Registered Nurse, RN B

Enrolled Nurse, EN C

Residential Home

A Report by the

Deputy Health and Disability Commissioner

(Case 14HDC01280)

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Executive summary

1. At the time of these events, Mr A was in his seventies, and had an intellectual disability and diabetes. He also required assistance with mobility and used a wheelchair. In late 2013, Mr A's resuscitation status had been discussed with his GP, Dr D, who was recorded as stating that Mr A was to have active resuscitation.

2. On a day in mid 2014 Mr A's progress notes document unexplained bruising and an unwitnessed fall the following day. An undated incident report was completed for Mr A's unwitnessed fall.

3. At approximately 1.50am a few days after the fall, Enrolled Nurse (EN) C reviewed Mr A and observed that he was in discomfort. She took a full set of observations and then contacted the registered nurse (RN) on duty, RN B. EN C relayed Mr A's observations and told RN B that Mr A's breathing was laboured, his skin was clammy, and he was not responding to commands. RN B told EN C to give Mr A 20ml paracetamol elixir in accordance with his prescription, following which Mr A was put into bed and EN C remained with him.

4. EN C sat with Mr A for approximately 20 minutes, at which point she believed he appeared more settled and less agitated. EN C then saw Mr A's legs rise and gently fall and noted that he appeared to have stopped breathing. At approximately 2.40am EN C checked Mr A's pulse and recognised that he had died. EN C did not commence CPR. She contacted RN B and told her that she could not find Mr A's pulse, and that he appeared not to be breathing. RN B told EN C that she would come to the residential home immediately. Shortly afterwards RN B arrived at the residential home and called the Police.

Findings

5. RN B failed to take prompt and appropriate action when EN C advised her that Mr A had symptoms of laboured breathing and clammy skin. Accordingly, RN B failed to provide Mr A with services with reasonable care and skill and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1] Adverse comment is also made in respect of RN B regarding the lack of detailed instruction listed in Mr A's care plan.

6. EN C should have ensured that active CPR was commenced and emergency services were contacted when Mr A stopped breathing. Accordingly, EN C failed to provide Mr A with services with reasonable care and skill and breached Right 4(1) of the Code.

7. Adverse comment is made in respect of the residential home regarding the actions taken following Mr A's unwitnessed fall and his resuscitation status.

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

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Complaint and investigation

8. The Commissioner received a complaint from the Coroner about the services provided to Mr A (deceased). The complaint was supported by Mr A's executor.

9. The following issues were identified for investigation:

- *Whether the residential home provided an appropriate standard of care to Mr A in 2014.*
- *Whether RN B provided an appropriate standard of care to Mr A in 2014.*
- *Whether EN C provided an appropriate standard of care to Mr A in 2014.*

10. An investigation was commenced on 21 July 2015.

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

12. The key parties referred to in this report are:

Mr A	Consumer
RN B	Registered nurse/Clinical Nurse Manager
EN C	Enrolled nurse
Dr D	General practitioner
RN E	Registered nurse/General Manager
The residential home	Provider

13. Information was also reviewed from:

The New Zealand Police
The Coroner

Also mentioned in this report:

Mr F	Care assistant

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

Information gathered during investigation

Introduction

15. Mr A, aged in his seventies at the time of his death, had been a resident at the residential home for many years. The residential home is certified to provide support to clients with intellectual, physical and sensory disabilities, as well as clients with age-related disabilities. At the time of these events, Clinical Nurse Manager RN B had been employed at the residential home as a charge nurse/manager for a number of years.

HDC

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16. It is recorded in Mr A's 2014 care plan (the care plan) at the residential home that he had an intellectual disability, required assistance with mobility, and used a wheelchair, and that he could "confuse information given to him, so please speak slowly and clearly". It is also documented that Mr A had "non insulin" (Type 2) diabetes and required a diabetic diet, and that his blood sugar levels (BSLs) should be maintained "around 5–10 (mmols/L)".[2] The care plan further required Mr A's BSLs to be monitored and documented in the morning and at "teatime".

17. In late 2013, Mr A was reviewed by his general practitioner (GP), Dr D. In an addendum to Dr D's clinical note recording this consultation, RN B documented:

> "[Mr A's] Resuscitation status discussed. [Mr A] unable to participate, family remote, [Dr D] feels that [Mr A's] health is stable and he should be for active resuscitation at this time."

18. With regard to falls, Mr A's care plan stated: "[Mr A] requires assistance with mobility." It is noted that he could walk, but needed full assistance for safety reasons and used a wheelchair. The plan states: "[Mr A] is a falls risk. He is to be discouraged from attempting to mobilise or transfer himself. Any concerns please liaise with RN and document in progress notes."

19. With regard to his mood, the care plan stated that Mr A was "usually a quiet, well mannered, friendly person", but became "very agitated if reminded to do anything or if he doesn't understand what is happening. His outbursts of anger or frustration are usually over very quickly, so allow time for him to calm down."

20. During the days leading to Mr A's unwitnessed fall, Mr A's progress notes refer to his mood having been pleasant, stable, bright, fine or good, and there is no reference to him being agitated.

Unexplained bruising

21. At around 5.20am on Day 2[3], it was noted that Mr A had "[bruising]". At 2.50pm the notes record: "[Mr A has bruising] […] [Mr A] unsure if he had a fall or bumped into furniture??? States discomfort around bruised area." At 10.40pm it is documented: "[Mr A] told staff that he fell out of bed on [Day 1] and got himself of[f] the floor. [Mr A] has complained of [a] sore back and tum[my] tonight."

22. Subsequent records that day refer to Mr A having severe bruising and state that Mr A was complaining of lower back pain and was "very agitated when being transferred from bed to toilet".

23. At 12.15pm on Day 3, RN B documented that she had checked the bruising and noted: "[Mr A] unclear how this happened. Looks like an external injury caused it to me. Continue to observe."

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[2] Recommended blood sugar levels for people with type 2 diabetes are: before meals, 4 to 7mmol/L; and after meals, under 8.5mmol/L.

[3] Relevant dates are referred to as Day 1-7 to protect privacy.

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24. The residential home told HDC that "[Mr A] was a poor historian regarding what may have happened regarding most events", and stated that it was "physically impossible" for Mr A to have managed to get up off the floor unassisted.

Suspected fall

25. At 11.30pm on Day 3, it is recorded: "[A]pparently [Mr A] had a fall at [10.40pm] as caregiver from nights asked to go over and assist with [Mr A]." It is further documented: "[Mr A] has a grazed area on the L[eft] side of his forehead. No other injuries observed by night staff." There is no record of any neurological assessment being undertaken, and the residential home told HDC that no Falls Risk Assessment was completed following this suspected fall.

26. An incident report records that Mr A had a fall at 10.55pm, but the report is not dated. It states: "[S]taff heard a noise [and] found [Mr A] on [the] floor [with a] red mark on [his] forehead." The residential home told HDC that after checking with relevant staff members the report recorded that Mr A's fall occurred on the night of Day 3.

Day 4-5

27. On Day 4 at 10pm it is noted that Mr A was very agitated, and "appear[ed] very pale, complaining of pain under rib cage ? looks jaundiced". On Day 5, it is recorded that Mr A's bruising had increased. It is also documented that Mr A was very unsteady on his feet when transferring, and his mood was noted to be "bright and chatty with no agitation noted".

Day 6

28. At 3.30am on Day 6, it was recorded that Mr A woke "for toileting" and was having trouble passing urine. It was also documented that his abdomen was distended, "hard at touch" and that there was bruising present. Mr A's vital signs were taken and recorded as follows: blood pressure (BP) 134/64mmHg,[4] pulse 109 beats per minute (bpm),[5] temperature 36.2°C,[6] oxygen saturation 87%,[7] and BSL 20.4mmol/L.[8]

Review by Dr D

29. At 12.30pm, RN B documented that general practitioner (GP) Dr D conducted his three-monthly review of Mr A. Dr D documented in his progress notes that Mr A's "mobilisation continue[d] to deteriorate" and that he was "agitated at times" and complained of lower back pain, which was "worse when lying down". Dr D noted that Mr A's "blood sugar [levels] ha[d] been high last 2–3 days" and that he was experiencing difficulty with micturition.[9] Dr D also noted that Mr A had "bruising around [his] umbilicus[10] with tracking bruising [downwards]" and queried whether this related to an injury. Mr A's abdomen was recorded as being soft and non tender.

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[4] Normal blood pressure for adults aged 60 years or older is below 150/90mmHg.
[5] Normal resting heart rate is between 70 and 100 bpm.
[6] Normal body temperature ranges between 36.1°C and 37.2°C.
[7] Normal oxygen saturation in an otherwise healthy individual at sea level is over 95%.
[8] Above the normal range.
[9] Micturition is the ejection of urine from the urinary bladder through the urethra to the outside of the body.
[10] Also known as a person's "belly button".

HDC

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30. Dr D queried whether Mr A had a urinary tract infection (UTI) and requested an X-ray of his lumbar spine,[11] a prostate-specific antigen (PSA) test,[12] and a mid-stream urine (MSU) test. Dr D also made a plan to monitor Mr A's blood sugar levels, prescribed an antibiotic (trimethoprim) and increased Mr A's prescription for doxazosin.[13]

31. Dr D told HDC that he saw Mr A on Day 6 for his three-monthly review, and that the review was done at the residential home because Mr A's mobility had gradually deteriorated and it had become difficult for staff to take him to the surgery. Dr D stated: "[Mr A] appeared initially to be his usual self but was agitated on movement … he was complaining of back pain more than usual but I could find no local features."

32. In contrast, RN B told HDC:

> "[Dr D] reviewed Mr A on [Day 6] at my request as I was concerned about the bruising that was evident, his rising blood sugar levels (BSL) and what appeared to be difficulty passing urine. Although the medical note written by [Dr D] shows this as '3/12 R/V' this review was outside of the normal routine 3 monthly GP review which was not due yet."

33. RN B noted that following Dr D's review, a short-term care plan for Mr A was activated.

34. At 2.18pm on Day 6, it is noted that Mr A's BSL was "14.3, 24.0 [mmol/L]". It is also recorded that Mr A's "abdomen [was] not distended or hard to touch when checked". At 9.38pm Mr A's BSL was 18.6mmol/L.[14]

Overnight Day 6-7

35. Overnight on Day 6-7, the staff on duty were EN C, and two care assistants. RN B was on call. She was not on site, but was available by telephone and could come on site if needed.

36. EN C was employed at the residential home as a part-time care assistant following a clinical placement with the residential home during the final months of her Enrolled Nurse Diploma training. After completing her studies, EN C was employed as an enrolled nurse/supervisor. She worked 32–40 hours per week on rostered shifts. EN C has since resigned from the residential home.

37. EN C told the residential home that, at the beginning of her shift on Day 6, at 10.45pm, she was given a handover regarding Mr A's condition and told of Dr D's medical review earlier that day.

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[11] The lumbar spine is the segment of the human spine above the pelvis (ie, the lower back).

[12] Prostate-specific antigen, or PSA, is a protein produced by cells of the prostate gland. The PSA test measures the level of PSA in a man's blood.

[13] Doxazosin is used to treat high blood pressure and symptoms including difficulty in urinating.

[14] Mr A's Blood Glucose Results chart records that on Day 6, his BSLs were as follows: 3.45am, 20.4mmol/L; 8am, 14.3mmol/L; "before lunch", 24.0mmol/L; and "before tea", 18.6mmol/L.

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38. On Day 7 at 1.50am, it is recorded in the clinical notes:

> "On doing room check, CA [Mr F] found [Mr A] agitated, breathing appeared laboured, skin clammy at touch, CA [Mr F] assisted [Mr A] from bed to chair, supervisor [EN C] informed, Supervisor [EN C] found [Mr A] agitated, [and] and non responsive to verbal command."

39. EN C told HDC that she reviewed Mr A. She said that he was sitting in his chair and holding his abdomen tightly. EN C stated that while Mr A's verbal communication was poor, she observed that he had abdominal pain. She said that she took a full set of observations and then at 2.20am contacted RN B to seek direction.

First telephone call to RN B

40. The clinical notes record:

> "Charge nurse [RN B] informed at [2.20am], given 20mls paracetamol elixir, assisted to bed by supervisor [EN C] and CA [Mr F]."

41. EN C stated that she called RN B and reported Mr A's observations, which were: blood pressure 166/76mmHg, pulse 100bpm, temperature 36.2°C, oxygen saturation 81%, and BSL 29.1mmol/L. EN C said that RN B told her to give Mr A 20ml paracetamol elixir, which she did.

42. RN B told HDC that when she received the call from EN C, she was informed that "[Mr A] did not appear well, that he was agitated, with laboured breathing, skin was clammy and that he was not responding to commands".

43. RN B said that EN C "gave [her] Mr A's observations" and that she remembers Mr A's BSL being elevated (29.1mmol/L). However, RN B further stated that she could not "specifically recall the exact details of the other observations including his O_2 [oxygen] saturation details or if they were mentioned". RN B said that she clarified Mr A's symptoms with EN C and ascertained that Mr A was not answering questions or doing what he was asked, as he was agitated. RN B told HDC:

> "[T]his was [Mr A's] 'normal'. He was always difficult to communicate with, often becoming agitated, almost on a daily basis. This was **stable** for [Mr A]. [Emphasis in original.]
>
> …
>
> I did not consider it necessary to be present at the rest home to take over [Mr A's] care at this point going on the information given to me. I would have certainly come in and/or advised [EN C] to call for an ambulance had I believed that [Mr A] was unstable."

44. RN B told HDC that Dr D had seen Mr A 12 hours earlier and had not been concerned about Mr A. She said that paracetamol had been given for treatment of Mr A's agitation in the past with good effect. She further commented:

> "Given what I was told by [EN C] and my understanding of that information as well as the clarification from [EN C] regarding his agitation and my knowledge of

HDC

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> [Mr A], I felt it was reasonable to give him some paracetamol and see if he settled. I did tell [EN C] to ring me back if he did not settle. I did not feel that [Mr A] was unstable or acute at this time. For these reasons I considered it to be appropriate for me to continue to delegate his care to [EN C] as being within the enrolled nurse scope of practice."

45. RN B noted that Mr A's BSL was high when EN C contacted her at 2.20am. RN B stated:

> "Because this was the only symptom not attributable to [Mr A's] normal presentation, I did not consider this so urgent at this time as to warrant calling an ambulance. However I was sufficiently concerned about the level that I made a decision to notify [Dr D] that day rather than wait until the end of the week."

46. There is no clinical record of a decision having been made to contact Dr D. RN B stated that she believes that her decision not to recommend that EN C call an ambulance at 2.20am was reasonable in the circumstances.

Mr A's death and second telephone call to RN B

47. The clinical notes record that "once settled to bed, supervisor [EN C] sat with [Mr A], [he] appeared settled once in bed. [Mr A] passed away at [2.40am], charge nurse informed [2.43am]."

48. EN C told HDC that, with the help of a care assistant, she settled Mr A into bed in a semi-Fowler's position[15] and remained with him "to see if he would settle". EN C told the residential home that she sat with Mr A for approximately 20 minutes, at which point he appeared more settled and less agitated. She stated:

> "[A]s [Mr A] settled I witnessed his legs rise and gently fall, he appeared to stop breathing. I then got up and checked [Mr A's] pulse and recognised [Mr A] had passed away, the time was approximately [2.40am]. I then immediately informed my on-call charge nurse of [Mr A's] condition stating that I could not find a pulse and that he appeared to not be breathing."

49. EN C told HDC that after she checked Mr A's pulse she called for the care assistant to return to the room and assist her by double-checking Mr A's pulse. EN C stated that while the care assistant was checking Mr A's pulse, she "immediately rang" RN B and told her:

> "I could not find a pulse and it appeared [Mr A] had stopped breathing. I asked 'what should I do, should I call an ambulance?' I recall that [RN B] said 'no' and said that the police will need to be called and that she would contact the police. We did not discuss resuscitation."

50. EN C told the Police that she did not call an ambulance, and that RN B arrived shortly after Mr A's death and called the Police.

[15] The semi-Fowler's position is the position of a patient who is lying in bed in a supine position with the head of the bed at approximately 30 to 45 degrees.

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51. EN C told HDC:

> "I did not attempt to resuscitate [Mr A]. In my role as an EN, I should have known [Mr A's] resuscitation status and I didn't. I take full responsibility for this. I do have a current First Aid Certificate and I do know how to perform CPR [cardiopulmonary resuscitation]."

52. EN C told HDC that, on the night of Mr A's death, she felt that RN B did not give her adequate direction, and that combined with her (EN C's) inexperience and lack of confidence this meant she did not call an ambulance or start resuscitation.

53. RN B told HDC that, at 2.43am, when she was called for a second time, she did not recommend that EN C commence CPR or call an ambulance because of the time lapse that had already occurred between EN C deciding that Mr A was pulseless and not breathing, to relaying the information to her. RN B told EN C that she would be there immediately.

Subsequent events

54. At 4am on Day 7, the Police arrived on site and took statements from the staff. Later that day, the Police contacted Dr D, who stated that he had seen Mr A the previous day and that he would not issue a death certificate, as there was nothing to indicate to him that Mr A was likely to die. The matter was then referred to the Coroner. Dr D told the Coroner that Mr A's resuscitation status, which had been discussed in late 2013, was that he should be for active resuscitation, and that this had not been changed and still applied at the time of his death.

55. An autopsy was conducted, but at the time of the post mortem the pathologist did not know about Mr A's raised BSLs, so no samples were taken. Staff had told the Police that all observations were within Mr A's normal range. The pathologist found that Mr A's death was due to cardiac arrhythmia.

Policies and training

Resuscitation Policy

56. The residential home Resuscitation Policy in force at the time stated:

> "1. Initiation of Resuscitation
> Cardiac Arrest procedures will be initiated on all Residents who have an unanticipated cardiac and/or respiratory arrest — unless they have a DNR order in place.
>
> ***(ie. All Residents without a DNR will have active treatment to prolong life.)***"
> (Emphasis in original.)

Staff orientation and training

57. The residential home advised HDC that all nursing staff and activity co-ordinators maintain a current First Aid Certificate to enable the service to have at least one first aid trained staff member on every shift.

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58. The residential home stated that during the orientation period for nursing supervisors, the Resuscitation Policy is included among the compulsory policies to be read and understood prior to a shift being worked independently.

59. The residential home provided training records for RN B and EN C.[16]

Care planning

60. The residential home told HDC that RN B develops the residents' care plans in conjunction with the resident, their family and other significant persons as the resident wishes. Other staff members assist this group on a six-monthly basis thereafter to review and update the care plan. If a resident's support needs alter within the six-month period, the care plan is reviewed earlier as required.

61. The residential home stated that nutritional, pain, falls, pressure and behavioural assessments are carried out where appropriate on admission and reviewed six monthly for all residents, except for the resuscitation status, which is reviewed annually on a routine basis or at any other time the resident requests that this occur.

Further information

62. The General Manager RN E told HDC:

> "While it is noted by [RN B] (hand written notation) in [late] 2013 that [Dr D] 'feels that [Mr A] should be for active resuscitation at this time', [Mr A] was unable to participate in this discussion/decision making, due to probable lack of capacity, and his nearest family support was […] of remote locality …
>
> [Mr A's] family were also surprised by his passing, but like the staff at [the residential home], accepted that enough was enough for [Mr A] and his quality of life had become compromised to a point where he was not enjoying much in life. There does come a time to die and our suffering be eased."

63. The residential home stated that it has reviewed its resuscitation policy and developed a flow chart that outlines "the steps to be taken to source assistance and maintain the safety of the resident while waiting for assistance to arrive". Further education on the residential home's resuscitation policy has also been provided to staff.

64. The residential home told HDC that, following Mr A's death, it developed a policy to ensure that neurological observations are conducted on any resident following an unwitnessed fall, or a seizure or witnessed fall where a head injury has occurred.

65. The residential home also told HDC that "utilisation of risk assessment tools (generally) was identified as an area for potential improvement during [its] Certification Audit [in 2014]", and that "necessary quality improvements" were made following the audit.

66. RN E also told HDC:

[16] Details of RN B's and EN C's training records were comprehensive and included such topics as wound care, food safety and fire evacuation drills.

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"[RN B has] reflected carefully and with due consideration on the information she was given by [EN C] and the subsequent advice she offered. She does not consider that she would alter the advice given, with the fullness of time and in hindsight. To have called an ambulance based on the information available at 0220 hours when the first call was made, would not have been appropriate (general agitation and high BSL). Had further calls transpired and [Mr A's] health status had continued to deteriorate in an acute and an unmanageable way, emergency services would have been utilised."

67. RN B told HDC:

"While I can understand that a RN who did not know [Mr A] and his day to day presentation and looking solely at [Mr A's] symptoms, on paper, would be concerned an ambulance was not called for at 2.20am on the morning of [Day 7] I believe my response was reasonable in the circumstances. I was given this information verbally by [EN C], I was able to and had asked for clarification from [EN C], I knew the resident and his usual presentation really well, and I knew that he had been seen by his GP within the last 24hrs."

Responses to the provisional opinion

68. The parties were given an opportunity to comment on the relevant sections of the provisional opinion. The executor of Mr A's estate stated that they did not wish to comment on the "facts gathered" section of this opinion. The residential home and EN C stated that they did not have any comment to make on my provisional opinion. RN B stated that she had read and considered the extracts of the provisional opinion which concerned her and did not wish to make any comment in regard to the opinion.

Relevant standards

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

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

70. The NCNZ publication *Competencies for enrolled nurses* (April 2012) states:

"**Enrolled nurse scope of practice**

Enrolled nurses practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings. Enrolled nurses contribute to nursing assessments, care planning, implementation and evaluation of care for health consumers and/or families/whanau. The registered nurse maintains overall responsibility for the plan of care. Enrolled nurses assist health consumers with the activities of daily living, observe changes in health consumers'

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conditions and report these to the registered nurse, administer medicines and undertake other nursing care responsibilities appropriate to their assessed competence.

In acute settings, enrolled nurses must work in a team with a registered nurse who is responsible for directing and delegating nursing interventions. In some settings, enrolled nurses may coordinate a team of health care assistants under the direction and delegation of a registered nurse …

In these situations the enrolled nurse must have registered nurse supervision and must not assume overall responsibility for nursing assessment or care planning. Enrolled nurses are accountable for their nursing actions and practise competently in accordance with legislation, to their level of knowledge and experience. They work in partnership with health consumers, families/whanau and multidisciplinary teams."

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

"Registered nurses are responsible for ensuring enrolled nurses have the knowledge and skills to undertake delegated nursing activities. They should inform health consumers when they are delegating aspects of nursing care to enrolled nurses.

Both registered and enrolled nurses accept responsibility for ensuring their nursing practice and conduct meet the standards of professional, ethical and relevant legislative requirements.

Enrolled nurses must accept responsibility for their actions and decision making within the enrolled nurse scope of practice. Enrolled nurses are responsible for ensuring they have the knowledge and skills to perform nursing care before accepting responsibility.

The responsibilities of the registered nurse

…

(a) The health consumer must have a plan of care developed by a registered nurse. This may be developed in collaboration with the enrolled nurse.

(b) The registered nurse must determine if it is appropriate for an enrolled nurse to complete interventions based on the complexity of the health consumer's needs.

(c) The registered nurse must provide ongoing monitoring of the health status of the health consumers for whom he/she is responsible.

(d) The registered nurse must be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation.

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(e) If the registered nurse has made a professional judgment that delegation is inappropriate, she or he must communicate (and document) this to the enrolled nurse and the employer.

(f) It is the registered nurse's responsibility to provide direct or indirect guidance according to the interventions and the competence of the enrolled nurse. He/she must be available for timely advice regarding any nursing needs. If the registered nurse, whose role it is to provide direction, is off the premises and not contactable, another registered nurse must be contactable for such guidance.

(g) Processes for seeking contact with and support from the registered nurse must be clearly documented and communicated within the nursing setting.

(h) An appropriately educated and experienced registered nurse may direct care across more than one setting if health consumer needs are predictable and the requirements for timely response can be met.

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

The responsibilities of the enrolled nurse

The enrolled nurse has a responsibility to ensure he/she:

(a) accepts and recognises the legal limitations and ethical parameters of the role

(b) understands the enrolled nurse's scope of practice and the registered nurse's responsibility and accountability for direction and delegation of nursing care

(c) can name the registered nurse who is providing direction

(d) knows how and when to obtain further direction and assistance from that registered nurse

(e) demonstrates knowledge and skill in carrying out delegated nursing care

(f) informs and seeks guidance from the registered nurse when he/she encounters situations or aspects of care which are beyond his/her educational preparation and competency to perform

(g) documents the transfer of all or part of a health consumer's care to a registered nurse when the health consumer's needs are beyond their scope of practice

(h) informs the registered nurse and documents information about changes in the condition of a health consumer and the outcomes of delegated care.

…

Working as part of a team with a registered nurse when nursing acutely ill or complex health consumers

Enrolled nurses must work as part of a team with a registered nurse in a situation where a health consumer has an unstable, unpredictable and/or complex health status. A registered nurse is required to assess, monitor and evaluate a health consumer when the health consumer's condition or diagnosis is uncertain, their health status is unpredictable or fluctuating, and the risk of harm or immediacy of

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negative outcomes is high. In these situations the enrolled nurse may assist the registered nurse and can provide an additional level of qualified nursing support but he or she may not be assigned sole responsibility for the health consumer. The registered nurse is responsible for assessing the health status of the health consumer and determining whether the assignment of care to an enrolled nurse is appropriate. The enrolled nurse is responsible for recognising and reporting changes in health status to the registered nurse."

Opinion: Introduction

72. This report is concerned with the care provided to Mr A between Day 2 and Day 7 by the residential home and its staff.

73. At the time of these events, Mr A was aged in his seventies and had an intellectual disability and diabetes. He also required assistance with mobility and used a wheelchair. In 2013, Mr A's resuscitation status had been discussed with his GP, Dr D, who was recorded as stating that Mr A was to have active resuscitation.

74. Mr A's progress notes document unexplained bruising on Day 2, and an unwitnessed fall on Day 3. An undated incident report was completed for Mr A's unwitnessed fall on Day 3.

75. At approximately 1.50am on Day 7, EN C reviewed Mr A and observed that he was in discomfort. She took a full set of observations and then contacted the registered nurse on duty, RN B. EN C relayed Mr A's observations and told RN B that Mr A's breathing was laboured, his skin was clammy, and he was not responding to commands. RN B told EN C to give Mr A 20ml paracetamol elixir, following which Mr A was put into bed and EN C remained with him.

76. EN C sat with Mr A for approximately 20 minutes, at which point she believed he appeared more settled and less agitated. EN C then saw Mr A's legs rise and gently fall, and then noted that he appeared to have stopped breathing. At approximately 2.40am EN C checked Mr A's pulse and recognised that he had died. EN C did not commence CPR. She contacted RN B and told her that she could not find Mr A's pulse and that he appeared not to be breathing. RN B told EN C that she would come to the residential home immediately. Shortly afterwards RN B arrived at the residential home and called the Police.

Opinion: RN B — Breach

Care provided on Day 7

77. RN B had been employed at the residential home as a charge nurse/manager for a number of years. She was on call overnight on the night of Day 6/7 and, although not on site, was available by telephone and could come on site if needed.

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78. When EN C called RN B at 2.20am on Day 7 she informed RN B of Mr A's observations, and said that he was agitated with laboured breathing, his skin was clammy, and he was not responding to commands. RN B clarified with EN C that Mr A was not answering questions or doing what he was asked as he was agitated. RN B noted that Mr A's BSL was high but, as she considered that it was the only symptom not attributable to Mr A's "normal" presentation, she did not consider an ambulance was required.

79. I note that the Nursing Council of New Zealand's *Guideline: Responsibilities for direction and delegation to enrolled nurses* (May 2011) (the Guideline) states that enrolled nurses must work as part of a team in a situation where a health consumer has an unstable, unpredictable and/or complex health status. According to the Guideline:

> "A [registered nurse] is required to assess, monitor and evaluate a health consumer when the health consumer's condition or diagnosis is uncertain, their health status is unpredictable or fluctuating, and the risk of harm or immediacy of negative outcomes is high. In these situations the enrolled nurse may assist the registered nurse and can provide an additional level of qualified nursing support but he or she may not be assigned sole responsibility for the health consumer."

80. The Guideline also states that it is the responsibility of the registered nurse to "be directly involved with the health consumer when the health consumer's responses are less predictable or changing, and/or the health consumer needs frequent assessment, care planning and evaluation".

81. My expert advisor, RN Dawn Carey, advised me that in her opinion EN C reported significant and adverse symptoms to RN B, which indicated a resident whose condition was not currently stable. RN Carey advised that the appropriate advice from RN B would have included the instruction to call 111 or the on-call GP. RN Carey stated:

> "I would also have expected [RN B] to have considered that the reported symptoms would have necessitated her attendance at [the residential home] as [Mr A's] condition and health outcome was no longer predictable."

82. RN B stated that she felt it was reasonable to give Mr A paracetamol and see whether he settled, and that she did not feel that Mr A was unstable or acute. She submitted that Mr A "was always difficult to communicate with, often becoming agitated", and stated that "for these reasons I considered it to be appropriate to continue to delegate his care to [EN C] as being in the Enrolled Nurse scope of practice".

83. RN Carey noted that although agitation was a feature of Mr A's regular behaviour, there was no evidence that it was usually accompanied by laboured breathing and clammy skin. RN Carey advised: "I … view these as significant and adverse symptoms." RN Carey further advised that RN B's response and advice to EN C during their first telephone call (2.20am) was inadequate and represented a departure from accepted registered nursing standards. I accept this advice.

HDC

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84. With regard to the second telephone call (at 2.43am), RN B had a responsibility to provide EN C with appropriate advice, such as to assess Mr A for signs of life and, if appropriate, to commence CPR. RN B said she did not recommend that EN C commence CPR or call an ambulance because of the time lapse that had already occurred between EN C deciding that Mr A was pulseless and not breathing and the telephone call to her.

85. RN Carey advised that owing to the passage of time she considers it appropriate and adequate that when RN B was advised of Mr A's death, she did not instruct EN C to commence CPR or call an ambulance. I accept RN Carey's advice that in these circumstances RN B's advice was appropriate.

86. In my view, by failing to take prompt and appropriate action when EN C advised her that Mr A had concerning symptoms of laboured breathing and clammy skin, RN B failed to provide services to Mr A with reasonable care and skill. Accordingly, I find that RN B breached Right 4(1) of the Code.

Care planning

87. The residential home told HDC that RN B develops resident care plans in conjunction with the resident, his or her family and other significant persons as the resident wishes. Other staff members assist that group on a six-monthly basis thereafter to review and update the care plan. If support needs to be altered within the six-month period, the care plan is reviewed earlier as required.

88. The residential home stated that nutritional, pain, falls, pressure and behavioural assessments are carried out on admission and reviewed six monthly for all residents, except for the resuscitation status, which is reviewed annually on a routine basis or at any other time the resident requests that this occur.

89. Mr A's long-term care plan at the residential home included the information that he required assistance with mobility and had an intellectual disability. It also stated that Mr A had diabetes, required a diabetic diet, and his blood sugar levels (BSLs) were to be maintained "around 5–10 (mmols/L)". With regard to falls, Mr A's care plan stated: "[Mr A] requires assistance with mobility." It is noted that he could walk, but needed full assistance for safety reasons and used a wheelchair. The plan states: "[Mr A] is a falls risk. He is to be discouraged from attempting to mobilise or transfer himself. Any concerns please liaise with RN and document in progress notes."

90. With regard to his mood, the care plan stated that Mr A was "usually a quiet, well mannered, friendly person" but became very agitated "if reminded to do anything or if he doesn't understand what is happening. His outbursts of anger or frustration are usually over very quickly, so allow time for him to calm down."

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91. I note that the *New Zealand Standard Health and Disability Services (Core) Standards* (NZS 8134.1:2008) state:

> "2.2 The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers. …
>
> 3.5 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. …
>
> 3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner."

92. RN Carey advised that in order to comply with NZS 8134.1:2008, resident care plans need to specify the level of support or intervention required. RN Carey advised that Mr A's lifestyle/care plan was inadequate in that regard, especially as Mr A's care team included unregistered health workers. I accept RN Carey's advice and am critical that RN B did not ensure that Mr A's care plan provided more specific instruction to unregistered healthcare providers involved in Mr A's care, particularly regarding how to manage his falls risk appropriately.

Opinion: EN C — Breach

93. EN C began her employment at the residential home as a part-time care assistant and, after completing her Enrolled Nurse Diploma training, was employed as an enrolled nurse/supervisor.

94. In late 2013, Mr A was reviewed by his GP, Dr D, and it was recorded in the clinical notes: "[Dr D] feels that [Mr A's] health is stable and he should be for active resuscitation at this time."

95. At 10.45pm on Day 6, EN C was given a handover at the beginning of her shift regarding Mr A's condition. When EN C reviewed Mr A at 1.50am she observed that he was in discomfort and took a full set of observations. She then contacted RN B and informed her of Mr A's observations, and said that he was agitated with laboured breathing, his skin was clammy, and he was not responding to commands.

96. RN Carey advised me that it was appropriate that EN C reported the changes in Mr A's health status to RN B. RN Carey stated: "I consider this action to be expected and consistent with requirements of her scope of nursing practice."

97. At around 2.40am, EN C noticed that Mr A appeared to have stopped breathing, so she checked his pulse and "recognised that [Mr A] had passed away". She did not commence CPR or call an ambulance, but did contact RN B. EN C stated:

> "I did not attempt to resuscitate [Mr A]. In my role as an EN, I should have known [Mr A's] resuscitation status and I didn't. I take full responsibility for this. I do have a current First Aid Certificate and I do know how to perform CPR."

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98. RN Carey advised: "[A]s the duty supervisor of the night shift [Day 6/7], I would expect that [EN C] would be cognisant of the residential home resuscitation policy and [Mr A's] resuscitation status." RN Carey further stated that the appropriate and expected actions would have been for EN C to have called for assistance from another staff member, and for CPR to have been commenced. RN Carey stated:

> "[A] 111 telephone call and update to [RN B] would also have been required actions. These subsequent actions may have been delegated depending on the available staff members and their abilities."

99. RN Carey advised that EN C's failure to commence CPR or telephone 111 when she witnessed Mr A stop breathing and could not find a pulse represented a significant departure from accepted nursing standards. I accept this advice.

100. In my view, EN C should have ensured that active CPR was commenced and emergency services contacted when Mr A stopped breathing. I consider that failing to do so was poor nursing care. Accordingly, I find that EN C failed to provide Mr A with services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Residential home — Adverse comment

Resuscitation

101. The residential home had in place a resuscitation policy that stated clearly that if a resident had not been recorded as "Not for Resuscitation", active resuscitation should be provided. This was appropriate.

102. In late 2013, it was recorded that GP Dr D felt that "[Mr A's] health [was] stable" and that "he should be for active resuscitation at this time". I am concerned by the residential home's general manager RN E's statement that while Dr D felt that Mr A should have an "active" resuscitation status, Mr A was unable to participate in the decision "due to probable lack of capacity", and that his family were also not involved in the decision-making process. I am also concerned by RN E's statement that Mr A's quality of life had become compromised to a point where he was not enjoying much in life, and that "there comes a time to die and our suffering be eased".

103. In my view, it is not the role of staff to reach such a conclusion. Mr A's GP had determined in late 2013 that it was in Mr A's best interests to receive active resuscitation in the event of a cardiopulmonary event. I am critical that Dr D's medical assessment appears to have been questioned. Had the staff had concerns about Mr A's resuscitation status, it would have been appropriate to discuss these concerns with a medical officer during Mr A's periodic medical examinations.

Mr A's unexplained bruising noted on Day 2

104. On Day 2, it is noted that Mr A had some bruising. At 2.50pm on Day 2 the records state: "[Mr A has bruising] […] [Mr A] unsure if he had a fall or bumped into furniture??? States discomfort around bruised area." At 10.40pm it is documented: "[Mr A] told staff that he fell out of bed [Day 1] and got himself off the floor."

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105. Subsequent records on Day 2 refer to Mr A having severe bruising and state that Mr A was complaining of lower back pain and was "very agitated". On Day 3, RN B assessed Mr A's bruising and made a plan to "continue to observe". On Day 6, Mr A's bruising was reviewed by GP Dr D. The residential home told HDC that Mr A was a difficult historian, and that it was "physically impossible" for Mr A to have managed to get up off the floor unassisted.

106. Accepting Mr A's cognitive issues and inconsistency, RN Carey advised that it was reasonable for the residential home staff not to have completed an incident form reporting the injury and possible fall. RN Carey advised that Mr A's bruising was noted, assessed and monitored appropriately. I accept RN Carey's advice.

Mr A's unwitnessed fall on Day 3

107. On Day 3, it is recorded that Mr A had an unwitnessed fall at around 10.40pm. The incident form states: "Staff heard noise [and] found [Mr A] on [the] floor [with a] red mark on [his] forehead." RN Carey advised that following Mr A's fall, "a period of neurological observations should have commenced".

108. I note that there is no clinical record of Mr A receiving a neurological assessment on Day 3. I further note that the residential home stated that, subsequent to these events, it developed a policy to ensure that neurological observations are conducted on any resident following an unwitnessed fall. I am critical that no requirement to conduct neurological observations following a resident's fall was included in the residential home's policies at the time of these events. It is the residential home's responsibility to ensure that it has appropriate policies in place to help guide staff in the provision of care to its residents.

109. RN Carey advised that "[Mr A's] risk and strategies to manage his falls risk" should have been re-evaluated following his fall on Day 3. I accept RN Carey's advice and am critical that no staff completed a falls assessment subsequent to Mr A's fall. I note that the residential home told HDC that in August 2014 it underwent a certification audit, which identified the utilisation of risk assessment tools as "an area for improvement". The residential home has stated that following this audit it made "necessary quality improvements".

Recommendations

110. I recommend that RN B provide a written apology to Mr A's family for her breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

111. In my provisional report I recommended that EN C provide a written apology to Mr A's family for her breach of the Code. In response to the provisional report, EN C supplied HDC with an apology letter for forwarding to Mr A's family.

112. I recommend that the Nursing Council of New Zealand consider whether a review of EN C's competence is warranted.

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113. I recommend that the residential home undertake the following actions:

a) Conduct an audit on staff compliance with the neurological observations policy within the last six months from the date of the final report.

b) Review the care plans of all residents identified as having a high risk of falls to ensure that there are detailed instructions for the management of falls risks for staff, including unregistered healthcare providers.

c) Provide training to all staff on its resuscitation policy and the implementation of "Not for Resuscitation" orders.

114. The residential home should report to HDC on the outcome of the review and audit, and provide the report concerning the certification audit and evidence of the training having been conducted, within three months of the date of this report.

Follow-up actions

115. A copy of this report will be sent to the Coroner.

116. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Nursing Council of New Zealand, and it will be advised of the names of RN B and EN C.

117. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the district health board and the Ministry of Health (HealthCERT). The district health board will be advised of RN B's and EN C's name and the name of the residential home. The Ministry of Health (HealthCERT) will be advised of the name of the residential home.

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

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Appendix A: Independent nursing advice to the Commissioner

Report One:

The following expert advice was obtained from registered nurse Dawn Carey:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [the Coroner] concerning the nursing care provided to [Mr A] prior to his death at [the residential home] on [Day 7]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the documentation on file: correspondence from [the Coroner] including documentation collated as part of the Coronial enquiry; response from [Dr D]; response from [the residential home] including submitted [Mr A's] clinical notes for [mid] 2014, and submitted policies.

3. The consumer, [Mr A], passed away in his bed at [the residential home] on [Day 7], in the presence of an enrolled nurse. He was [in his seventies], had diabetes, and an intellectual disability. [Mr A's] resuscitation status had last been reviewed in [late] 2013 and 'active resuscitation' was deemed to be an appropriate level of intervention.

   [Mr A's] mobility was generally poor and it is reported that he sustained falls on [two occasions]. [Bruising was noted]. In response to staff concerns about his general health, the GP — [Dr D] — saw [Mr A] on [Day 6] and prescribed oral antibiotics for a suspected urinary tract infection (UTI). Continued twice daily monitoring of his blood sugar levels (BSLs) was also requested and that [Dr D] be contacted in a week if [Mr A's] BSLs remained consistently elevated.

   [Dr D] was surprised to hear that [Mr A] had died in the early hours of [Day 7] and refused to sign a death certificate. [Mr A's] death was referred to the Coroner for investigation.

   I have been asked to review the care provided to [Mr A] and comment specifically on the nursing management in relation to:

   1. Risk assessment and management and assessment following [Mr A's] falls.
   2. Monitoring and management of his BSLs.
   3. Actions following the observations taken at 1.50am on [Day 7].

4. I have reviewed the response from [the residential home]. For the purpose of brevity I have chosen not to repeat the response details here. I note that the response is consistent with the contemporaneous clinical notes.

5. Review of clinical records

   i. [Mr A] had a long term care plan in situ. This identified him as a diabetic and noted that he required a diabetic diet, twice daily BSL monitoring, 3 monthly and pro re nata (PRN) blood pressure (BP) checks. It is reported that his BP *must remain below 140/80, any increase RN to liaise with GP.*

HDC

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[Mr A] is also reported as having poor mobility and being at risk of falls; requiring assistance with activities of daily living due to his mobility difficulties and cognitive impairment. [Mr A's] resuscitation status is also recorded in his care plan.

Comment: It is appropriate that [Mr A] had a long term care plan in situ. I note that a nursing review is reported following [Dr D's] medical review on [Day 6], which is also appropriate. This review documents the commencement of a short term care plan (STCP) for the presumed UTI and that there are otherwise no changes. The completed STCP has not been submitted for review.

[Mr A's] resuscitation status is documented as being discussed in [late] 2013 with his medical notes and nursing care plan noting that he was for active resuscitation. Notes indicate that he was reviewed at three monthly intervals by [Dr D] or his locum. In my opinion, it is expected that the nursing staff would discuss any concerns about a resident's resuscitation status rather than make a unilateral decision.

ii. Documentation shows that [Mr A's] BSLs were monitored regularly and were generally stable prior to [Day 3].

iii. Progress notes (PN) entries first report the presence of [bruising] on [Day 1]. Questioning over the next day reports [Mr A] being unsure if he had sustained the bruising from a fall or bumped into furniture. Evening shift reports [Mr A] telling staff that he had fallen out of bed on [Day 1].

iv. PN entries continue to report the development of [bruising]. [Mr A's] reports of pain were managed with Panadol elixir. On [Day 3] a RN checked [Mr A's bruising] and again noted him not being sure how he sustained the bruises. Night shift documentation reports following up on the reportage that [Mr A] had sustained a fall at approximately 10.40pm. The presence of a graze to the left side of his forehead is noted.

v. Due to agitation, [Mr A's] vital signs were checked on [Day 4] and were unremarkable — BP 124/76, pulse rate 98, temperature 36.4°C.

vi. [Mr A's] vital signs were again checked on [Day 5] in response to a further episode of agitation. Again they were generally unremarkable except for oxygen saturations SpO_2 (87%) and BSL (20.4mmols/L).

Comment: A number of factors affect 'normal' oxygen saturations in an elderly patient and it is expected that it is evaluated holistically — alongside respiration rate, work of breathing and conscious level — rather than as an isolated number. I am critical of [Mr A's] oxygen saturations being monitored in isolation of his respiratory rate.

vii. [Mr A] was examined by [Dr D] on [Day 6]. A UTI was suspected and [Mr A] was commenced on oral antibiotics. His prescribed dose of Doxazosin was also increased. A nursing plan was made to obtain a urine specimen for analysis and for the monitoring of his BSLs to be continued.

viii. On [Day 7] it is reported that a care assistant performing a routine night check noted [Mr A] to be … *agitated, breathing appeared laboured, skin clammy to touch … Supervisor found [Mr A] agitated, non responsive to*

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verbal command ... BP166/76, pulse 100, Temp 36.2°C, O_2 sats 81, BSL 29.1. Charge nurse informed at 0220hrs, given 20mls Paracetamol elixir ... supervisor AG sat with [Mr A], appeared settled once in bed. [Mr A] passed away at 0240hrs, Charge nurse informed 0243hrs.

Comment: There is some ambiguity as to whether [Mr A's] signs and symptoms — as documented — were relayed to the oncall RN during the phone call on [Day 7]. The response from [the residential home] refers solely to [Mr A's] agitation and high BSL and the RN - basing the treatment decision — administer Paracetamol elixir — on such symptoms. I would suggest that further clarification is sought from the parties involved.

6. Further comments
   i. Copies of [the residential home's] Falls risk assessment form and Incident reporting policy have been submitted. These documents refer to the need to complete a falls assessment and an incident form following a resident's fall. I agree that these are expected assessments and documentation following a fall. No completed Falls risk assessment form or Injury/incident form has been submitted as part of [Mr A's] clinical notes.

      Accepting [Mr A's] cognitive issues and inconsistency, I am of the opinion that it was reasonable for staff not to have completed an incident form reporting an unwitnessed fall on [Day 1]. I agree that it is expected and appropriate that the presence of bruising be noted, assessed and monitored. I consider that the PN entries meet requirements in this regard.

   ii. There is evidence that [Mr A's] blood sugar levels were monitored regularly and pre administration of his insulin therapy. I note that monitoring of his BSLs increased in response to elevated results being recorded. [the residential home] response reports that in response to [Mr A's] elevated BSLs the Charge Nurse Manager proactively requested a medical review from his GP. In my opinion, these are appropriate actions.

   iii. Whilst I agree with the provider response that hyperglycaemia can be indicative of infection and that UTI was a working diagnosis that [Mr A] was being treated for, his result on [Day 7] was a lot higher than previous elevated results. In my opinion, this result should have prompted further contact with [Dr D]. I would consider that it would be reasonable for [Dr D] to be contacted during normal business hours rather than urgently at 2am if hyperglycaemia was the only concerning symptom noted on [Day 7].

   iv. Different factors can affect pulse oximetry reading and its accuracy in the elderly. However, I would consider [Mr A's] SpO_2 result on [Day 7] to be much lower than expected. I note that there is a difference of 6% between the oxygen saturations documented on [Day 5] and [Day 7]. I consider this to be a significant difference. Coupled with commentary such as clammy skin, laboured breathing, and unresponsive to verbal command, I consider that staff were noting significant and adverse symptoms in a resident who was identified for active resuscitation.

HDC

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7. Clinical advice
   - **Risk assessment and management and assessment following [Mr A's] falls**
     In my opinion, an Injury/Incident form and falls risk assessment form should have been completed following [Mr A's] fall on [Day 3].
   - **Monitoring and management of BSLs**
     I consider the overall management and monitoring of [Mr A's] BSLs to be appropriate.
   - **Actions following the observations taken at 1.50am on [Day 7]**
     I consider that [EN C] failed to recognise signs of an acute deterioration in a resident who was identified as for active resuscitation. In my opinion, the appropriate action would have been to telephone 111 and I am critical that this action did not occur.

     I also have concerns about the failure to commence cardiopulmonary resuscitative measures or to telephone 111 when [Mr A] was noted to be unresponsive and without a pulse. The resuscitation policy referred to in [the residential home] response has not been submitted for review. I would be very critical if this policy supported the lack of action as occurred in this case.

In my opinion, the nursing care provided to [Mr A] on [Day 7] departed from accepted standards. I would recommend that further information is obtained from [the residential home] and the individual providers — [EN C] and [RN B].

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland"

The following further expert advice reports were obtained from registered nurse Dawn Carey:

Report Two:

"1. Thank you for the request that I provide additional clinical advice in relation to the complaint from [the Coroner] concerning the nursing care provided to [Mr A] prior to his death at [the residential home] on [Day 7]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the additional documentation received: response from [the residential home] to my previous clinical advice including incident form completed following [Mr A's] fall on [Day 3], statement from [EN C], [corrective actions progress monitoring report and outcome findings for the residential home], organisation resuscitation policy; statement from [RN B]; my previous clinical advice dated 12 January 2015.

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3. Review of additional documentation with comments
   i. I disagree with [the residential home's] response that [Mr A] was *clearly identified as a high falls risk client on his Lifestyle/Care Plan …*
   In order to comply with the necessary standards[1], resident care plans need to specify the required level of support or intervention required. In my opinion, the submitted Lifestyle/Care plan is inadequate in this regard especially as [Mr A's] care team included unregistered health workers[2].
   ii. The response confirms that a Falls Risk Assessment was not completed after [Mr A's] fall on [Day 3]. Subsequent to this fall, progress notes (PN) entries report [Mr A] as *very unsteady* when transferring.

   I remain of the opinion that [Mr A's] falls risk should have been reassessed following this fall.
   iii. I note that an incident form was completed following [Mr A's] fall on [Day 3]. This is appropriate and expected. The form reports *Staff heard noise, found [Mr A] on floor, red mark on forehead …* As the fall was unwitnessed and the PN and incident form report a mark/graze on [Mr A's] forehead, I am of the opinion that a period of neurological observations should have been commenced. I would also have expected [Dr D] to have been informed of the fall when he reviewed [Mr A] on [Day 6].
   iv. [The residential home's] resuscitation policy is appropriate and states that unless a Do Not Resuscitate (DNR) or Advance Directive Form is completed all attempts to resuscitate will occur.
   v. [RN B] was the RN who was contacted by [EN C] at 2.20am on [Day 7]. She was offsite but rostered 'oncall'. Her statement reports being told … *that [Mr A] did not appear well; that he was agitated, with laboured breathing, skin was clammy and that he was not responding to commands. I assumed that this meant that he was not answering questions or doing what was asked as he was agitated. I clarified this with [EN C] who agreed … [Mr A's] agitation was* [my] *predominant concern. Because he was often agitated, was extremely pale in appearance and could be difficult to communicate with … I was not unduly concerned about the symptoms … with the exception of the high BSL …*

   The scope of practice for enrolled nurses changed in 2010[3]. In my opinion, [EN C] reported significant and adverse symptoms to [RN B], indicative of a resident whose condition was not currently stable. The contact and reporting is an appropriate and expected action by [EN C]. In my opinion, the appropriate advice from [RN B] would have included the instruction to contact 111 or the oncall GP. I would also have expected [RN B] to have considered that the reported symptoms would have necessitated her

[1] New Zealand Standards (NZS), *8134.1:2008 Health & disability services (core) standards* (Wellington: NZS, 2008).
[2] Nursing Council of New Zealand (NCNZ), *Guideline: Direction and delegation* (Wellington: NCNZ, 2008).
[3] Nursing Council of New Zealand (NCNZ), *Competencies for the enrolled nurse scope of practice* (Wellington: NCNZ, 2012).

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attendance at [the residential home] as [Mr A's] condition and health outcome was no longer predictable[4].

vi. [EN C's] provided statement confirms the contemporaneous clinical documentation as accurate noting that ... *recognised that [Mr A] had passed away, the time was approximately 02.40hrs. I immediately informed my On-call Charge nurse of [Mr A's] condition stating that I could not find a pulse that he appeared to not be breathing ...*

[EN C] does not comment as to why she did not commence cardiopulmonary resuscitation (CPR) or whether she was aware that [Mr A's] resuscitation status was for active treatment. As the duty supervisor of the night shift [Day 6-7], I would expect that she would be cognisant of [the residential home] resuscitation policy and [Mr A's] resuscitation status. [RN B] reports that it was [EN C's] first experience of someone dying and that she initially had difficulty in understanding her during the second phone call. While I can appreciate that an unexpected resident/patient collapse can be unnerving, it is still expected that required actions/ interventions such as CPR or contacting an ambulance service are carried out.

vii. [The residential home's] response reports the belief that [Mr A] was entitled to a peaceful and supported death. Whilst I do not necessarily disagree that active resuscitation may not have been in [Mr A's] best interests, it is not within the scope of New Zealand nursing practice to over rule a medical assessment that has deemed otherwise. [Mr A] was identified by his treating medical officer — [Dr D] — as being appropriate for active resuscitation; therefore I am critical that [EN C] did not commence CPR when she witnessed [Mr A] to stop breathing on [Day 7].

4. Further comment
As part of the strategies to prevent future occurrence of such an incident, I would suggest that [the residential home] consider adding a flow chart to their Resuscitation Policy specifying the actions that should occur in the event of a resident needing resuscitation.

5. Clinical advice

i. Risk assessment and management and assessment following [Mr A's] fall on [Day 3]

I am critical that [Mr A's] risk and strategies to manage his falls risk were not re-evaluated following his fall on [Day 3]. I also critical of the lack of neurological monitoring and that [Dr D] was not informed of [Mr A's] fall when he reviewed him on [Day 6].

In my opinion, the provided care demonstrates a mild–moderate departure from accepted nursing standards post an unwitnessed fall.

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

ii. **Actions following the observations taken at 1.50am on [Day 7]**
In my opinion, it was appropriate that [EN C] reported to [RN B] the changes in [Mr A's] health status. I consider this action to be expected and consistent with the requirements of her scope of nursing practice. I consider [RN B's] response and advice to [EN C] to be inadequate and a moderate departure from accepted RN standards.

iii. **Actions following [Mr A] appearing to stop breathing and no pulse being detected**
In my opinion, the appropriate and expected actions would have been for [EN C] to have called for assistance from another staff member and for CPR to have been commenced. A 111 telephone call and update to [RN B] would also have been required actions. These subsequent actions may have been delegated depending on the available staff members and their abilities.

I am critical that [EN C] did not commence CPR or telephone 111 when she witnessed [Mr A] to stop breathing and could find no pulse. I consider her inaction to demonstrate a significant departure from accepted nursing standards.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner"

Report Three:
"1. Thank you for the request that I provide further clinical advice in relation to the complaint from [the Coroner] concerning the nursing care provided to [Mr A] prior to his death at [the residential home] on [Day 7]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following documentation: statements from [RN B] dated 17 March 2015 and 5 August 2015; response from [the residential home] dated 18 August 2015 including supporting documentation — training and orientation records for [RN B] and [EN C], neurological observations policy, resuscitation policy, annual resuscitation order review form, sudden collapse flow chart; statement from [EN C] dated 17 November 2015 including correspondence to [EN C] from [the residential home] dated 16 February 2015; [Mr A's] Lifestyle Care Plan including progress notes; my previous clinical advice on this file.

3. I have been asked to review the provider responses and advise whether this causes me to amend my advice on this case. I have also been asked to consider the following questions:

   i. The adequacy and appropriateness of the care provided by [RN B] in her capacity as a registered nurse and nursing supervisor, on [Day 6 and 7].

   ii. The adequacy and appropriateness of the care provided by [EN C] to [Mr A] in her capacity as an enrolled nurse, on [Day 6 and 7].

Names have been removed (except the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

iii. The adequacy and appropriateness of the services provided by [the residential home] to [Mr A] in [2014]. Where relevant, I have been asked to provided comment on the adequacy and appropriateness of [the residential home's]:

a) policies and processes;
b) training and orientation for [RN B] and [EN C];
c) changes made to practice.

4. **[RN B]**
[RN B] reports clarifying [Mr A's] symptoms when she received the initial phone call and that [EN C] ... *agreed he was not answering questions or doing what he was asked as he was agitated. This was [Mr A's] 'normal'. He was always difficult to communicate with, often becoming agitated, almost on daily basis. This was* ***stable*** *for [Mr A] … I did not consider it necessary to be present … to take over [Mr A's] care at this point going on the information given to me … I agree that [Mr A's] BSL was high when [EN C] notified me … because this was the only symptom not attributable to [Mr A's] normal presentation, I did not consider this so urgent at this time to warrant calling an ambulance … I did not recommend to [EN C] to call an ambulance for a resident with agitation, because in this case agitation was a normal presentation for [Mr A] and did not indicate anything out of the ordinary or a change in his normal condition …*

… When [EN C] telephoned me the second time at 2.43am I did not recommend that she commence CPR or call an ambulance because of the time that had already elapsed … I did however tell her I would be there immediately …

[RN B] reports making changes to her practice —

- *Consistently advising staff to call an ambulance when she [is] contacted out of hours and notified of a change in status.*
- *She has reviewed and updated the Resuscitation/Advanced Directives paperwork and has instituted coloured 'dots' to indicate the resuscitation status for each resident. The inclusion of the coloured 'dots' on the resident folders provides a quick visual reference for staff.*

5. **[EN C]**
[EN C] reports having resigned from [the residential home] and not being able to recall [Mr A's] death without tears and anguish. In relation to the events of [Day 7], she reports telling [RN B] of [Mr A's] vital signs during the initial phone call. After determining that [Mr A] was pulseless and not breathing, she acknowledges that she did not attempt to resuscitate him … *In my role as an EN, I should have known [Mr A's] resuscitation status and I didn't. I take full responsibility for this. I do have a current First Aid Certificate and I do know how to perform CPR … My training had drummed into me that I needed to take the direction from my on call clinical nurse and I did ring her immediately and ask her what to do. She did not direct me to attempt resuscitation or call an ambulance … The lack of direction, combined with my inexperience and lack of confidence meant that I didn't call an ambulance or start resuscitation …*

6. **Comments**
I have again reviewed [Mr A's] progress notes entries and Lifestyle/care plans. While I acknowledge that agitation was a feature of his regular behaviours, it does not appear to be usually accompanied with laboured breathing and clammy skin.

[RN B's] previous responses acknowledged that these descriptors were part of the information relayed by [EN C]. I continue to view these as significant and adverse symptoms. [EN C] reports relaying [Mr A's] vital signs also and this is not disputed by [RN B].

7. **Clinical advice**
Following a review of the information detailed in section 2, I have determined no cause to amend my advice on this case. For the purpose of clarity:

i. Post fall care: I consider that the care provided to [Mr A] post his fall — [Day 3] — and the failure to inform [Dr D] — [Day 6] — of the fall event to be a mild–moderate departure from accepted nursing standards post an unwitnessed fall.

ii. [RN B]: I remain of the opinion that the response and advice given to [EN C] on [Day 7], was inadequate and a moderate departure from accepted RN standards. I agree that it was appropriate and adequate that [RN B] attended [the residential home] after being notified of [Mr A's] death. Due to the passage of time, I also consider it appropriate and adequate that [RN B] did not instruct [EN C] to commence cardiopulmonary resuscitation (CPR) or to call an ambulance when she received the second phone call notifying her of [Mr A's] death. In my opinion, the reported changes in practice are appropriate and adequate.

iii. [EN C]: While I can continue to appreciate that [EN C] was shocked by [Mr A's] sudden passing it does not change the fact that the care she provided was a departure from the accepted standards of nursing care for a resident identified as for active resuscitation. As she acknowledges she should have known [Mr A's] resuscitation status and should have acted accordingly. I remain of the opinion that [EN C's] inaction when she witnessed [Mr A] to stop breathing and could not find a pulse was inappropriate and a significant departure from accepted nursing standards.

iv. [The residential home]:
   a) In my opinion, the neurological observations policy and resuscitation policy are adequate and appropriate.
   b) I consider the training and orientation for [RN B] and [EN C] to be appropriate and adequate. I note that [RN B] has far exceeded the requirement of 60 hours professional development education per three years and that [EN C] was on track to achieve this requirement when she resigned from [the residential home].
   c) In my opinion the changes that [the residential home has] incorporated into their practice are appropriate and adequate.

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner"

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