Registered Nurse, RN C

Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00188)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman while she was a resident at a rest home. The report highlights the importance of interpreting cardiac symptoms accurately and responding to the symptoms appropriately.

2. The woman, then aged in her late eighties, had a medical history that included coronary heart disease and COPD.[1] On 3 January 2019, she experienced pain in her shoulder and her breast. At 3.30am on 4 January, the caregiver became concerned and called the on-call registered nurse, at her home. The nurse instructed the caregiver to record the woman's blood pressure every hour and to call back if her condition deteriorated. The nurse and the caregivers discussed the woman's condition by telephone on two further occasions, but the nurse did not assess the woman in person. At 11.45am, the nurse became concerned about the woman's blood pressure and instructed a caregiver to call a GP. However, owing to a miscommunication, a GP did not attend the woman.

3. During the afternoon, the nurse did not attend the woman to assess her, or call the rest home to monitor her condition.

4. The woman's family was concerned about her and was in contact with the rest home during the day. At 3.30pm, the woman's son called an ambulance because the rest home had not done so. Later, the nurse telephoned the woman's son and expressed her displeasure that he had called an ambulance.

Findings

5. The Deputy Commissioner found the nurse in breach of Right 4(1) of the Code because the instructions she gave to the caregiver at 3.30am were poor; by 9.30am, medical intervention was required, and the nurse did not provide it herself or arrange for it to be provided; at 11.45am, when she became concerned about the woman's condition, the nurse did not conduct a face-to-face assessment of the woman, nor did she attend the woman at any time thereafter; during the afternoon, she did not check to determine whether the locum GP had arrived at the rest home; and the nurse's communication with the woman's son was inappropriate.

6. The Deputy Commissioner found the rest home in breach of Right 4(1) of the Code because its procedure for obtaining assistance from a GP was inadequate; the nurse's workload and performance were not monitored effectively; the caregivers did not recognise the seriousness of the woman's condition, and failed to take steps to obtain urgent medical care; and the Emergency Policy was out of date.

Recommendations

7. The Deputy Commissioner recommended that the nurse attend training in cardiac management, communication with family members, and the responsibilities of a sole registered nurse at an aged-care facility.

[1] A lung disease.

8. The Deputy Commissioner noted that in response to the recommendations in the provisional opinion, the rest home developed a plan for professional supervision for the nurse; provided training to caregivers on documentation; updated the "When to Call 111" poster; introduced a checklist to ensure that current care plans are up to date and appropriate; and, in conjunction with the nurse, provided HDC with an apology to the family.

9. The Deputy Commissioner also recommended that the rest home provide training to caregivers on the assessment of residents' vital signs and the escalation of care, and review its processes for requesting GP and locum GP assistance.

10. In addition, the Deputy Commissioner recommended that the district health board consider continuing to monitor the care and services provided at the rest home.

Complaint and investigation

11. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his mother, Mrs A, by the rest home. The following issues were identified for investigation:

- *Whether RN C provided Mrs A with an appropriate standard of care in January 2019.*
- *Whether the rest home provided Mrs A with an appropriate standard of care in January 2019.*

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

13. The parties directly involved in the investigation were:

Mr B	Mrs A's son
RN C	Registered nurse
Rest home	Provider

14. Further information was received from:

Ms D	Caregiver
Ms E	Senior caregiver
Ms F	Caregiver
Ms G	Caregiver

15. Also mentioned in this report:

Ms H	Caregiver
Dr I	GP

16. Independent expert advice was obtained from Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

Background

17. The rest home provides rest-home-level care for up to 19 residents. At the time of events it was fully occupied.

18. The staffing arrangements at the rest home in 2017 included two caregivers on site during the day, and one caregiver on site overnight between 7pm and 7am. One registered nurse was on site between 9am and 3pm Monday to Thursday, and the same registered nurse was on call at all other times.[2]

19. RN C was the sole registered nurse at the rest home. RN C did not have a formal employment or contractor agreement with the rest home. RN C was also one of the owners, the sole Director, and the Manager of the rest home.

20. Mrs A had a medical history that included coronary heart disease and chronic obstructive pulmonary disease (COPD).

21. On 15 March 2017, Mrs A moved into the rest home. She was then aged in her late eighties.

22. On 6 April 2017, RN C completed a Nursing Care Plan, which stated:

> "Report any signs and symptoms of difficulty in breathing, chest infection/pain or swelling to feet/legs. [Mrs A] does suffer with SOB [shortness of breath] on exertion related to COPD and smoking. Ensure all inhalers are administered as prescribed. Blood pressure to be monitored monthly. Report significant changes to RN/GP."

23. The Nursing Care Plan was reviewed on 3 October 2017 and again on 1 November 2018.

24. The Care Plans policy[3] states:

> "Each care plan is evaluated, reviewed and amended either when clinically indicated by a change in the resident's condition or at least every six months, whichever is the earlier. Resident, staff and relative involvement is encouraged during development and evaluation."

[2] The district health board told HDC that there must be one care staff member on duty and one care staff member on call at all times. RN C confirmed that she is the on-call staff member at all times.
[3] Dated 9 August 2017.

25. RN C completed an interRAI[4] assessment for Mrs A on 16 October 2017 and 26 October 2018.

Events of 3 January 2019

26. Ms D was the caregiver responsible for Mrs A's care on Thursday 3 January 2019. Ms D started her shift at 2.45pm. RN C was not on site at the rest home, but she was on call.

27. Ms D told HDC that at 3.45pm, Mrs A approached her in the rest-home kitchen and advised her that she had indigestion and would like some Mylanta.[5]

28. Ms D told HDC that when she went to Mrs A's room to give her the Mylanta, Mrs A said that she was feeling unwell and was experiencing pain in her shoulder and her breast. Ms D said that Mrs A indicated that the pain was similar to pain she had experienced previously, and she agreed to an anti-inflammatory herbal cream being applied to her shoulder.

29. Ms D told HDC that she took Mrs A's blood pressure, and it was 120/59mmHg. Ms D did not record the reading in the Recordings Chart, but did record it in the Daily Report. Ms D recorded a pulse rate of 82 beats per minute (bpm).

30. The Recordings policy[6] indicates that a normal blood pressure is 120/80mmHg, and states: "In case of higher or lower report to RN."

31. Ms D stated: "I know from looking at the previous readings on the Recordings Chart that the reading I took was normal for her." Ms D told HDC: "The Mylanta seemed to have settled her pain, and her blood pressure was normal, so I didn't see any need to call [RN C]."

32. At 4pm, Ms D gave Mrs A her medications.

33. Ms D told HDC that at 5pm she took Mrs A some sushi for dinner, and at 7pm[7] she took Mrs A a cup of tea. Ms D stated: "At this time she didn't complain at all and I thought she was feeling better."

34. At 8pm, Ms D woke Mrs A to administer her medications. Ms D stated:

> "I remember that she seemed a bit lethargic, but that was also quite normal for [Mrs A]. She didn't complain about her shoulder again, so I thought the [anti-inflammatory cream] must have helped."

[4] A suite of clinical assessment instruments used by trained nurses and registered healthcare workers to assess an older person's care needs. An interRAI assessment should be completed within 21 days of admission, and every six months thereafter.
[5] Medication used to treat indigestion.
[6] Dated 6 September 2018.
[7] The rest home told HDC that between 9 and 9.30pm Ms D took Mrs A a cup of tea and gave her Mylanta.

35. At 10pm, Ms D checked Mrs A, who was sleeping, and made an entry in the Daily Report, which included the following: "[Mrs A] said her pains were not as bad but feels very weak."

36. Ms D then finished her shift and went home.

Overnight shift 3–4 January 2019

37. Ms H was the caregiver responsible for Mrs A's care overnight. RN C was on call.

38. The rest home told HDC that Ms H is no longer employed by the rest home, and it was unable to contact her.

39. The rest home said that at 3.20am, Ms H became concerned about Mrs A and called RN C to discuss Mrs A's symptoms.

40. Ms H made the following entry in the Daily Report:[8]

> "Noticed [Mrs A] very weak, she says all her body in pain, cannot sit up too long, needed help to go to the toilet, laying on [her] bed, deep panting, with [her] tongue out of her mouth. Called [RN C], we agreed, I just monitor her for now."

41. RN C told HDC that Ms H told her that Mrs A was "laying on [her] back, deep panting, with [her] tongue out of her mouth". RN C said that based on the information provided by Ms H, she did not consider Mrs A to be exhibiting any signs of cardiac issues, so she instructed Ms H to record Mrs A's blood pressure and pulse every hour and to call her back if she deteriorated.

42. Ms H did not record any blood pressure readings in the Daily Report.

43. Two blood pressure readings were recorded in two separate Recordings Charts two hours later at 5.30am. The readings were recorded as 103/53mmHg and 113/53mmHg.[9] It is not clear who recorded the readings, why there were two readings, and why they were recorded on two separate Recordings Charts.

Morning shift 4 January 2019

44. Ms E is a senior caregiver at the rest home, and Ms F is a caregiver at the rest home. Ms E and Ms F were the caregivers on duty on the morning of Friday 4 January. RN C was on call.

45. Ms F told HDC that she arrived early at the rest home, at 6am, and that Ms H and Mrs A both told her that Mrs A had been feeling unwell. Ms F said that she took Mrs A's blood pressure but did not record it in the Recordings Chart.

[8] The entry was made at 4.45am.
[9] Low blood pressure readings.

46. Ms F stated that she went to pick up Ms E, and in the car on the way back to the rest home she told Ms E that Mrs A was unwell. Ms F told HDC that when they arrived at the rest home: "We took her blood pressure and, according to the Recordings Chart, it was low."

47. The Recordings Chart documents that Mrs A's blood pressure was taken at 7am and was 115/65mmHg.

48. Ms E told HDC that RN C called her at 7.10am to advise her that Mrs A had experienced breathing difficulties overnight. However, the rest home's telephone records do not show a telephone call occurring at 7.10am. In her initial response to HDC, RN C stated that she telephoned the rest home at 7.15am, but later she revised her statement and said that she called the rest home at 8.45am for an update on Mrs A's condition. This telephone call is confirmed by the telephone records, although the Daily Report, completed retrospectively, does not record a conversation at this time.

49. RN C stated:

> "I spoke to the caregiver on duty for the morning shift, [Ms E], who told me the latest blood pressure and pulse readings. She explained that [Mrs A] was in bed and asking for a cigarette … it was my opinion, based on the information I had been provided, that [Mrs A's] blood pressure was acceptable, although a little low. For that reason, I instructed … [Ms E] not to give [Mrs A] a cigarette, to elevate the foot of the bed and continue monitoring her blood pressure and pulse."

50. Ms E told HDC that at 9.30am Mr B arrived at the rest home and, having seen his mother, asked whether his mother needed an ECG.[10]

51. The Daily Report records that a conversation took place between Ms E and RN C at approximately 9.30am. The telephone records confirm that a telephone call was made from the rest home to RN C's telephone at 9.35am. The Daily Report states:

> "[Mrs A's] speech was bit slurry. At 9.30am [Mrs A's] blood pressure was 104/47 then 98/44. Contacted [RN C]. She told us to raise her legs up on pillows and keep her well hydrated and take her [blood pressure] again in an [hour].

52. In respect of the telephone call from the rest home at 9.35am, RN C stated:

> "Again, it was my opinion that, although her blood pressure was a little low, there was nothing to make me immediately concerned that [Mrs A] required urgent medical attention."

53. Mrs A's blood pressure was taken again at 10.40am, and was 106/53mmHg.

54. At 11.45am, RN C called the rest home for an update. She stated:

[10] An electrocardiogram (ECG) measures the electrical activity of the heart.

> "I spoke to [Ms E] who told me [Mrs A's] [blood pressure] was still low and fluctuating. Because there had not been any significant improvement, I was now quite concerned for [Mrs A]. I instructed the caregiver to call the GP, which I understand she did."

Telephone call to locum GP

55. The telephone records show that at 11.54am two calls were made to the locum GP. Ms E said that she left two messages but received no response to her calls. The locum GP did not call back the rest home or attend the rest home.

56. The rest home has a contractual arrangement for GP services with Dr I. The contract states that the GP is to attend within 48 hours of an admission, and within four hours for acute calls.

57. On 27 December 2018, Dr I emailed the rest home to advise that he would be on leave in January 2019, and that another GP would provide cover. The email did not specify the dates on which Dr I would be on leave, and the rest home told HDC that staff assumed that he was away for the entire month.

58. RN C told HDC:

> "Unfortunately we subsequently found out that our regular GP did not, in fact, go on leave until the following week and for this reason the locum did not action the message left by the caregiver. At the time we were unaware of this and expected the locum GP to arrive shortly to assess [Mrs A] … Unfortunately I was not informed that the locum had not called back (or shown up); or that the caregivers were concerned about the delay. As I did not hear anything further, I assumed that all was well with [Mrs A] and she had received the medical attention sought on her behalf."

59. Mr B told HDC that he called the rest home at approximately 12pm and was advised that the locum GP had not called back and that staff were following up on him.

60. At 1pm, Ms E's shift ended. Ms E told HDC that she told the afternoon staff to monitor Mrs A and to keep in touch with RN C. Ms F noted in the Daily Report: "Have not heard from locum."

61. Ms F told HDC that she continued to monitor Mrs A until her shift ended at 3pm. Ms F said that she would not provide Mrs A with a cigarette when she asked for one, and that Mrs A said that she did not want an ambulance.

62. Ms F told HDC:

> "When I handed over to [Ms G], the afternoon caregiver, I explained that [Ms E] had called the locum GP, but we hadn't heard back yet. I was a bit worried that we hadn't heard back."

Afternoon shift on 4 January 2019

63. Ms G is a caregiver at the rest home, and was on the 2.45pm to 11pm shift on 4 January.

64. Ms G told HDC that she received a handover from Ms F, and was told that Mrs A had not been well that day, that her blood pressure was being monitored, and that she should continue to do this.

65. Ms G said that shortly after the handover, she was contacted by Mr B. Ms G stated that she provided Mr B with an update on Mrs A's condition, and advised him that the locum GP had not called back. The Daily Record states that Mr B asked Ms G to call an ambulance, but that she told him: "I am not allowed to authorise this [calling an ambulance] and that he should ring [RN C]."

66. The Emergency Policy[11] stated:

> "Only necessary to dial 111 for emergency if staff or visitors have a bad accident or cardiac arrest [or for life-threatening situations] ... For all non-urgent ambulance transfers, the RN must be notified prior to arranging transfer."

67. The "When to call 111" poster stated:

> "Someone complaining of severe chest pain with pain in left arm, shoulder, neck for example and altered BP and pulse — unable to get breath — this could indicate heart attack."

68. Ms G said that Mrs A's two grandsons arrived and she asked them to wait until she had taken Mrs A's blood pressure. The blood pressure reading in the Recordings Chart at 3.30pm was 104/44mmHg.

69. Ms G told HDC that Mrs A then told her that her grandsons wanted her to go to hospital. Ms G said that she reassured Mrs A that RN C was aware of what was happening and would send her to hospital if that was necessary.

70. Ms G told HDC that Mrs A's grandsons then asked her to call an ambulance, and she told them that she could not do so without RN C's authorisation.

71. At 3.29pm, an ambulance was called by Mr B. Staff at the rest home did not call the ambulance.

72. The paramedics arrived at 3.55pm and assessed Mrs A, and at 4.06pm she was taken to the public hospital, where she was treated for pulmonary oedema (excess fluid on the lungs) and a myocardial infarction (heart attack). Subsequently, Mrs A was discharged to another aged-care facility.

73. RN C told HDC that Ms G advised her that a member of Mrs A's family had called an ambulance, and that Mrs A had been taken to hospital. RN C said that she called Mr B at

[11] Dated 13 August 2017.

about 5pm. She stated: "I was very angry that he had not notified me of ringing the ambulance — I did say who rang the b— ambulance — apologies — this was not professional."

74. Mr B told HDC that this telephone call took place on the evening of Saturday 5 January, and not on the evening of 4 January.

Recordings Chart

75. The Recordings Chart does not document any blood pressure readings for Mrs A on 3 January 2019.

76. Ms F told HDC that on 4 January she and Ms E both took blood pressure readings. The following readings were recorded on the main Recordings Chart for 4 January:

- 5.30am 103/53mmHg pulse 98bpm
- 9.40am 84/47 and 95/47mmHg pulse 64/64bpm
- 10.42am 106/53mmHg pulse 70bpm

77. On a separate Recordings Chart, the following readings were recorded:

- 5.30am 113/53mmHg pulse 98bpm
- 7am 115/65mmHg pulse 96bpm
- 9.30am 104/47mmHg pulse 78bpm
- 10.40am 106/53mmHg pulse 70bpm
- 12pm 119/59mmHg pulse 68bpm
- 1pm 117/39mmHg pulse 64bpm
- 1.40pm 102/35mmHg pulse 59bpm
- 3.30pm 104/44mmHg pulse 63bpm

Further information from RN C

78. RN C told HDC:

> "With the benefit of hindsight, I wish that I had gone into [the rest home] on 4 January 2019 and assessed [Mrs A] personally and acknowledge there are things I could have … done differently. For that I apologise.
>
> …
>
> Given the information presented to me on the actual day, however, it was my professional opinion that it was not necessary until around midday to obtain medical assistance for [Mrs A]. At that time, I made the decision that, rather than go in myself, it was more appropriate for the GP to attend to [Mrs A]. Had I known that the GP would not come in a timely manner, I would certainly have gone in myself. As

> mentioned, we have never had an issue with the GP coming to [the rest home] to assess a patient before. When I did not hear further from the caregivers I thought this must have occurred. I appreciate that I should have followed this up, and not relied on the caregivers."

79. RN C told HDC that all interRAI assessments at the rest home are now up to date, and her competency to complete the assessments has also been assessed by interRAI NZ.

80. RN C has also completed a Medication Administration Competency Assessment and a Nurses Practising in Management Competence Assessment, as recommended by the DHB.

Further information from the rest home

81. The rest home told HDC:

> "The Complaint has highlighted to the rest home that the demands of providing hands-on nursing care and keeping up with the administration and paperwork necessary to run a rest home properly has proved too much for one person ([RN C]) … [The rest home] has taken immediate steps to rectify this."

82. Since these events, the rest home has employed additional registered nurses.

Information from HealthCERT

83. HealthCERT is the regulatory body responsible for ensuring that hospitals, rest homes, and residential disability care facilities comply with the Health and Disability Services Standards 2008 and provide safe and reasonable levels of service for consumers. All rest homes and aged residential-care facilities are audited by designated auditing agencies and certified by HealthCERT.

84. The rest home has a three-year Certification for Rest Home services from 20 November 2017 to 20 November 2020.

85. A complaint made by another consumer to HDC in 2018 raised concerns about the care that was being provided to residents at the rest home. As a result, the DHB directed resources to help to manage and rectify a range of issues at the rest home.

86. In March 2019, HealthCERT conducted an unannounced surveillance audit in order to measure the improvements that had been made as a result of the DHB input.

87. HealthCERT told HDC:

> "The findings of this audit demonstrated no progress had been made and in discussion with the DHB portfolio manager a second surveillance audit will be required three months either side of 20 February 2020."

88. In December 2019, HealthCERT conducted a second unannounced audit. Five of the six shortfalls identified as part of the previous audit were found to have been addressed. These related to incident forms, the assessment process, care interventions, aspects of

medication management, and fire evacuation practices. The audit stated that improvements to medication prescribing continued to be required.

Information from the DHB Health of Older People

89. Since being advised of the earlier HDC complaint in 2018, the DHB's Health of Older People (HOP) team has provided extensive monitoring and support to the rest home, including numerous site visits, presentations at staff meetings, and telephone and email communication.

90. Following the HealthCERT unannounced surveillance audit in March 2019, the DHB developed a Corrective Action Plan to address the issues raised in the audit. Subsequently, other concerning issues were identified, and on 17 June 2019 the DHB notified the Nursing Council of New Zealand of its concerns about RN C's competence. The DHB continued to monitor the rest home.

91. The DHB's intervention resulted in the appointment of a short-term subcontracted registered nurse, who provided interim support at the rest home, and the appointment of a new permanent registered nurse. There is now a registered nurse at the rest home six days a week. The DHB told HDC that RN C acknowledged the issues around her being the sole on-call contact, and has started to delegate this responsibility to the other registered nurses.

92. The DHB told HDC that RN C provides copies of all Incident Reports to the DHB as any incidents occur, and these reflect an improved response and understanding of incident management. The DHB stated:

> "Staff have been recorded as contacting the on-call RN at the time incidents occur, and subsequent actions were appropriately taken, although clear documentation of these actions remains a work in progress."

93. The DHB told HDC that interRAI NZ conducted a random competence audit and concluded that RN C required upskilling. The DHB reviewed the interRAI assessments for 10 residents at the rest home, and identified numerous deficiencies.

94. The DHB concluded:

> "While there [are] still gaps to be addressed [the rest home] now appears to be making steady quality improvements in their service. The [DHB's] Health HOP team will continue with onsite and phone/email support and monitoring."

Responses to provisional opinion

Mr B

95. Mr B was given an opportunity to comment on the "information gathered" section of the provisional opinion, and his response has been incorporated above as appropriate.

96. Mr B reiterated his concern that an elderly woman with known heart problems had to wait for 14 hours for medical help. He stated: "[Rest home owners] have a duty of care to those who we trust with our elderly, and those in need."

RN C

97. RN C was given an opportunity to comment on the provisional report, as it relates to her. Her response has been incorporated into the "information gathered" section above where appropriate.

98. RN C stated that she accepts the recommendations for training in the provisional opinion, and she is in the process of identifying suitable courses. RN C advised that she has attended a New Zealand Nurses Organisation forum on scope of practice, which included information on communication, and a DHB Aged Residential Care meeting, which covered professionalism in nursing. RN C also stated that she is enrolled to attend the New Zealand Aged Care Association's workshop on managing challenging behaviours.

99. RN C said that she actively engaged with a mentor who is a registered nurse at another rest home and who has assisted and supervised her at the rest home previously. RN C also said that the Nursing Council of New Zealand continues to monitor her practice to ensure that she remains fit to practise. RN C also noted that the rest home, and her role as a registered nurse and a manager, have been audited repeatedly over the last year, and that a further audit of the rest home conducted by HealthCERT on 15 September 2020 found that all standards had been attained.

100. In response to the recommendation in the provisional opinion, RN C provided HDC with a written apology to Mrs A's family.

Rest home

101. The rest home was given an opportunity to comment on the provisional opinion. The rest home stated that it acknowledged the criticisms made of it, that it apologised unreservedly to the family, and that it accepted the proposed recommendations.

102. The rest home confirmed that RN C continues to work with a professional mentor, and that other staff have engaged in training on communication, reporting, and documentation. The rest home advised that staff continue to be trained at orientation and reassessed annually, and that ongoing training on assessment of vital signs and escalation of care is proposed.

103. The rest home also advised that it has implemented a Multipurpose Recording Chart to ensure that blood pressure readings and other important information are recorded accurately, and it has updated its "When to Call 111" poster. In addition, a checklist for residents' care plans has been introduced to ensure that all care plans are reviewed appropriately.

Opinion: RN C — breach

104. On 15 March 2017, Mrs A moved into the rest home. Her medical history included coronary heart disease.

105. This section of the report discusses the care that RN C provided to Mrs A at the rest home.

Care Plan

106. On 6 April 2017, RN C completed a Nursing Care Plan for Mrs A, which stated that she should be monitored for shortness of breath and chest pain. The Care Plan policy requires a care plan to be evaluated, reviewed, and amended at least every six months.

107. Mrs A's initial Nursing Care Plan was reviewed on 3 October 2017 but not again until 1 November 2018.

108. My expert clinical advisor, RN Hilda Johnson-Bogaerts, stated:

> "It is accepted practice and a requirement in line with the Health and Disability Sector Standards[12] that a care plan is reviewed ongoing when changes occur or at least every 6 months. I am concerned that no evidence was found that [Mrs A's] care plan was updated or reviewed since its development in April 2017. In addition no evidence was found that this care plan was developed with input from and/or agreed with the consumer."

109. I am critical that RN C did not review or update Mrs A's nursing care plan in accordance with the rest home policy and the Health and Disability Sector Standards, although I note that it was reviewed in October 2017 and November 2018. I would also be concerned if a care plan was developed without input from the consumer.

110. In response to my provisional report, RN C confirmed that interRAI assessments were completed in October 2017 and October 2018. However, I remain critical that an interRAI assessment did not occur within the requisite timeframes.

Escalation of care

111. During the afternoon of 3 January 2019, Mrs A began to feel unwell. She felt weak and was experiencing pain in her shoulder and left breast.

112. At 3am on 4 January 2019, Mrs A was observed to be very weak, and she complained that her whole body was in pain. She was lying on her bed, "deep panting, with [her] tongue out of her mouth". The caregiver called RN C and reported this. RN C said that she advised the caregiver to record Mrs A's blood pressure every hour and to call her back if Mrs A deteriorated. The caregiver did not record Mrs A's blood pressure for another two hours, and did not call RN C. RN C did not follow up on her instructions to the caregiver until later that morning.

[12] Standard 3.5.1: "Service delivery plans are individualised, accurate and up to date."

113. RN Johnson-Bogaerts advised:

> "Seeing [Mrs A's] cardiac history I am concerned that [RN C's] instructions to the caregiver who rang that night (reporting that [Mrs A] was very weak and presented with deep panting with the tongue out of her mouth) did not include to take her vital signs and report back immediately."

114. I share my expert advisor's concerns, and consider that Mrs A's symptoms warranted a more urgent response from RN C. I am critical that RN C did not request a more thorough assessment and instruct that Mrs A's vital signs be taken immediately, and that the vital signs be relayed to her immediately.

115. Mrs A's blood pressure was not taken until 5.30am. Two readings were recorded separately as 103/53mmHg and 113/53mmHg. I note that the the rest home Recordings policy states that a normal blood pressure is 120/80mmHg. Based on this information, neither blood pressure reading was normal.

116. The next blood pressure reading was not taken until 7am, and this was recorded as 115/65mmHg.

117. There is some confusion about when RN C and staff at the rest home were in contact with each other following the 3am telephone call between RN C and the caregiver. Ms E stated that RN C called her at 7.10am. RN C told HDC that she contacted the rest home at 8.45am for an update, and this is supported by the telephone records. Based on this information, I find that RN C called the rest home at 8.45am.

118. A blood pressure reading was taken at approximately 9.30am and recorded as 104/47mmHg. This is an abnormal blood pressure reading.

119. At 9.35am, the telephone records document a call from the rest home to RN C. Ms E also recorded in the Daily Report that she called RN C at 9.30am. As a result, I find that a telephone call did take place at 9.35am.

120. RN C acknowledged that she was aware of Mrs A's low blood pressure, and told HDC that in her opinion it was not necessary to obtain medical assistance for Mrs A until around midday. However, RN Johnson-Bogaerts advised:

> "I am critical [RN C] did not refer [Mrs A] for urgent medical attention when she was advised of the observations taken at 5.30hrs and 9.30hrs. Hypotension[13] combined with a raised pulse, shortness of breath and a feeling of weakness are symptoms pointing in the direction of an acute cardiovascular event requiring urgent medical attention."

[13] Abnormally low blood pressure.

121. I accept RN Johnson-Bogaert's advice. By 9.35am,[14] RN C was aware that Mrs A's blood pressure was abnormal. In my view, Mrs A's symptoms were sufficiently concerning to warrant medical intervention. I am critical that RN C did not arrange for immediate medical attention, or at least attend the rest home to assess Mrs A herself.

122. At 10.40am, Mrs A's blood pressure was recorded as 106/53mmHg.

123. At 11.45am, over two hours after her earlier conversation with Ms E, RN C called the rest home for an update on Mrs A's condition. RN C then instructed the caregiver to call the locum GP, but she did not attend the rest home to assess Mrs A. It appears that there was no further contact between RN C and the rest home to discuss either Mrs A's condition or the whereabouts of the locum GP until 4.06pm, when RN C was advised that Mrs A had been taken to hospital.

124. RN Johnson-Bogaerts stated that she would expect that having instructed that the GP be called, RN C would have telephoned the caregiver back within an hour. RN Johnson-Bogaerts advised:

> "I am also concerned that [RN C] as registered nurse on call did not come in to assess the situation herself which I believe would have provided her with a clearer picture and history of events. After the decision was made to call the locum GP there does not appear to have been any further checking in by her as RN on call and to follow through on the situation."

125. I agree. RN C was responsible for Mrs A's care, and at 11.45am RN C had concerns about Mrs A's condition. RN C acknowledged in hindsight that she should have attended the rest home. Given those concerns, and the absence of any other medical personnel at the rest home, I am critical that RN C did not attend Mrs A in person at 11.45am. I am also critical that during the course of the afternoon, for a period of four hours, RN C did not follow up on Mrs A's condition or check the progress of the locum GP, by telephone or in person. This is a poor response to an increasingly concerning clinical situation.

Communication with Mr B

126. RN C rang Mr B about Mrs A's admission to hospital. I note that RN C said that this telephone call took place on the evening of 4 January 2019, and Mr B said that it took place on the evening of 5 January 2019.

127. I do not need to determine the date of this conversation, but I accept that a conversation took place. I also accept that the purpose of the telephone call was to discuss Mrs A's admission to hospital, and whether Mr B should have called an ambulance.

128. RN C stated: "I was very angry that he had not notified me of ringing the ambulance — I did say who rang the b— ambulance — apologies — this was not professional."

[14] 9.35am was the confirmed time of the telephone call from the rest home to RN C. It was recorded in the clinical notes as occurring at 9.30am.

129. I agree that this was not a professional response by RN C, and I am concerned that she responded aggressively to a resident's family member who had concerns about the care being provided. I encourage RN C to reflect on the manner in which she communicates with family members of residents.

Conclusion

130. RN Johnson-Bogaerts concluded:

> "In these circumstances the standard of care provided by [RN C] would be seen by my colleagues as a moderate to significant deviation from accepted practice."

131. I accept RN Johnson-Bogaert's advice, and I share her concerns about the standard of care that RN C provided to Mrs A. As a result, Mrs A's conditions went undiagnosed and untreated for many hours. I find that RN C breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[15] for the following reasons:

- The instructions that RN C gave to the caregiver at 3.30am were poor. RN C should have instructed that Mrs A's vital signs be taken and relayed to her immediately.
- By 9.35am, medical intervention was required, and RN C did not provide it herself or arrange for it to be provided.
- At 11.45am, when she became concerned about Mrs A's condition, RN C did not conduct a face-to-face assessment of Mrs A, nor did she attend Mrs A at any time thereafter.
- During the afternoon, RN C did not check to determine whether the locum GP had arrived at the rest home.
- RN C's communication with Mr B was inappropriate.

Opinion: Rest home — breach

132. The rest home employed one registered nurse and a team of caregivers to provide care to 19 residents. As outlined above, the care provided by RN C to Mrs A was poor. In addition, I am critical of some aspects of the care provided by the caregivers, and of some of the systems in place at the facility.

System for contacting locum GP

133. The contract between the rest home and Dr I required a GP to attend the rest home within 48 hours of an admission, and within four hours for acute calls. The rest home requested a GP at 11.54am, and it received no response to the request.

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

134. It appears that there was a miscommunication between the rest home, the regular GP, and the locum GP. As a result, Mrs A was not provided with medical attention.

135. I accept that there was a system in place at the rest home for obtaining medical assistance from a GP, and for ensuring that locum GP cover was available when the regular GP was not available. However, in this instance the system did not work. A telephone message was left for the locum GP, but the locum GP did not respond, and the regular GP was not contacted. I am critical that the rest home did not have in place an adequate system for obtaining the assistance of a GP when urgent assistance was required.

Supervision and support of registered nurse

136. The rest home told HDC that it was required to have a registered nurse on call at all times, and that RN C was the registered nurse on call at all times. RN C was also the Facility Manager and an owner.

137. The rest home told HDC:

> "The Complaint has highlighted to the rest home that the demands of providing hands-on nursing care and keeping up with the administration and paperwork necessary to run a rest home properly has proved too much for one person ([RN C]) … the rest home has taken immediate steps to rectify this."

138. RN Johnson-Bogaerts advised:

> "Being the only RN and having [the] sole responsibility for clinical care in the care home, it would be good practice to have an arrangement with a colleague for peer reciprocal supervision or to be part of a forum for professional and clinical supervision. Supervision is an important component for nurses or any health practitioner working in isolation, to ensure quality care of their patients. It could be described as a regular meeting with a peer/peers for reflection and learning."

139. It is clear that RN C was not monitoring her workload and performance effectively, and I am critical that there were no systems in place at the rest home to recognise or rectify this.

140. I acknowledge that significant work has now been done to improve the workload at the rest home, such as hiring additional nurses, and I encourage RN C and the rest home to reflect upon how collegial support and supervision could be improved for nurses at the rest home in the future.

Care provided by caregivers

141. At 3.20am and again at 9.35am on 4 January, caregivers contacted RN C with concerns about Mrs A's condition. RN C also contacted the rest home at 8.45am. Mrs A's blood pressure was low, her pulse rate was concerning, and she was noted to be short of breath. Later in the morning, RN C instructed staff to call the GP, which they did at 11.54am. The rest home did not receive a response from the GP, but staff did not attempt to locate the

GP, nor did they contact RN C. Between 11.54am and 4.06pm, when Mrs A was taken to hospital, no further attempts were made to obtain urgent medical assistance.

142. In addition, family members spoke to different caregivers at 9.30am and again at 12pm and expressed their concern about Mrs A's condition. Finally, at approximately 3.30pm, the family made a request to another caregiver for an ambulance to be called, and this request was denied. As a result, the family were placed in the unenviable position of having to obtain medical assistance against the expressed wishes of staff at the rest home.

143. RN Johnson-Bogaerts advised:

> "The consumer was clearly in distress. It would have been expected that the caregiver who rang the GP would have called the RN when the GP had not returned the calls within the hour."

144. From 11.54am, it should have been clear to staff that there were serious concerns about Mrs A's health. RN C had instructed that the GP be called, and the family were concerned about her. However, staff did not react to these developing events by attempting to obtain urgent medical care for Mrs A. In my view, this suggests a lack of insight into the seriousness of the situation, and a lack of initiative in managing it.

"When to call 111" poster

145. RN Johnson-Bogaerts reviewed the rest home's Emergency Policy, which includes a poster entitled "When to call 111 for medical emergency". RN Johnson-Bogaerts noted that the poster stated:

> "Someone complaining of severe chest pain with pain in left arm, shoulder, neck for example and altered BP and pulse — unable to get breath — this could indicate heart attack."

146. RN Johnson-Bogaerts recommended that this policy be updated in light of recent findings that women experiencing cardiac events can have more obscure symptoms.

147. I accept this advice, and have made a recommendation to this effect.

Conclusion

148. As outlined above, I have concerns about the critical thinking demonstrated by the caregivers at the rest home, and with the systems within the rest home, which did not enable the facility to provide adequate care to Mrs A. As a result, I find that the rest home breached Right 4(1) of the Code for the following reasons:

- The procedure for obtaining assistance from a GP was inadequate.
- RN C's workload and performance were not monitored effectively.
- The caregivers did not recognise the seriousness of Mrs A's condition, and failed to take steps to obtain urgent medical care.

- The Emergency Policy was out of date.

Recommendations

149. I recommend that RN C attend training in cardiac management, communication with family members, and the responsibilities of a sole registered nurse at an aged-care facility, and provide evidence of the training to HDC within four months of the date of this report.

150. In response to the recommendations in the provisional opinion, RN C provided HDC with an apology to Mrs A's family.

151. I recommend that the Nursing Council of New Zealand consider whether a review of RN C's competence is warranted, and advise HDC accordingly within three months of the date of this report.

152. I recommend that the rest home:

a) Provide training to caregivers on the assessment of residents' vital signs and the escalation of care.
b) Review its processes for requesting GP and locum GP assistance, to ensure that a robust system is in place, particularly for circumstances where follow-up of the GP may be required.

153. The rest home should report back to HDC on the outcome of the above recommendations within three months of the date of this report.

154. In response to the recommendations in the provisional opinion, the rest home developed a plan for professional supervision for RN C, provided training to caregivers on documentation, updated the "When to Call 111" poster, introduced a checklist to ensure that current care plans are up to date and appropriate, and provided HDC with an apology to Mrs A's family.

155. I recommend that the DHB consider continuing to monitor the care and services provided at the rest home and, within three months of the date of this report:

a) Provide HDC with an update on the rest home's progress.
b) Request HealthCERT to conduct an unannounced surveillance audit if it is warranted.

Follow-up actions

156. A copy of this report will be sent to the DHB and HealthCERT.

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

158. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the NZ Nurses Organisation and the Health Quality & Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Hilda Johnson-Bogaerts:

"**CLINICAL ADVICE — AGED CARE**

CONSUMER : [Mrs A]

PROVIDER : [Rest Home]

FILE NUMBER : C19HDC00188

DATE : 21 July 2019

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the rest home] to [Mrs A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I was asked to advise whether the standard of care provided to [Mrs A] was appropriate in the circumstances. In particular I was asked whether [RN C's] oversight of care and clinical instructions to the Rest Home caregivers on 4 January 2019 was sufficient.

Documents reviewed

Complaint dated 31 January 2019

Response from [RN C] (RN/Manager) dated 25 February 2019

Clinical notes from [the rest home] for the period of January 2019 to February 2019

Policies of [the rest home]

Clinical notes from [the] DHB for presentation in ED on 4 January 2019 only, patient was then admitted to hospital in the general medical ward.

Complaint

[Mrs A] was diagnosed with non STEMI 4/1/19. Her son has raised concerns about a delay in treatment as staff in [the rest home] refused to call an ambulance and failed to recognise the signs of an acute coronary syndrome, thereby failing to seek urgent medical attention.

[Mrs A] has a cardiac history, suffering a STEMI in 2008. On the morning of 4/1/19 it is documented she was weak, had pain, later documented as chest pain, difficulty with breathing 'deep panting with tongue out'. It was not documented but in letter of response [RN C] advises she was called, had no concerns that [Mrs A's] symptoms were cardiac and advised caregivers to monitor observations.

[RN C] then responds that she called again 0715 and 0940 to check up on observations, no instruction appears to be given to caregivers regarding [Mrs A's] hypotension.

Later in the day [Mr B] advises when he ascertained no doctor had seen his mother he called an ambulance. [Mrs A] is admitted to [hospital] with delayed presentation of NSTEMI and acute pulmonary oedema.

Review of clinical records

[Mrs A] was [in her late eighties] when she moved into [the rest home] in March 2017. Her medical history includes coronary heart disease and chronic obstructive pulmonary disease. The interRAI assessment completed in [the rest home] on 26 October 2018 provides a picture of a fairly independent lady with a severe vision and hearing impairment.

A Nursing Care Plan was developed dated 6 April 2017 and signed by [RN C]. The part relating to 'Breathing and Circulation' includes the following instructions '*report any signs and symptoms of difficulty in breathing, chest infection/pain or swelling to feet/legs. [Mrs A] suffers from shortness of breath on exertion related to COPD and smoking. Ensure inhalers are administered. Blood pressure to be monitored monthly. Report significant changes to RN/GP.'*

[Rest home] Emergency Policy/When to ring 111 for medical emergency states: '*Someone complaining of severe chest pain with pain in left arm, shoulder, neck for example and altered BP and pulse — unable to get breath — this could indicate heart attack'.*

3 January 2019, the Daily Report of 22.00hrs includes that [Mrs A] had pains in her back and under her left breast. The caregiver took her blood pressure which was 120/51, pulse 82. '*gave Mylanta x2*' and further when she gave a cup of tea *'said her pains were not so bad but feels very weak'.*

During that night the caregiver noticed that [Mrs A] was '*very weak*' and needed unusually more help. '*deep panting with tongue out of her mouth*' '*called [RN C], we agreed I just monitor for now*'. This entry was dated and timed 4 January 2019 4.45am. No observations were included at that time. The 11am report includes observations taken early morning 5.30am being BP 103/53, pulse 98 '*very weak, speech a bit slurry*'. '*At 9.30 am BP 104/47 then 95/44 — contacted [RN C]. She told us to raise her legs up on pillows and keep her well hydrated and take BP again in 1 hour.'* Monitoring continued with [Mrs A's] symptoms of hypotension and weakness to continue. 12.00hrs the notes include that [RN C] was rung again and that she decided that the locum GP be called. Voicemail was left. When the caregiver did not hear back from the GP before the end of the shift, instructions were left for the next shift in the Daily Notes to stay in contact with [RN C]. That evening the care staff continued to monitor blood pressure and pulse. No entries were made that [RN C] continued to receive reports or that she would have called in to check in with progress.

Comments

Seeing [Mrs A's] cardiac history I am concerned that [RN C's] instructions to the caregiver who rang that night (reporting that [Mrs A] was very weak and presented

with deep panting with the tongue out of her mouth) did not include to take her vital signs and report back immediately. Further I am critical [RN C] did not refer [Mrs A] for urgent medical attention when she was advised of the observations taken at 5.30hrs and 9.30hrs. Hypotension combined with a raised pulse, shortness of breath and a feeling of weakness are symptoms pointing in the direction of an acute cardiovascular event requiring urgent medical attention. The rest home's procedure for 'When to ring 111 for medical emergency' includes the symptoms of 'heart attack'.

I am also concerned that [RN C] as registered nurse on call did not come in to assess the situation herself which I believe would have provided her with a clearer picture and history of events. After the decision was made to call the locum GP there does not appear to have been any further checking in by her as RN on call and to follow through on the situation.

In these circumstances the standard of care provided by [RN C] would be seen by my colleagues as a moderate to significant deviation from accepted practice.

Other comments on documents reviewed

It is accepted practice and a requirement in line with the Health and Disability Sector Standards that a care plan is reviewed ongoing when changes occur or at least every 6 months. I am concerned that no evidence was found that [Mrs A's] care plan was updated or reviewed since its development in April 2017. In addition no evidence was found that this care plan was developed with input from and/or agreed with the consumer.

[Rest home] Emergency Policy/When to ring 111 for medical emergency states: '*Someone complaining of severe chest pain with pain in left arm, shoulder, neck for example and altered BP and pulse — unable to get breath — this could indicate heart attack'*. It is recommended that this point be updated with the latest findings on how cardiac events can be experiencing more obscured symptoms especially by women.

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

The following further expert advice was provided by RN Johnson-Bogaerts on 4 February 2020:

"I reviewed the letter of response from [RN C] and have not found anything to change the opinion provided.

Kind regards

Hilda Johnson-Bogaerts — Clinical Advisor — Aged Care
Office of the Health and Disability Commissioner"

The following further expert advice was provided by RN Johnson-Bogaerts on 12 April 2020:

"**1.** I think it would be a good idea to find out why the GP did not return the call or attend. Was the GP on call? or was the wrong GP called? The provider must make arrangements with a medical service to ensure on call emergency service. This information of who to ring must be available to the senior person on duty.

It is common practice that in the situation that the GP is not available the resident is referred to public hospital.

The consumer was clearly in distress. It would have been expected that the caregiver who rang the GP would have called the RN when the GP had not returned the calls within the hour. In the same scenario it is expected that the RN who is responsible for the clinical care would remain in close contact with the caregiver and ring back for an update within the hour.

2. Workload management:

The provider is responsible to provide sufficient staff to meet the health and personal needs of residents at all times.

When providing rest home level care only there is a requirement according to the ARC agreement that there is a RN on-call at all times. On call means that the person is available to attend the need of any resident within 20 min after being notified.

In the case that the provider/owner is the only RN it would be good practice to have a staffing plan in place for those times one cannot attend within 20 min. This could be through the use of bureau staff or employment of RN.

Sole RN competence management:

Being the only RN and having sole responsibility for clinical care in the care home, it would be good practice to have an arrangement with a colleague for peer reciprocal supervision or to be part of a forum for professional and clinical supervision. Supervision is an important component for nurses or any health practitioner working in isolation, to ensure quality care of their patients. It could be described as a regular meeting with a peer/peers for reflection and learning. During such meetings there is a process of review, reflection, critique of clinical care and replenishment/keeping abreast of new developments.

Hope this answers the questions you had.

Kind regards

Hilda Johnson-Bogaerts — Clinical Advisor — Aged Care
Office of the Health and Disability Commissioner"