Decision 21HDC00390
24 June 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to recognise respite-care resident's deterioration

Introduction

1. At the outset, I express my sympathy and heartfelt condolences to the family and friends of Mrs A for their loss. I hope that this report brings some closure for Mrs A's family.

Complaint background

2. Mrs A was a resident at Bob Scott Retirement Village Limited (operating as Bob Scott Retirement Village). On 22 February 2021 this Office received a complaint from Mrs A's daughter, Mrs B, about the care provided to her mother. Mrs A (aged 89 years at the time of events) was receiving respite care (at dementia level of care) between 2019 and 2020. Mrs B had concerns about a lack of escalation of care for Mrs A when she deteriorated, despite requests from the family; and that the family were not informed about Mrs A's decline in health. Mrs B also had concerns that staff failed to call an ambulance when Mrs A became unresponsive, and that the family had to drive her to the hospital. Sadly, Mrs A passed away in a public hospital.[1]

3. Mrs A had a history of vascular dementia,[2] hypertension,[3] breast cancer, COPD,[4] osteoporosis,[5] recurrent urinary tract infections (UTIs)[6] and malnourishment.[7] Mrs B held an activated Enduring Power of Attorney (EPOA)[8] for Mrs A's personal care and welfare (and property).

Outcome sought

4. Mrs B told HDC that she wanted an investigation into the care provided to her mother, and reassurance that the care provided was of an appropriate standard.

Scope of investigation

5. The following issue arising from the complaint was investigated by HDC:

- *Whether Bob Scott Retirement Village Limited (operating as Bob Scott Retirement Village) provided [Mrs A] with an appropriate standard of care from [Day 1] 2019 to [Day 18] 2020 (inclusive).*

---

[1] Heath New Zealand|Te Whatu Ora.
[2] Dementia caused by impaired blood flow to the brain, leading to brain damage and cognitive decline.
[3] High blood pressure.
[4] Chronic obstructive pulmonary disease — a long-term disease that makes it hard to breathe.
[5] A condition that weakens bones, making them more prone to fractures.
[6] Infections in the urinary system (such as the kidneys or bladder).
[7] Poor nutrition.
[8] A legal document in which a person (the donor, in this case Mrs A) appoints another person (the attorney — Mrs B) to make decisions on their behalf if the donor becomes incompetent. A doctor is required to provide a medical certificate outlining the consumer's mental capacity in order to invoke or 'activate' the EPOA.

Names (except the advisor on this case and Bob Scott Retirement Village Limited (operating as Bob Scott Retirement Village)) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

HDC investigation findings

6. HDC gathered information from Bob Scott Retirement Village, including clinical records, guidelines, and the internal investigation conducted by Bob Scott Retirement Village. On review of this information, the following conclusions were reached.

Escalation of care — failure to seek medical review and contact Mrs A's family

- The New Zealand Nursing Council (NZNC) competencies for registered nurses outline the skills and knowledge nurses need to ensure that they are competent to practise. There are four domains of competence. Domain two — Management of nursing care competency 2.1 — provides that nurses administer treatments and interventions within legislation and according to authorised prescription and established policy and guidelines.
- Bob Scott Retirement Village's Assessment and Management of the Acutely Unwell Resident guidelines (last reviewed September 2019) provided guidance on how to assess whether a resident is deteriorating, such as assessing for delirium, taking vital observations, and reviewing the resident's hydration status. The guidelines provide that the registered nurse must keep the family/next of kin 'fully informed' while they are assessing the resident. The guidelines also provide that if there is no GP available to review the resident, the resident should be transferred to the hospital via an ambulance.
- From its internal review, Bob Scott Retirement Village accepted that it would have been appropriate for the staff to have escalated Mrs A's care due to her deterioration and to have sought a medical review, and it acknowledged that this did not occur.
- Bob Scott Retirement Village stated that on Day 14 and Day 15 when Mrs A was deteriorating further, her family should have been contacted, and it acknowledged that this did not occur.
- Bob Scott Retirement Village told HDC that Mrs A's family visited regularly, and staff had regular conversations with them, but these interactions were not recorded in Mrs A's progress notes.

Management of Mrs A's hydration and nutritional needs

- On admission into Bob Scott Retirement Village, it was noted that Mrs A was at risk of malnutrition. Her weight was recorded on admission (41kg), but no further weights were recorded to monitor whether she was losing weight and therefore required intervention by the nursing staff.
- Mrs A's Ensure[9] drinks were recorded inconsistently on the administration (signing) sheet of her medication chart, leading to an inaccurate record of what Mrs A was eating and drinking. Staff were therefore unable to assess whether she required more nutritional support.

[9] A nutritional supplement and meal replacement.

- Bob Scott Retirement Village acknowledged that there was poor documentation in this area.

Documentation of Mrs A's care during her respite stay

- A caregiver stated to Bob Scott Retirement Village that although they advised a nurse verbally about a change in Mrs A's condition, they did not document this.
- Bob Scott Retirement Village acknowledged and apologised for the lack of documentation while Mrs A was in respite care and stated: '[T]he team's communication was not optimal.'

In-house advice

7. In-house aged-care advice was sought from registered nurse (RN) Victoria Simon (Appendix A). RN Simon considers that overall, the care provided to Mrs A was not to an acceptable professional standard, and that largely this was attributable to the actions or inactions of the registered nurses. RN Simon noted that the nursing staff failed to recognise Mrs A's clinical decline and failed to escalate her care to a GP or the ambulance service appropriately.

8. RN Simon identified the following departures from the accepted standard of care provided by Bob Scott Retirement Village:

- Escalation of care — failure to seek medical review and contact Mrs A's family — **severe departure**.
- Management of Mrs A's hydration and nutritional needs — **moderate to severe departure**.
- Documentation of Mrs A's care during her respite stay — **moderate to severe departure.**

Response to provisional opinion

Bob Scott Retirement Village

9. Bob Scott Retirement Village extended its sincere apologies to the whānau of Mrs A and agreed that overall, Mrs A's care while a resident in the Village fell short of accepted standards. Bob Scott Retirement Village acknowledged the following:

- On Day 14 and Day 15 there were missed opportunities to seek medical attention for Mrs A. Her symptoms indicated that a medical review was required, but nursing staff failed to arrange this.
- Staff failed to inform the family of Mrs A's deterioration despite the facility's guidelines.
- Conversations with Mrs A's family were not documented in her progress notes.
- Mrs A's Ensure drinks were not recorded on her medication chart.
- Mrs A's weight was not taken again after the initial measurement.

Mrs B

10. Mrs B was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

11. Mrs B told HDC that regarding her concerns, it wasn't just a lack of escalation of care, it was a refusal to acknowledge concerns raised or check her condition when it was suggested that [Mrs A] didn't seem quite right'.

12. Mrs B stated that Mrs A 'was collected by family on [Day 15]. Staff refused to acknowledge her obvious state but assisted with [Mrs A's] departure that day by lifting her by the arms and legs and transferring her to a wheelchair.'

13. Mrs B told HDC that Mrs A's weight was measured twice, and the recording showed that she was 19kg heavier.

14. Mrs B told HDC:

> 'Despite [Mrs A's] medical history, [she] was not incontinent, had never broken a bone nor suffered any fractures. She was not dependent upon, nor did she require medication at all. Her biggest medical disadvantage was vascular dementia which robbed her of the ability to self-manage her health. Up until that point, she was careful to live a disciplined health regime. [She] was still swinging a pick in her garden in her late 70's early 80's.'

Decision — breach

15. The issue in this matter is whether Bob Scott Retirement Village provided Mrs A with an appropriate standard of care from Day 1 to Day 18 (inclusive). RN Simon identified issues in three areas of Mrs A's care and advised that in all three areas, the care provided by Bob Scott Retirement Village fell below the accepted standard of care. I accept RN Simon's advice.

16. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[10] requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that Bob Scott Retirement Village Limited (operating as Bob Scott Retirement Village) did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Changes made since events

17. Bob Scott Retirement Village told HDC that following its internal review into Mrs A's care, additional education and training was provided to its staff in the following areas:

- Managing a resident who is admitted for respite care
- Recognising the signs of a deteriorating resident

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

- Behaviour as a form of communication
- Managing nutrition and hydration needs of an acutely unwell resident
- The importance of regular communication with family and next of kin
- Understanding complaints and the complaints process and incident reporting
- Managing a urinary tract infection
- Recognising and monitoring weight loss
- Care planning
- Clinical reasoning

Recommendations

18. RN Simon noted that the corrective actions undertaken by Bob Scott Retirement Village were appropriate. I acknowledge the changes made by Bob Scott Retirement Village and agree that these were appropriate in the circumstances.

19. I recommend that:

a) Bob Scott Retirement Village Limited provide a written apology to Mrs A's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b) Registered nurses complete the HDC online modules and provide feedback, within three months of the date of this report.

Follow-up actions

20. A copy of this report with details identifying the parties removed, except the advisor on this case and Bob Scott Retirement Village Limited (operating as Bob Scott Retirement Village), will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Victoria Simon:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Bob Scott Retirement Village Limited. 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. Documents reviewed

I have been provided with the following information to base my review on:

- Bob Scott Retirement Village Limited's responses.
- [Mrs A's] clinical file.
- Complaint.

3. Complaint

[Mrs A] was admitted for 14 day respite on [Day 1] and discharged back to her family on [Day 15]. Mrs A's family on [Day 15] took her to [a public] hospital where she passed away on … Her family are concerned about the management of her care whilst at the facility.

4. Review of clinical records

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

1. Management of her condition during [Day 1 – Day 17] in particular the management of her fluid intake and output.

[Mrs A's] medical history included vascular dementia, COPD, breast cancer, hypertension, IHD, Tuberculosis, Osteoporosis, hearing impairment, constipation, recurrent urinary tract infections (UTI) and malnourishment.

[Mrs A] was hospitalised after a collapse [a couple of months earlier] with a UTI and delirium. [Mrs A] was assessed by [Health NZ] and recommended respite and admitted into the facility on [Day 1].

The facility investigation report stated "the administration of ensure drinks was not always recorded on the signing sheet (as per policy)". One entry on [Day 2] a CG had documented "*ensure for breakfast*". The clinical documentation provided on food and fluid recordings included on [Day 2] at 1539pm "*food and fluid assessment completed*".

[A staff member] reported in the nursing note "*[Mrs B] in a stable mood, poor food intake which has been an ongoing issue when at home, on supplement drink, compliant with drink, constipated, prn laxatives and kiwi crush drink given — monitor effect*". The CG's recorded food and fluid intake throughout, on [Day 12] a HCA reported at 8am "*no breakfast as couldn't get her to have any breakfast again*". At 1215pm the same day a HCA reported "*refused lunch saying felt sick*" and "*offered juice*" at 1500pm. At 1700pm it was reported "*refused dinner*". On [Day 13] the CG reported "*just had liquid for lunch, so hard to feed*". I concur that the facility have acknowledged and apologised for the poor documentation and therefore care in this regard.

Competencies for registered nurses (Nursing Council of NZ: 2010) Domain Two: Management of nursing care competency 2.1 states: "provides planned nursing care to achieve identified outcomes". Indicator four states: "Administers intervention, treatments and medications within legislation, codes and scope of practice, and according to authorised prescription established policy and guidelines." I concur that this competency was not met by nursing staff and it would be viewed similarly by my peers. In the circumstances I consider this to be a moderate to severe deviation from accepted practice.

2. Documentation of care during the period of [Day 1 to Day 15].

The facility acknowledged and apologised for the lack of documentation. A CG stated in her statement that she verbally advised the RN of the change in condition and regrets not documenting this. [A senior staff member's] response dated the 29th April 2021 stated "*the team's communication was not optimal*". On reading of all the clinical documentation I concur that the competency domain two: management of nursing care competency was not met by nursing staff and it would be viewed similarly by my peers. In the circumstances I consider this to be a moderate to severe deviation from accepted practice.

3. Comment on the escalation of care and whether this was done appropriately.

The [senior staff member's] response dated the 29th April 2021 stated "*they accept that when [Mrs A] deteriorated during the end of her stay it would have been appropriate for the team to have sought a medical review*" however the RN statement does not address why she did not escalate or seek medical review either via an urgent GP or ambulance. As part of the facility investigation on [Days 14 and 15] "*the RNs should have contacted the family and didn't and have apologised for this*". I concur that the competency domain two: management of nursing care competency was not met by nursing staff and it would be viewed similarly by my peers. In the circumstances I consider this to be a severe deviation from accepted practice.

4. The appropriateness of the actions taken by the facility since the complaint was made.

The [senior staff member's] response dated the 29th April 2021 included the Quality Improvement Plan (QIP) related to recognising the signs of deteriorating resident,

following respite care policies and procedures including oversight, communication, documentation and handovers. Further training was provided on the management of UTI, nutrition, hydration, management of the acutely unwell resident, weight loss and respite care. Further webinars conducted by … on recognising the signs of a deteriorating resident is appropriate and acceptable training.

The actions undertaken reinforced by the [management] and [staff] that they provide daily oversight, regular communication with the next of kin and documented accordingly. Also, the QIP included continued monitoring of compliance in these areas which is appropriate and acceptable.

1. **Clinical advice**

[Mrs A's] health deteriorated quite acutely in … and in particular the days before her death. Management of her worsening clinical condition although the staff have had recent re-education and training of acceptable clinical protocols family needed responsive communication which was acted on and documented by staff might help avoid this in the future.

Overall, I believe the care delivered to [Mrs A] was not of an acceptable professional standard. I believe that this was due to a lack of registered nursing input. Clinical reporting was lacking and this affected the discussion and planning of appropriate care. There appeared to be gaps in communication of clinical findings in the following areas:

- Recognising clinical red flags, particularly when [Mrs A's] condition continues to deteriorate.
- Taking the initiative to seek medical help and discuss the clinical recordings and findings collected.
- Taking the lead and responding in a timely way with family concerns and documenting these discussions. The above discrepancies all contributed to inadequate nursing assessment and appropriate actions by nursing staff and a failure to recognise the decline in [Mrs A's] condition.

The [management's] response dated the 29th April 2021 "*based on our assessment and management of an acutely unwell resident policy it would have been appropriate to use the 'stop and watch' assessment tool which would have indicated a need for medical review"* i.e.

STOP

She was different to usual;

She was not **T**alking and communicating less;

Overall, she needed more help; she was **P**articipating less in activities. **AND** She **A**te less and it was reported she was having difficulty with eating;

No bowel motion or diarrhoea; She was **D**rinking less

and **WATCH**

Weight change (however as she was not weighed again this is not known); **A**gitated and **T**ired, weak, confused and/or drowsy; **C**hange in condition and needed **H**elp with walking, transferring and toileting.

If acute deterioration is identified using this process, the RN should:

1. Review recent history — read at least the last 48 hours of progress notes; review observations and vital signs, and review medication chart to determine if medications had been taken appropriately including ensure and laxatives **(I was not provided with the medication chart for this period)**.
2. Take observations — reviewing for signs of sepsis.
3. Review hydration status and fluid balance ensuring input and output is equal in 24 hours and offer fluids every 1–2 hours.
4. Assess for delirium which included neurological assessment — extremities, equal power in opposing limbs, face and body symmetry and weakness.
5. Review pain status.
6. Review for constipation or diarrhoea. Bowels not open for 3 days or watery stools and review the bowel chart **(I was not provided with the bowel chart for this period)**. I did note a bowel assessment was completed on [Day 2] and there are recordings throughout on bowels i.e. on [Day 3] 8pm BO Type 1 Large; [Day 6] laxatives given at 12 midday @ Type 5 Large recorded @2030pm. There are recordings on [Day 7] @ 10am Type 7 small; 8pm Type 3 Medium on [Day 7] and BO at 8pm-ish on [Day 10]. Review for laxative or antidiarrheal use and assess for dehydration.
7. Review goals of care — what does the resident/whānau want to happen. Ask, is the resident for hospitalisation, talk to the GP, how does the family feel about the situation and what would the next of kin/whānau like to happen now. Unfortunately, this did not occur.

2. **Cultural advice**

Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2011) states: "Cultural safety is an outcome of nursing education [and nursing practice] that enables **safe service to be defined by those who receive the service**".

Bob Scott Retirement Village Limited's [senior staff member] provided information from their QIP on the work completed since and Bob Scott Retirement Village Limited has acknowledged and apologised. I would recommend continuing communication training be provided to nursing staff in relation to culturally safe communication when working with [other cultures] who advocate on behalf of their parent and require responsive communication and documentation of this communication to prevent a similar

occurrence in the future and provide certainty this will not happen again to another whānau.

Victoria Simon, RN MN and MSocSc
Aged Care Advisor
Health and Disability Commissioner'