms A accepted the offer.

63. Between 14 and 16 Month3, various messages went back and forth between Ms A, Access, and the medical centre concerning the possibility of Ms A being seen by either a doctor or a nurse. On 16 Month3, a nurse documented that RN J had successfully referred Ms A's care to the DHB's District Nursing service. On the same day, the DHB documented that it accepted RN J's referral.

*17 Month3*

64. On 17 Month3, a district nurse visited Ms A at her house. The nurse documented that Ms A had an "infected fungus infection in [her] groin area", and that she described her pain as being "8–10 on pain scale". The district nurse documented that she "organised a non-urgent ambulance" for Ms A.

**Admission to hospital and deterioration**

65. The ambulance reached Ms A at 12.20pm on 17 Month3. Because of difficulties with removing Ms A from her bedroom and house, the ambulance did not leave the house until 1.37pm. The "Ambulance Care Summary" documented that Ms A was being referred to the Emergency Department for "severe cellulitis", but that her status was "[u]nlikely threat to life".

66. Following presentation to the hospital at 2.13pm, it was documented that Ms A's vital signs were "[a]bnormal". Her temperature was 36.8°C,[29] her heart rate was 71 beats per minute,[30] respiratory rate 28 breaths per minute,[31] blood pressure 121/68mmHg,[32] and oxygen saturation 93%.[33] Her initial diagnosis was cellulitis with "[u]nderlying intertrigo"[34]

[29] A normal temperature for a healthy adult is 36.5–37.3°C.
[30] A normal heart rate for a healthy adult is 60–100 beats per minute.
[31] A normal respiratory rate for a healthy adult at rest is 12–18 breaths per minute.
[32] A normal blood pressure for a healthy adult is 90/60–120/80mmHg.
[33] A normal range of oxygen saturation of the blood is 94–98%.
[34] Skin inflammation caused by the rubbing together of folds of skin.

and a "likely fungal element". She was described as appearing "[s]ystemically well", and was administered intravenous antibiotics.

67. However, during Ms A's stay in hospital, her condition deteriorated and she developed sepsis and multi-organ failure associated with the cellulitis and her respiratory problems, and she died at 2.15pm on 21 Month3.

**Policies and job description**

*Vulnerable Client Monitoring policy*

68. Access's process for escalating support workers' concerns about clients is largely set out in its "Vulnerable Client Monitoring" policy. Under this policy, support workers must report their concerns about vulnerable clients to either a CC or a CSR, "who will escalate the call to the relevant clinical person".

69. The "rostered [CC or CSR] is responsible for monitoring and following up immediately any alerts … for vulnerable clients, to ensure that competent care is delivered within the specified timeframes for the allocated category", for "[e]nsuring any concerns reported by [support workers] are referred immediately to the relevant clinician", and for providing "clear and precise documentation under diary notes on Access Controller,[35] regarding all correspondence and activity relating to the identified client".

70. The community nurse is responsible for "[e]scalating information provided about a client's vulnerability to the appropriate people, both internal and external, involved in the person's care", while the Clinical Nurse Manager is required to oversee "any referrals by [Access nurses] to Funders, NASCs, Aged Concern, the client's GP or other relevant bodies to safeguard vulnerable clients".

71. Where a support worker reports concerns about a "V.1" client, that client must receive care within two hours of the support worker's report.

*Shared Care policy*

72. Access's "Shared Care" policy states that the Clinical Nurse Manager is responsible for "[e]nsuring that any change in the client's condition is reported to the [relevant] other agency through the agreed channels".

*RN B's job description*

73. RN B's Clinical Nurse Manager job description stated that she was required to "lead and manage the clinical aspects of the operation for the region, including day to day service delivery", to oversee "the service provided to clients with complex care requirements", and to "[m]onitor clinical on call and call out issues follow up and closure by clinical team leaders".

[35] Software used by Access.

*Relevant standards*

74. The Health and Disability Services Agreement between the DHB and Access states:

> "Support Worker concerns around the wellbeing of a Service user will be reported to the Provider who will, if it is appropriate, discuss further with the Referrer. Wherever possible, this will be undertaken in discussion with the Service user and/or their family and whānau [(Section 5.1.2)].
>
> …
>
> The Provider will ensure, where required by the needs of individual Service users, that their access to appropriate services are co-ordinated into a single package centred on the Service user's need. This will be done in conjunction with the Referrer [(Section 6)].
>
> For example, for 'Community health services' ensure 'clinical consultation and referral services that support continuity of care'."

75. The Home and community support sector Standard NZS 8158:2012 includes standards on skin integrity (Section 4.10) and review of service delivery (Section 4.11). Outcome 2, under organisational management, states: "Consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner."

**Further information**

*RN B*

76. RN B told HDC:

> "In hindsight now and after reviewing the information provided I do not believe the follow up was consistent with Access Community Health policy and procedure but as I explained earlier I was trying to do my work as well as covering for a clinician that had left whilst we were recruiting."

77. RN B stated:

> "I believe I was not adequately resourced at the time. There had been 2 recent resignations from the health care professionals that were responsible for that area in a short space of time. It was difficult to recruit into the role whilst trying to cover my role and also that of the clinician for the area … The regional manager at the time was aware of the situation."

78. RN B told HDC that she does not recall receiving specific training in escalating clients' care to other providers, but she does recall discussing the fact that it was important to contact a client's GP if there were concerns about a client's health.

*Access*

79. Access told HDC that "[Ms A] was aware of the concerns about her skin deterioration, but she chose not to seek further medical treatment at certain points in time".

80. Access told HDC that although its Vulnerable Client policy was in place, it was not reflective of the accepted standard in the sector but was in place for ACC purposes.[36]

81. Access acknowledged its role in Ms A's overall support and stated that Access is very sorry that it did not get everything right in this regard. It said:

> "Access wishes to acknowledge the very tragic and sad circumstances surrounding [Ms A's] death. We are truly sorry that [Ms A] died and that her family have lost a much loved and dear partner, mother, grandmother and great-grandmother."

82. Access reiterated its view that it "responded appropriately in response to the support worker's concerns being raised about [Ms A]". Access told HDC that it acknowledges that it did not get everything right in this case.

83. Access accepted that RN B did not meet clinical best practice in documenting the relevant discussions and steps taken in the care of Ms A during Month1–Month3 and that RN B's manager could have taken more active steps in monitoring RN B's practice and ensuring that sufficient documentation was in place.

84. Access told HDC that it has introduced a number of changes and initiatives to its service delivery and policies, including a focus on clinical incident management and documentation; complaint management training; consumer rights training; a review of the On-Call clinical process; and a number of IT enhancements, including improvements to the support workers' mobile phone application to show any changes to the client's support plan or Health and Safety issues. Access is revising its Vulnerable Clients policy to apply only to clients receiving ACC Integrated Community Support Services.

85. Access told HDC that it was not its process for clinicians to report their interventions to support workers. Access stated:

> "With approximately 3,000 Support Workers throughout Access going back to each Support Worker every time would be an unachievable task. If there were any changes made following a report by the Support Worker, these would be identified in an updated Support Plan in the client's home."

86. Access told HDC that it was "very surprised and disappointed" by RN B's statement that she does not believe the follow-up provided to Ms A complied with Access's policies. Access stated that it always had sufficient staff to ensure that "workload was always well managed". Moreover, it stated that RN B did not tell her Regional Manager that she was struggling with her workload, and Access learned that RN B felt this way only during the course of HDC's investigation.

[36] ACC required a policy for certain complex clients under one particular service agreement. Access decided to introduce the policy for all clients receiving support.

87. Access told HDC that when a "Comprehensive Report" document is finalised, it is sent to the Regional Manager to review. Access stated:

> "Clinical Nursing Manager [RN B] would address each clinical incident in a timely manner in response to these email alerts, and the Regional Manager could see this was being addressed. What the Regional Manager did not realise was that [RN B] was not [finalising the Comprehensive Reports], nor was she doing complete clinical notes."

88. Access said that it has since implemented a system whereby the Regional Manager will receive an automatic alert if a "Comprehensive Report" is commenced but not finalised within a certain number of days.

89. Access submitted:

> "[A]s a Registered Health Professional [RN B] has her own nursing standards, ethics and responsibilities to uphold, which allows her management team the security of not having to oversee every detail of her work."

*Dr C*

90. Dr C told HDC:

> "[Ms A] did not listen to medical advice, did not take medical advice and refused to engage in a meaningful two way responsible relationship with a GP. Even her main carer [Mr A] acknowledged that our position and his were impossible and that we were constrained to try and help as best we could with someone who did not want to help herself for much of the time."

91. Dr C stated: "[M]any many times I tried to break this relationship [with Ms A] as it was toxic and was not beneficial." He said that although theoretically he could have called or visited Ms A more frequently, he was very sceptical that Ms A would have cooperated with him to improve her situation.

**Responses to provisional opinion**

92. Ms A's family were given an opportunity to respond to the "information gathered" section of the provisional report. Where appropriate, their comments have been incorporated into this report.

93. In response to the first provisional opinion, Ms A's daughter told HDC: "If [Dr C] knew my mum needed [an] ambulance why didn't he just ring one for her? [H]e knew it was bad and yet he could have still done what was right for her??"

94. Ms A's daughter also told HDC:

> "This has been a huge loss for my family since my mums passing things will never be the same again as each day I can see nothing but the pain and hurt in my family."

95. Access, RN B, and Dr C were each given the opportunity to respond to relevant parts of my provisional opinion. Their responses have been incorporated into this report where appropriate. In addition, I note the following:

96. RN B told HDC that she has no further comments to make, and that she accepts the Deputy Commissioner's recommendations.

97. Access told HDC that it has no further comments to make, and that it accepts the Deputy Commissioner's recommendations.

98. Dr C reiterated his comments about the difficulty he had dealing with Ms A.

## Opinion: Introductory comment

99. I have attempted to ascertain what action, if any, Access and its staff took in response to Ms E's 16 Month1, 6 Month2, and 13 Month2 reports in which she expressed concern that Ms A's skin condition was deteriorating. In determining this matter, I have considered all the evidence obtained, including the following:

- Access told HDC that it is "confident that [it] responded appropriately in response to [Ms E's reports]" and "confident [that its] escalation process was followed". In particular, Access stated that RN B "would address each clinical incident in a timely manner in response to these email alerts".
- RN B told HDC that she recalls talking with Ms A about the possibility of her being reassessed, and also recalls being in contact with the DHB about Ms A. RN B accepts that she cannot recall when the contact took place.
- Access's Clinical Diary Note Report system does not record any actions taken by Access to address the concerns raised in Ms E's reports, other than preparing two "Comprehensive Report" documents in relation to her 30 Month1 and 13 Month2 reports.
- Access's two "Comprehensive Reports", prepared by a CSR and Ms H, which concern Ms E's 30 Month1 and 13 Month2 reports, are mostly incomplete, contain no details about the actions taken to address the concerns raised in any of Ms E's reports, and were not finalised for the Regional Manager to review.
- Neither the medical centre nor the DHB have any record of Access contacting them about Ms E's reports.
- Ms I (DHB social worker) told HDC that she initiated her 22 Month2 visit to Ms A's house, and cannot recall anyone contacting her about Ms A during this time.

- There is no indication in the support workers' later reports concerning Ms A's skin deterioration that Access had responded to the concerns that Ms E had expressed in her previous reports.
- On 20 Month2, Ms E reported to Ms H that she was concerned about Ms A; there is no documentation of any actions taken by Access in response to this report.
- Ms E's entry dated 25 Month2 in Ms A's Client Communication Book states that she was "still waiting for Access to initiate a visit".

100. Having examined this evidence, I consider it more likely than not that until 2 Month3, Access and RN B took no action to address the support workers' concerns that Ms A's skin condition was deteriorating.

101. Regarding Ms E's 30 Month1 report about Ms A's recent fall, I note that Dr C documented on 9 Month2 that he was aware of this fall. However, it is not documented how he received this information.

## Opinion: Access Community Health Limited — breach

102. In accordance with the Code of Health and Disability Services Consumers' Rights (the Code), Access had a duty to provide its clients with services of an appropriate standard. In addition, the Home and community support sector Standard NZS 8158:2012 requires organisations to ensure that consumers receive services that comply with legislation and are managed in a safe, efficient, and effective manner.

103. Access was contractually responsible for providing personal care and household support services to its clients in accordance with the Ministry of Health's "Community Services Home Support Services (Personal Care and Household Support) For People with Chronic Health Conditions, Tier Level Two Service Specification". This service specification requires Access to ensure that "Support Worker concerns around the wellbeing of a Service user will be reported to the Provider who will, if it is appropriate, discuss further with the Referrer. Wherever possible, this will be undertaken in discussion with the Service user and/or their family and whānau." There is also a requirement for Access to ensure that "access to appropriate services are co-ordinated into a single package centred on the Service user's need. This will be done in conjunction with the Referrer." This can include "clinical consultation and referral services that support continuity of care".

104. This requirement is developed in Access's "Vulnerable Client Monitoring" policy, which establishes a process by which support workers must escalate health concerns to CCs and CSRs. CCs and CSRs must escalate concerns to nurses, and nurses must (where appropriate) escalate concerns to external providers. Additionally, Access's "Shared Care" policy makes the Clinical Nurse Manager responsible for "[e]nsuring that any change in the client's condition is reported to the [relevant] other agency".

105. On 16 Month1, 6 Month2, 13 Month2, and 2 Month3, support workers reported concerns to the CCs and CSRs that Ms A's skin condition was deteriorating. As discussed above, I have found that Access took no action in response to these concerns until 2 Month3. In particular, it did not initiate a nursing review or communicate the concerns to Ms A's GP (as per the Vulnerable Client Monitoring Policy), and did not "discuss further with the Referrer" ie, the DHB (as per the Service Specification).

106. My in-house nursing advisor, RN Hilda Johnson-Bogaerts, advised:

> "There is no evidence of care coordination other than passing on of a message. Good practice requires a check in that messages are received in good order, that relevant clinical information is shared (i.e written and verbal referrals), that progress reports are exchanged. No evidence was provided of such care coordination internally between ACH nurses and with [support] workers, or externally with District Nurses Service and the GP service. It would appear that the service coordination was limited to passing on of messages and did not assure messages were received in good order or were followed up. Seeing the vulnerability status of [Ms A] this would be seen as a moderate departure from accepted practice.
>
> … I [am] concerned that there is no system in place whereby actions taken by RNs as a result of concerns raised by a S[upport] W[orker] is not reported back to the S[upport] W[orker] so they can be confident that their concern/communications have been picked up. Such a feedback loop is not only professional it is also essential for having an effective escalation process and a way to manage the potential risk of an escalation not being picked up in a timely manner."

107. I accept this advice. Further, I suggest that an effective feedback loop would support a team culture within Access where staff are readily able to see the value and impact their individual contribution is making for their clients. Under its "Vulnerable Client Monitoring" policy, Access was responsible for ensuring that its staff appropriately escalated clients' health concerns. As Ms Johnson-Bogaerts advises, a reliable escalation system requires a mechanism for confirming that an escalation has been "received in good order" by someone who will be responsible for following up that escalation. Access's support workers did not have access to documented feedback on concerns they reported. At the time, Access's system does not appear to have had such a quality assurance mechanism, so a CC or CSR who had tried to escalate a concern may not have known whether their escalation was successful, or whether they needed to keep trying. This poses the risk of attempted escalations falling through the cracks, and concerns not being acted upon in an appropriate timeframe.

108. Concerning Access support worker Ms E's reports, RN Johnson-Bogaerts advised:

> "The notes include messages from the S[upport] W[orker] requesting for a nurse to follow up on health concerns. Following notes are silent on any contact made by a Care Coordinator with an ACH nurse or district nurse. Some messages have a repeat from

> the [Support] Worker requesting for nurse follow up. Seeing the vulnerability status of [Ms A] and the significance of issues raised by the [Support] Worker this would be considered as a significant departure from accepted practice."

109. I agree and am troubled that Ms E's repeated reports about Ms A's skin deterioration did not trigger action by Access before Month3. Ms A was a vulnerable client with "V1" "Vulnerable Client Status", meaning that Access was required to ensure that Ms A received care within two hours of Ms E reporting her concerns.

110. I also note that Ms A had a history of being hospitalised for skin infections. Access's support plan specifically noted that support workers should "[w]atch skin for rash spreading or not resolving with cream being used". Therefore, it is disappointing that when Ms E duly reported her concerns about Ms A's skin, Access's system did not ensure that her concerns were escalated to a responsible person, investigated, and acted upon promptly.

111. Access submitted that it was entitled to rely on RN B, a registered health professional, to uphold professional nursing standards without the Access management team "having to oversee every detail of her work". However, Access was responsible for ensuring that concerns about Ms A's condition were addressed appropriately and escalated, in accordance with its policy, and in line with the Service Specification and Sector Standard. Concerns raised by support workers were not addressed on a number of occasions, there was a lack of a reliable escalation system, and no feedback loop to support workers. In addition, there was a lack of oversight of Comprehensive Reports that were commenced but not finalised. I note that Access has since implemented a system of automatic alerts to advise the Regional Manager if reports are not finalised. In this case, on several occasions Access failed to ensure that its system appropriately recognised and escalated concerns about Ms A, with the consequence that opportunities were missed to take action regarding her skin deterioration between mid-Month1 and mid-Month2.

**Conclusion**

112. In my view, the service failures described above contributed to the delay in Ms A receiving a review of her deteriorating skin condition, and consequently opportunities were missed for her to receive the clinical care and medical intervention she needed. I find that Access failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.[37]

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

## Opinion: RN B — breach

### Omission to act on support workers' concerns

113. As the relevant Clinical Nurse Manager, and as the acting community nurse providing nursing services to Ms A, RN B was responsible for:

- Leading and managing the clinical aspects of Access's operations for the region.[38]
- Overseeing the service provided to clients with complex care requirements.[39]
- Monitoring clinical on-call and call-out issues, and follow-up and closure by clinical team leaders.[40]
- Escalating information provided about a client's vulnerability to the appropriate people, both internal and external, involved in the person's care.[41]
- Overseeing any referrals by Access nurses to funders, NASC, Aged Concern, the client's GP, or other relevant bodies.[42]
- Ensuring that any change in the client's condition was reported to other appropriate agencies through the agreed channels.[43]

114. On 16 Month1, 6 Month2, 13 Month2, and 2 Month3 support workers reported concerns to CCs and CSRs that Ms A's skin condition was deteriorating. As discussed above, I have found that Access took no action to address these concerns until 2 Month3. In particular, it did not initiate a review or communicate the concerns to Ms A's GP.

115. My in-house nursing advisor, RN Johnson-Bogaerts, advised:

> "The notes include messages from the S[upport] W[orker] requesting for a nurse to follow up on health concerns. Following notes are silent on any contact made by a Care Coordinator with an ACH nurse or district nurse. Some messages have a repeat from the [Support] Worker requesting for nurse follow up. Seeing the vulnerability status of [Ms A] and the significance of issues raised by the [Support] Worker this would be considered as a **significant departure from accepted practice**."

116. I accept this advice. Although Access was responsible for providing a reliable escalation system, RN B — as both the Clinical Nurse Manager and the relevant community nurse — was responsible for responding to health concerns escalated by the CCs and CSRs concerning Ms A's health. Accordingly, I am critical that RN B did not either address Ms E's reports herself or ensure that another clinician addressed them. This omission meant that

[38] RN B's job description.
[39] RN B's job description.
[40] RN B's job description.
[41] Access's Vulnerable Client Monitoring policy
[42] Access's Vulnerable Client Monitoring policy.
[43] Access's Shared Care policy.

opportunities were missed to address Ms A's skin deterioration and resulting cellulitis between mid-Month1 and mid-Month2.

**Documentation**

117. RN B spoke about Ms A's health with both Ms K and Ms A in Month3; however, there is no documentation of these conversations. RN Johnson-Bogaerts advised:

> "I am also concerned that no nurse's entries were made in the Clinical Diary Note Report following any visits by ACH nurses or following phone calls made by the CNM to [Ms A]. Good practice requires nurses to make clinical notes in patients' files. **Deviation from accepted practice moderate to mild**".

118. I accept this advice. RN B should have documented her advice to Ms K and Ms A to support continuity of care, and I am critical that she did not do so.

**Conclusion**

119. I have considered RN B's statement that she "was not adequately resourced at the time" and that her Regional Manager "was aware of the situation". I have also considered Access's statements that RN B never told her Regional Manager that she felt inadequately resourced, and that Access had sufficient staff to ensure that "workload was always well managed".

120. Given these conflicting recollections, and the absence of any contemporaneous documentation, I am unable to make a factual finding regarding whether RN B told Access that she was struggling with her workload. I accept that it is possible that RN B was not resourced adequately. However, RN B held a key role in Access's escalation system, and it was her responsibility to respond appropriately when concerns were raised on multiple occasions. If she was unable to do so, or was struggling with her workload, it was her responsibility to raise this with her employer, and there is no evidence that she did so.

121. For omitting to respond appropriately to repeated concerns raised by support workers, and for poor documentation of the advice given, I find that RN B did not provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.[44]

## Opinion: Dr C — adverse comment

**Introduction**

122. The medical centre was Ms A's primary care service provider, and Dr C, a Director and general practitioner at the medical centre, prescribed various medications to Ms A to treat her health conditions. During the course of this investigation, some issues with the service Dr C provided have come to light.

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

**Departure from "Repeat Prescribing" policy**

123. The medical centre's "Repeat Prescribing" policy states that "[r]epeat prescriptions may only be given if the patient has been seen within the last 6 months". My in-house medical advisor, Dr David Maplesden, advised that he approves of this policy, and that it is consistent with Medical Council of New Zealand guidance that "[p]atients receiving repeat prescriptions should be assessed in person on a regular basis", and that "[p]atients who need a further examination or assessment should not receive repeat prescriptions without being seen by a doctor".[45]

124. Ms A had been Dr C's patient at the medical centre since 2009. It appears that Dr C did not review her between 2016 and 6 Month3. This was because Ms A, who suffered from mobility issues, was unwilling or unable to present to Dr C's clinic. Despite this, Ms A's husband, Mr A, asked Dr C to prescribe his wife various medications between 2016 and 2018, and Dr C prescribed those medications. This contravened the medical centre's "Repeat Prescribing" policy.

125. On multiple occasions when Mr A sought prescriptions for his wife, Dr C asked that Ms A either present physically to his clinic or find another doctor. On each occasion, Ms A and Mr A declined both of these options and persisted in seeking further prescriptions. Dr C stated that each time he refused Mr A's request, "[Mr A] would beg for my help and foolishly I would capitulate."

126. Dr Maplesden advised:

> "[Dr C] was placed in a somewhat difficult situation of having a patient with high health needs who refused (and was eventually unable) to attend his surgery for appropriate clinical review, but required regular medications."

127. Dr Maplesden also advised that "[i]t is difficult to establish 'accepted practice' in a situation such as this", and agreed with Dr C that simply stopping Ms A's prescriptions "because she would not attend for review" would have been problematic.

128. Nonetheless, Dr Maplesden was "mildly critical of the somewhat passive approach taken by [Dr C] to establishing and attempting to meet [Ms A's] high health needs". Dr Maplesden advised that Dr C should have explored "more structured involvement by [the medical centre] in the oversight of [Ms A's] care", such as a six-monthly GP visit or a quarterly practice nurse review. Dr Maplesden noted that he does not know whether there would have been "resource issues in providing such a service", whether "such interventions would have altered Ms A's eventual clinical course", or even whether Ms A would have consented to such an arrangement. Dr Maplesden also advised that Dr C's ongoing contact with Mr A was a "significant mitigating factor".

129. I acknowledge that this was a difficult situation for Dr C; however, I expect general practitioners in situations such as this to be more proactive about resolving problematic

[45] Medical Council of New Zealand. *Good prescribing practice* (November 2016) at p 35.

relationships with their patients. In this case, I would have expected Dr C to initiate a discussion directly with Ms A about alternatives to her visiting the clinic, and to have documented that discussion. I am critical that he did not do so.

**Lack of follow-up**

130. On 6 Month3, Dr C reviewed Ms A and identified that she was suffering from "major infected cellulitis". He advised her to go to the hospital, but she refused. Dr C advised Ms A that staying at home was "not a good decision", and advised Mr A "to ring an ambulance when [Ms A] agreed to go to hospital". Dr C stated: "When a rational patient ignores a serious plea from me to go to hospital expecting that I can improve their lot by staying at home I believe I can do little more."

131. Dr Maplesden was "mildly to moderately critical of the lack of proactivity regarding follow-up arrangements". He advised:

> "Having identified [Ms A] was significantly unwell and required hospital admission for IV antibiotics but refused to attend, I believe there was a need for somewhat closer monitoring than to review her at home in a week if she had not been hospitalized by then. Options might have included daily telephone contact by [Dr C] or his staff to check on her progress, involvement of the district nursing service or ACH registered nursing service to provide more intensive clinical oversight of [Ms A's] condition (if she consented to this and the service had capacity) or a further visit by [Dr C] or colleague before the end of that week (6 [Month3] being [early in the week]), again if consent was provided."

132. Dr Maplesden noted that proactive follow-up may have been of limited value if Ms A was "determined to stay out of hospital", but advised: "I do not think such an attitude could be assumed (and I note there was no apparent resistance to admission when arranged by the district nurse 11 days later)."

133. I accept this advice. I acknowledge Dr C's scepticism about whether further measures (such as Dr Maplesden suggested) would have helped Ms A. However, as Ms A's doctor, Dr C was responsible for proposing ways in which Ms A could be monitored more closely. Dr Maplesden outlined several options, including telephone contact by the medical centre staff, involvement of the district nursing service, or additional communication with Access's nurse. I am critical that Dr C did not propose further options to Ms A.

## Opinion: concluding comment

134. Consumers with high and complex health needs are more likely to live successfully in the community with an appropriate support system in place. This case highlights the importance of well co-ordinated service provision by all health service providers involved in a consumer's care, such that providers' respective roles and responsibilities are understood

clearly, communication channels work effectively, and providers are responsive to the changing needs of the individual.

## Recommendations

135. I recommend that Access:

a) Review the effectiveness of the system it introduced of incomplete "Comprehensive Reports" prompting automatic alerts to the Regional Manager when they are not finalised within a certain number of days, and report the outcome of its review to HDC within six months of the date of this report.

b) Review the training it provides to its clinical staff on responding to support workers' reports, and report the outcome of its review to HDC within six months of the date of this report.

c) Undertake a nationwide audit over a two-month period to determine whether clinical staff are complying with applicable documentation policies and documentation professional standards. The results of the audit, and a summary of any actions taken to address any significant findings from the audit, are to be reported to HDC within six months of the date of this report.

d) Review the training on documentation that it provides to its clinical staff, and report the outcome of its review to HDC within six months of the date of this report.

e) Provide a written apology to Ms A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

136. I recommend that RN B:

a) Reflect on her failings in this case and provide a written report to HDC on her reflections and the changes to her practice she has instigated as a result of this case, within three months of the date of this report.

b) Undergo further education on the subject of documentation, within six months of the date of this report, and provide evidence of that education to HDC within seven months of the date of this report.

c) Provide a written apology to Ms A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Ms A's family.

137. I recommend that Dr C read the Medical Council of New Zealand "Ending a doctor–patient relationship" guidance (December 2020) and reflect on areas for improvement in cases such as this. Dr C is to provide HDC with a written report on his reflections and the changes to his

practice he has instigated as a result of this case, within three months of the date of this report.

## Follow-up actions

138. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Access Community Health Limited, will be sent to the Nursing Council of New Zealand, and it will be advised of RN B's name.

139. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Access Community Health Limited, will be sent to the DHB, the Ministry of Health, the Health Quality & Safety Commission, the Accident Compensation Corporation, the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, and the New Zealand Nurses Organisation, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

## Appendix A: In-house nursing advice to the Commissioner

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

"Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Access Community Health. 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. In particular I was asked to review the documentation and advise whether the care provided to [Ms A] by Access Community Health was reasonable in the circumstances, and comment on:

The appropriateness of the care and oversight provided by Clinical Nurse Manager [RN B], and whether this was consistent with nursing best practice and Access Community Health's own policies.

Whether [Ms A's] deteriorating condition was appropriately escalated.

The adequacy of Access Community Health's coordination with other healthcare providers.

Any other matters which you consider constitute a departure from accepted practice.

**Documents reviewed**

[Emailed complaint]

[Further information from complainant]

[Responses from Access Community Health]

[Statement from RN B and emailed response]

Clinical notes from Access Community Health's *Job Description for Clinical Nurse Manager*

Access Community Health's *Initial Visit Procedure*

Access Community Health's *Shared Care* policy

Access Community Health's *Vulnerable Client Monitoring* policy.

**Background**

[Ms A] was a [woman in her sixties] with multiple comorbidities; morbid obesity (estimated weight 250kg), psoriasis, chronic obstructive pulmonary disease, cellulitis, probable diabetes and a history of serious skin infections including pressure injuries. She was bed bound and isolated on the second floor of her home due to limited mobility. She lived in her home with her husband and two adult sons.

[Ms A] was receiving daily support with personal cares from Access Community Health, and had previously received support from the District Health Board's District Nursing Service for wound care management.

In the months preceding her death, Access Community Health support workers raised concerns on multiple occasions about [Ms A's] deteriorating health and in particular, her skin health.

[Ms A] passed away on 21 [Month3] at [the public hospital]. Her death certificate stated the cause of death as cellulitis with sepsis with contributing factors of acute kidney injury, respiratory failure and morbid obesity.

**Review of provided documentation and clinical records**

Access Community Health's policy/process read as follows:

*'Support plan initiated by Community Nurse at first visit*

*Client centred goal developed with the client*

*Signed by both client and Community Nurse*

*Community Nurse instructs Care Coordinator on required skills of Service Worker to meet client's needs,*

*Care Coordinator makes arrangements.'*

The Clinical Nurse Manager Job Description includes *'to lead and manage the clinical aspects of the operation including day to day service delivery. … oversight of services provided to clients with complex care requirements, clinical mentoring and coaching'*.

Care Coordination with other providers is described in the Shared Care Procedure. The following relevant responsibilities are covered by this procedure:

Support workers, '*Report immediate change in client's condition to Access Care Coordinator for escalation to the Access Clinical Nurse'.*

Clinical Nurse Manager, '*Ensures that any change in the client's condition is reported to the other agency through the agreed channels'*. Any shared care arrangements need to be clearly documented with contact details on the support plan.

Care coordination is also described in the Vulnerable Client Monitoring Procedures. The following relevant items were extracted from this procedure:

'*Specific timeframe in which care must be provided: Acuity V.1 — within 2 hours*'. Support worker, *'reports concerns to CC/CRS who will escalate the call to the relevant clinical person …'* Care coordinator, *'Ensuring any concerns reported by the SW is referred immediately to the relevant clinician including after hours on call clinicians, and provide clear and precise documentation under the diary notes regarding all correspondence and activity relating to the client'*. Community Nurse, Support Worker Coordinator, *'provides clear documentation about any changes in client status and escalation of any new issues, concerns, reviews, variations and exception reporting'*. Clinical Nurse Manager, *'Oversight of any referrals by CN to funders … the clients GP or other relevant bodies to safeguard vulnerable clients'.*

A Support plan was initiated [in] 2016 and signed off by [Ms A]. This consisted of 'personal care — wash daily' and the planned activity for the service worker: *Prepare equipment for wash Set up in bedroom as its cold — use bathroom when warmer days Assist [Ms A] to do wash Check skin Assist to dry Apply ointment Assist to dress Clean and tidy and put equipment away.*

The support plan was reviewed and a new one developed [in] 2017 also signed off by the consumer [Ms A]. Her vulnerability status was identified as V1. The client's CN (Community Nurse) is assigned to be …, an 0800 number is provided which connects with Access Community Health contact centre.

The clinical concern raised in the support plan by the Coordinator … included the following: '*My main concern is her skin, especially around the groin, inner thighs and under her abdominal apron and under her breasts. She had a rash on the inner thigh which she is applying locoid cream to, and an area behind her back knee. She was admitted to hospital with cellulitis and sepsis after her rash became a staphylococcal skin infection …'* The following alerts were included:

'*ALERTS: Please observe, record and report the following issues: Watch for increased shortness of breath Monitor skin for signs of pressure areas Watch skin for rash spreading or not resolving with creams. … If she has any falls.'*

Planned activities included personal care — wash every day — 1 hour was allocated for this.

The provided Client Diary Note Reports starting onwards from [2017] show the following entries of interest:

24 [Month1], the client phoned the service *'needing a district nurse to help her change her wound urgently — called [RN B] — emailed Nurse team'*. In a follow up call, she was advised that this request was '*passed on to [nurses]'*. Same day a report was entered that [Ms A] had had a fall and dressing of the grazes needed to be changed — and that she is unable to be taken to hospital for a medical review — '*email was sent to local nurses to see if anything could be done'.*

It is not clear from the notes if a registered nurse did follow up and attended to the wounds — the next entry on 30 [Month1] reports a fall. The notes do not include a follow up by nursing. Did this wound only need to be redressed once?

6 [Month2], Support Worker [Ms E] advised she is concerned about the wellbeing and skin condition of [Ms A] — she feels more help is needed than the service worker can provide — she asked for a re-assessment for a higher level of care.

The notes are silent on a follow up on this concern.

10 [Month2] another fall was reported — The service worker enters that she thinks [Ms A] needs a re-assessment and requests for this to be followed up.

There is no evidence that concerns raised led to a follow up.

13 [Month2], the service worker '*is very concerned about the client and feels nothing is followed up … skin condition deteriorating … family not coping … client general mov[em]ent declined, not able to leave bedroom … had a couple of falls … called [RN] — adv [RN] — called [RN] N/A emailed [nurses] to follow up … emailed leadership for entry in system'.*

Again the notes are silent on a follow up or reporting that indeed a RN visit happened or not.

20 [Month2], '*email sent out to Nurses for urgent review*' and '*SW called to speak to nurse regarding the client — concerns for client — called [nurse] n/a — called …, advised to call [nurse], [nurse] not available, email nurse to follow up with SW'.* There are no notes indicating if this was followed up.

**Comment**

The documentation includes the Service Workers (SW) raising health concerns on several occasions during [Month1] and [Month2]. These included the deterioration of wounds, falls and issues with coping. Some of these entries are repeated with no evidence that concerns were passed on for appropriate follow up by a nurse or referred to a district nursing service. Other notes say that the district nurse service and other nurses were contacted with a request to follow up. During this period, the notes do not include any reference to visits, interventions or recommendations from any nurse — it would appear that when the service coordinator passed on a message there was no check if a follow up on issues occurred. No nursing notes were available. [Ms A's] vulnerability status was assessed as being V1 — which is the highest level of vulnerability. The Vulnerable Clients Monitoring Procedures requires a response time for care to be within 2 hours.

**Appropriateness of care and oversight by CNM**

The notes include messages from the SW requesting for a nurse to follow up on health concerns. Following notes are silent on any contact made by a Care Coordinator with an ACH nurse or district nurse. Some messages have a repeat from the Service Worker requesting for nurse follow up. Seeing the vulnerability status of [Ms A] and the significance of issues raised by the Service Worker this would be considered as a **significant departure from accepted practice**.

In the case that the concerns raised by the SW were referred to an appropriate service or ACH nurse and no entries were made that this referral occurred, this would be seen as a **mild departure from accepted practice**.

I am also concerned that no nurse's entries were made in the Clinical Diary Note Report following any visits by ACH nurses or following phone calls made by the CNM to [Ms A]. Good practice requires nurses to make clinical notes in patients' files. **Deviation from accepted practice moderate to mild**.

The notes refer on occasions that the care coordinator attempted to contact different nurses and that none were responding/available, resulting in an email being sent 'to follow up'. Such slow response was not in line with the organisation's response time for vulnerable clients. The Clinical Nurse Manager who is a recipient of such an email for nurses' response, has the responsibility for '*the assurance of optimum workflow and staff resourcing across and between the clinical teams*'. Seeing the availability issue of nurses to be able to respond in a timely manner, how was staff resourcing managed by the Clinical Nurse Manager? This brings up the question if at that time there was a systems/staffing issue and was ACH unable to deliver on the required response time to highly vulnerable clients? Does ACH service have a monitoring/escalation system/incident reporting system in place for instances when service commitments cannot or were not met?

**Appropriate care coordination internally and with other providers**

There is no evidence of care coordination other than passing on of a message. Good practice requires a check in that messages are received in good order, that relevant clinical information is shared (i.e. written and verbal referrals), that progress reports are exchanged. No evidence was provided of such care coordination internally between ACH nurses and with service workers, or externally with District Nurses Service and the GP service. It would appear that the service coordination was limited to passing on of messages and did not assure messages were received in good order or were followed up. Seeing the vulnerability status of [Ms A] this would be seen as a **moderate departure from accepted practice**.

**Appropriate escalation of deterioration**

**Clinical Notes**

2 [Month3], 'SW called client has sores on her body … she thinks it may be cellulitis as it has just come up in a day … SW wanted to query with RN re this … email sent to RN as SW advised it is urgent'.

Clinical Nurse Manager (CNM) [RN B] states that she responded to this email by calling the SW and [Ms A] but 'got no answer'. She advised the SW that 'we need to strongly advise [Ms A] to visit the GP for any medical concerns'.

CNM [RN B] followed up on 13 [Month3] with the SW who said [Ms A] could not leave the house to see GP. [RN B] spoke with [Ms A] on the phone.

On 14 [Month3] [Ms A] called the service to put her in contact with her doctor. Eventually and after overcoming some communication [Ms A] was seen by her GP who also completed a District Nurse referral.

17 [Month3], the District Nurse attended [Ms A] who arranged for immediate transfer to hospital by ambulance.

**Clinical Advice**

CNM [RN B] appropriately advised SW and [Ms A] that the concerns raised on [2 Month3] are best reviewed by her GP. [Ms A] however would not be able to visit the GP.

**Departure none**

Appropriate support was provided to the consumer when she was ready to have a GP review which she previously refused despite recommendations from the CNM. ACH call centre supported [Ms A] to get in contact with the GP clinic ([Ms A] was unable to call the GP herself due to a lack of fund on her phone). **Departure none**.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
**Aged Care Advisor**
Health and Disability Commissioner"

The following further in-house nursing advice was obtained from RN Johnson-Bogaerts:

"Thank you for the request that I provide additional clinical advice in relation to the complaint about the care provided by Access Community Health to [Ms A]. 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.

Specifically I have been asked to review additional information provided and advise whether it causes me to change, or add to, the original advice provided.

**Additional documents reviewed**

[Access's letter to HDC with appendices.]
[The DHB's letter to HDC with appendices.]
[The DHB's email to HDC.]
[Access's letter to HDC with appendices.]

**Comments**

In the [letter of response] Access Community Health explains that they are confident that [RN B] was communicating in a timely manner to the lead provider and sub providers for [Ms A] in response to the issues raised by her Support Worker (SW). I did not find documentation that this was the case for the issues raised by the SW on the specific dates early in [Month2] and mentioned in my previous advice. The DHB

response includes that their records mention no involvement by the district nursing service between [2016] and 16 [Month3].

Therefore I continue to be concerned regarding the lack of registered nurses' entries in the Clinical Diary Notes following concerns raised by a SW that include follow up actions taken.

The response from the provider includes that it is not their process to report back to a SW. '*If there were any changes made following a report by the SW, these would be identified in an updated Support Plan in the client's home'.* Does this mean that there are no 'integrated clinical notes' that include a full picture and accurate account of treatments and delivery allowing for communication and dissemination of information between members of the clinical team (in this case between SW and RN and CNM) in one place? It is good practice to record conversations and outcomes of conversations with other health professionals/agencies in the clinical notes and communicate these to the full healthcare team through documentation in clinical notes.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
**Aged Care Advisor**
**Nursing Advisor**
Health and Disability Commissioner"

The following further in-house nursing advice was obtained from RN Johnson-Bogaerts:

"I reviewed the responses and have the following thoughts:

Employment files are to be retained 7 years after the person leaves employment — these records typically include employee training records — the response from Access includes they do not need to retain employee training records for more than 1 year.

[RN B's] response suggests strongly that she was overwhelmed and not coping with the amount of work — did she let the service provider know and what did they do about it?

I did not see a cause to change my previous advice.

**Sharing clinical information with Support Workers**

While I agree with the provider that service workers don't need access to all clinical information of a client, I continue to be concerned that there is no system in place whereby actions taken by registered nurses as a result of concerns raised by a SW is not reported back to the SW so they can be confident that their concern/communications have been picked up. Such a feedback loop is not only professional it is also essential for having an effective escalation process and a way to manage the potential risk of an escalation not being picked up in a timely manner."

## Appendix B: In-house medical advice to the Commissioner

The following in-house medical advice was obtained from general practitioner Dr David Maplesden:

"1. Thank you for providing this file for advice. To the best of my knowledge I have no conflict of interest in providing this advice. I have reviewed the available information: complaint from [the] daughter of [Ms A] (dec); response from [Dr C]; GP notes and Repeat Prescribing policy [the medical centre]; Access Community Health (ACH) responses; [DHB] response and clinical notes [public hospital]; statement from [Mr A] ([Ms A's] partner and primary carer).

2. [Ms A] was admitted to [the public hospital] from her home on 17 [Month3] with suspected cellulitis of her abdominal apron. Despite antibiotic treatment in hospital she developed sepsis with acute kidney injury and worsening of her pre-existing type 2 respiratory failure and died on 21 [Month3]. [The complainant] is concerned that her mother's admission to hospital was delayed and earlier admission might have improved her chances of survival.

3. [Ms A] had a complicated medical history including morbid obesity (weight > 200kg), diet controlled diabetes, COPD secondary to cigarette smoking, type 2 respiratory failure secondary to COPD and obesity, and recurrent skin breakdown secondary to obesity and psoriasis. She had previous admissions to [the public hospital] in [2016 and 2017] with complications of skin infections. [Ms A] had been unable to mobilise out of the upper storey of her home since returning there from her [2017] [public hospital] admission. Daily assistance to shower and apply any prescribed skin ointments was provided by ACH staff who could liaise with the organisation's registered nurses or [Dr C's] surgery if required.

4. GP interactions from [2016] until 6 [Month3] are summarised below.

| Date | Provider | Comment |
|---|---|---|
| [2016] | [Dr C] | Repeat meds per partner. Recent discharge from hospital noted |
| [2016] | [Dr C] | Repeats Daivobet cream |
| [2016] | [Dr C] | Repeats Panadol, cilazapril, salbutamol and Flixotide |
| [2016] | [Dr C] | Repeats Daivobet and Rx clotrimazole cream |
| [2016] | [Dr C] | Repeats Locoid and Aqueous creams per partner. *Partner says she cannot walk. Need to see her. See ASAP.* |

| | | |
|---|---|---|
| [2016] | [Dr C] | Repeat meds Panaadol, cilazapril, diclofenac |
| [2017] | [Dr C] | Repeat Daivobet cream |
| [2017] | [Dr C] | Repeat meds per partner (Panadol, Flixotide, diclofenac, Aqueous cream). Comment '*is well*' |
| [2017] | [Dr C] | Repeat salbutamol |
| [2017] | [Dr C] | Repeats Locoid and Daivobet creams |
| [2017] | [Dr C] | Repeats cilazapril and diclofenac. *Has been in hospital — see discharge letter — bacteraemia.* |
| [2017] | [Dr C] | Repeat meds per partner (Flixotide, Panadol, Diclofenac, Ultibro) |
| [2017] | [Dr C] | Repeat meds per partner (salbutamol, Daivobet) |
| [2017] | [Dr C] | Repeats Aqueous and clotrimazole creams |
| [2017] | [Dr C] | Repeats Panadol and Locoid cream. '*See prn*' |
| [2017] | [Dr C] | Repeats Daivobet and cilazapril '*see prn*' |
| [2017] | [Dr C] | Repeats Ultibro *'see prn'* |
| [2017] | [Dr C] | Repeats diclofenac '*see prn*' |
| [2017] | Pract Nurse | *Missed calls from NASC Team in re: to client. Left message to F/U next week* |
| [2017] | [Dr C] | Repeat meds per partner |
| [2017] | [Dr C] | Repeat meds per partner |
| [2017] | [Dr C] | Repeat Daivonex cream |
| [2018] | [Dr C] | Repeats Daivonex, cilazapril. *Fell the other day, 4 firemen needed to lift her … see prn* |
| [2018] | Pract Nurse | *Spoke to patient, fell at home, cramping ++. @x falls, caregiver 1 hour a day, husband at home, top story home, social worker looking for accommodation … received call from Social Worker … who is looking for more suitable accommodation. Client reporting needs more medications, topical creams, advised she needs to come in for assessment* |

| | | |
|---|---|---|
| | | *from [Dr C]. Client reports she can only walk to toilet and back. Reports rashes on back. Husband in today. Wants medications for wife* Repeat med prescription provided by [Dr C]. |
| [2018] | Pract Nurse | *Social worker in with disability form for [Ms A] to apply for fees to cover home visit by GP. Form given to [Dr C] and discussed option of home visit.* |

6. On review of ACH documentation it appears concerns regarding an overall deterioration in [Ms A's] skin condition and general health was raised by a support worker ([Ms E]) on several occasions from late [Month1] until a more extensive letter of concern on 13 [Month2]. I am unable to determine precisely what action was taken by ACH in relation to these concerns. On 2 [Month3] another support worker (Ms K) reported concern that there had been a sudden deterioration in [Ms A's] skin lesions and the organization's clinical nurse manager at the time ([RN B]) was notified. Advice was provided by [RN B] that [Ms A] should be encouraged to visit her GP. It is unclear what steps were subsequently taken by the support worker but on 6 [Month3] [Ms A] was visited at home by [Dr C].

7. [Dr C's] notes dated 6 [Month3] include: *[Ms A] found sitting on her bedside watching TV, weight estimate 250kg+ rash under breasts and left groin, staph infection and cellulitis left forearm. OE chest clear, H1 H2, is on cilazapril, diclax, Ulitro Breezhaler, Daibonet, locoid lipocream, flixotide, Ventolin. Has run out of Flixotide. Needs clomazole, needs to lose weight, refuses to go to hospital. For meds below.* Prescriptions were provided for Crystaderm and Clomazol creams, antibiotic Augmentin and repeats of diclofenac and Flixotide. In his response to HDC, [Dr C] noted the following: Associated with [Ms A's] obesity there was *a huge area of foul smelling sloughing skin under massive abdominal folds and breasts which had not been tendered to very well by regular [public hospital] district nurse visits … She was afebrile, chest clear and heart sounds normal. She was not in distress but was suffering from a major infected cellulitis and required urgent hospital treatment. This I told her and said I was ordering an ambulance to pick her up. She refused to accept this and begged me to let her stay at home. I advise her was not a good decision but that I could not force her to go to hospital. I discussed her situation with her carer [Mr A] as he was also in the room with [Ms A], my practice nurse and I. I told him to ring an ambulance when she agreed to go to hospital. I prescribed oral antibiotics and antibiotic ointment but knew it would not be enough to treat the extensive area infected. She needed IV antibiotics and I told her this. She still refused to go to hospital. I planned to review her at home in a weeks' time but did not make a time as I was hoping she would go to hospital of her own volition.*

8. ACH clinical nurse manager [RN B] states she followed up with support worker [Ms K] on 13 [Month3] regarding [Ms A's] situation. [Ms K] *said that she found it very difficult*

*with this client because the client will not leave the house and would not see her GP regularly when she has a known history of severe skin infections.* The support worker was advised to encourage [Ms A] to contact her GP. On 14 [Month3] efforts were made to assist [Ms A] to contact her GP to arrange a house visit. These were unsuccessful so [RN B] states she rang the surgery herself and spoke with a practice nurse *to ensure a home visit is arranged as the client could not get to clinic. The practice nurse advised that she will try to arrange for the GP to visit during her lunch break and get back to [Ms A] with a confirmed appointment.* [RN B] advised [Ms A] of the situation. [RN B] states she called the GP clinic back and *the Practice Nurse advised that the GP will be visiting at 2pm the following day (15 [Month3]).* This message was relayed to [Ms A]. GP notes for 14 [Month3] (per practice nurse) record only two unsuccessful attempts to contact [Ms A] at 1100hrs and 1500hrs). The [medical centre's] response includes: *On the 14th of [Month3] we unfortunately do not have a record of a conversation with Access Community Health regarding a home visit for [Ms A] but we are aware this conversation did take place and our records show we were trying to get hold of the patient on this day as recommended following this phone call … On this day [Dr C] saw his last patient at 10.30am and the clinic closed at 12pm as per our normal scheduled clinic hours. All calls are diverted to the after-hours service and no calls are taken after this time due to the diversion … As per our records on the 15th of [Month3] contact was made with … from Access Community Health and with [Ms A] advising her a home visit was not possible, a referral had been made to the District Nurse for a urgent home visit to be done to assess her skin infection, our Practice Nurse has also encouraged her to ring an ambulance* (see below)*.*

9. [Ms A] contacted ACH on 15 [Month3] stating the expected visit by her GP had not eventuated. ACH contacted [the medical centre] with contact recorded as: *Called the client medical centre to confirm — RN was not aware o[f] the visit but will check with doctor and call client back to confirm … client rash has become worse — infected on both sides, her social worker has organized funding for home visits for her.* [Medical centre] practice nurse notes refer to this call noting [Ms A] *was expecting a home visit today. [Dr C] will visit next week. Due to receiving this call past 1530hrs I have been unsuccessful at reaching Community Access Centre DHN. I was put though to urgent DHN service 20 minutes ago and I was accidentally disconnected from line. I have contacted client and told her [t]hat she will not be receiving a visit from [Dr C] today. [Ms A] complaining [t]hat her antibiotics are not working, creams are ineffective and no improvement with her situation. I told her I would try to get a DHN referral tonight, and she may have to wait until tomorrow. [Ms A] sounded quite stressed. I further advised that if she has concerns about her current medical issues to call an ambulance.*

10. A District Nurse referral was completed that day and received by the service on 16 [Month3] (additional faxed referral requested by the service on 16 [Month3] and provided by [medical centre] staff the same day). The referral was given urgent priority with visit scheduled within 24 hours (17 [Month3]). On the evening of 16 [Month3] [Ms A] contacted ACH to advise them she had been in touch with [medical centre] staff who had confirmed a District Nurse was to visit. The District Nurse attended [Ms A] on 17

[Month3] and arranged for immediate transfer to [the public hospital] by ambulance although there was a significant delay involved in getting [Ms A] from her home into the ambulance.

11. It does not appear [Ms A] was severely unwell on 17 [Month3]. Ambulance notes include: *On arrival patient sitting on edge of bed, conscious and alert, not distressed … O/e A: patent B: tachypnoeic Chest vesicular all fields, no marked respiratory distress, Hx of COPD and type 2 respiratory failure C; regular radial pulse, skin warm and dry, good colour and CRT. Secondary survey: obvious cellulitis to abdomen, groin and left arm, wounds weeping, red — hot to touch …* Initial vital signs were P 72, RR 24, BP 142/54, O2 sats 90%, T 36.3. On arrival in ED vital signs were recorded as P 71, RR 28, BP 121/68, O2 sats 93%, T 36.8 … *Alert, not distressed, looks well …* skin infections were noted and *currently no evidence of systemic sepsis* secondary to the infections. Initial blood count was normal. IV antibiotics were commenced and surgical review undertaken (no indication for surgical intervention). However, [Ms A's] general condition slowly deteriorated over the next few days with worsening respiratory failure and acute kidney injury and despite supportive treatment she developed multi-organ failure and died on 21 [Month3].

12. Comments

(i) As far as I can ascertain, [Ms A] had not been assessed face-to-face by a GP at [the medical centre] since at least [2016] (the date from which GP notes are provided) until the visit by [Dr C] on 6 [Month3]. However, she had received numerous repeat prescriptions over this time including medications for hypertension, COPD and her skin conditions. Over this period she had had two hospital admissions with minor changes to her medication regime although a diagnosis of type-2 respiratory failure was noted. She was also attended by ACH staff on a daily basis (who had access to RN expertise if required) and there had been intermittent involvement of the DHB district nursing service. [Ms A's] partner and principal carer, [Mr A], regularly attended [the medical centre]. He would report to [Dr C] any specific health issues [Ms A] required addressing, and would request and collect medications on her behalf. It is important to note [Ms A] and [Mr A] were apparently advised by [medical centre] staff on many occasions that [Ms A] must attend [the medical centre] for a review, but she refused to do so. It is also apparent that in the months leading up to her final hospital admission she was probably physically unable to attend because of her poor mobility secondary to extreme obesity. The [medical centre's] Repeat Prescribing policy is similar to those I have reviewed from other practices, and requires a six-monthly review of patients requesting repeat prescriptions of regular medications although this can be waived at the doctor's discretion. This is consistent with MCNZ guidance[1]. [Dr C] was placed in a somewhat

[1] Patients receiving repeat prescriptions should be assessed in person on a regular basis to ensure that the prescription remains appropriate, adverse effects are monitored, and the patient is taking or using their medicines as intended. Patients who need a further examination or assessment should not receive repeat prescriptions without being seen by a doctor. This is particularly important in the case of medicines with potentially serious adverse effects. It is at the doctor's discretion whether a patient is given a repeat

difficult situation of having a patient with high health needs who refused (and was eventually unable) to attend his surgery for appropriate clinical review, but required regular medications. It appears [Dr C] was reasonably reassured that any clinical concerns requiring a visit by him would be communicated by either [Ms A] or her carers ([Mr A] and ACH staff) and no such request was received until early [Month3]. However, I am not convinced [Dr C] took adequate account of [Ms A's] high health needs or that he was sufficiently proactive in providing the degree of clinical oversight she required despite her apparent resistance to his involvement in her care. While I am unable to predict whether [Ms A] would have consented to more structured involvement by [the medical centre] in the oversight of her care, it does not appear options such as a quarterly practice-nurse review or six-monthly 'routine' GP visit were adequately explored, or more regular oversight by the DHB district nurses (which would require initiation by [the medical centre] once any hospital-initiated intervention had ceased). However, I cannot say that such interventions would have altered [Ms A's] eventual clinical course, and there may be resource issues in providing such a service. It is difficult to establish 'accepted practice' in a situation such as this. I do not think it was reasonable to refuse [Ms A] her prescriptions because she would not attend for review, although once it was established (if it was) that she was physically unable to attend for review I think a significant proportion of my colleagues would have taken a more proactive approach to clinical oversight such as that discussed above. A significant mitigating factor is the ongoing contact [Dr C] had with Mr A, and the reassurance provided by regular attendance of ACH staff who would be expected to (and eventually did) involve an RN if they perceived [Ms A] to have any significant unmet health needs. Under the circumstances, I am mildly critical of the somewhat passive approach taken by [Dr C] to establishing and attempting to meet [Ms A's] high health needs.

(ii) [Dr C] did visit [Ms A] on 6 [Month3]. He diagnosed her with cellulitis and states he strongly advised hospital admission. There is nothing to suggest [Ms A] lacked competency to make decisions regarding her health and she evidently declined [Dr C's] offer to arrange an ambulance. [Dr C's] documented assessment on this date is mildly deficient for a patient with possible sepsis in that there is no record of vital signs. However, [Dr C] states in his response that [Ms A] was afebrile, and I acknowledge measurement of blood pressure in a morbidly obese patient might not have been possible at a home visit unless a specialized cuff had been carried. [Ms A] was familiar with the treatment of cellulitis having had a previous hospital admission with the condition less than a year previously. I cannot dispute she made a reasonably informed decision to decline hospital admission and, under the circumstances, the treatment provided by [Dr C] on 6 [Month3] was reasonable. However, I am mildly to moderately critical of the lack of proactivity regarding follow-up arrangements. Having identified [Ms A] was significantly unwell and required hospital admission for IV antibiotics but refused to attend, I believe there was a need for somewhat closer monitoring than to

prescription. Decisions not to issue a repeat prescription should be explained to the patient and documented accordingly. Good prescribing practice — Medical Council of New Zealand (2016) https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Good-prescribing-practice.pdf

review her at home in a week if she had not been hospitalized by then. Options might have included daily telephone contact by [Dr C] or his staff to check on her progress, involvement of the district nursing service or ACH registered nursing service to provide more intensive clinical oversight of [Ms A's] condition (if she consented to this and the service had capacity) or a further visit by [Dr C] or colleague before the end of that week (6 [Month3] being [early in the week]), again if consent was provided. It could be argued such follow-up was of limited value if [Ms A] was determined to stay out of hospital, but I do not think such an attitude could be assumed (and I note there was no apparent resistance to admission when arranged by the district nurse 11 days later). With the benefit of hindsight, it does not appear [Ms A] was likely to have been suffering from sepsis on 6 [Month3] noting her apparent stability and vital signs on 17 [Month3], and initial hospital notes suggest she was not suffering from sepsis on admission there (qSOFA score 1) particularly as her elevated respiratory rate could be attributed to pre-existing type 2 respiratory failure. It is therefore not possible to determine that hospital admission earlier than 17 [Month3] would necessarily have altered [Ms A's] outcome.

(iii) There was apparent miscommunication between ACH staff and [medical centre] staff on 14 and 15 [Month3] although I am unable to determine the reasons for this. If [Dr C] was made aware on 14 or 15 [Month3] that [Ms A] was requesting a visit by him (which I am unable to confirm) I would be moderately critical that he did not undertake a visit or facilitate a suitable alternative option in a timely fashion, particularly as he states it was his intention to visit [Ms A] a week after the 6 [Month3] visit if she had not been admitted to hospital. He does say his staff reiterated to [Ms A], on the occasions they had contact with her over this period, the need for her to call an ambulance. As noted above, the district nurse attending [Ms A] on 17 [Month3] recognised the need for in-hospital management and facilitated this, presumably (on this occasion) with [Ms A's] consent."