HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Failings in management of acute deterioration of aged care resident's health

## Executive summary

1. Mrs A started living at Bethesda Care and Retirement Village (Bethesda) in Auckland in May 2018 and was receiving hospital-level care. On 24 June 2022, Mrs A's daughter complained that Mrs A's care was not escalated by Bethesda staff between 10 and 19 June 2022 when she experienced a deterioration in her health and multiple infections and had to be transferred to Middlemore Hospital.

2. Mrs A was discharged from hospital to Bethesda on 29 June 2022 with a primary diagnosis of cellulitis (a potentially serious bacterial infection of the deeper layers of the skin) on her right leg and a secondary diagnosis of cystitis (inflammation of the bladder from bacterial infection).

3. I have found that, when Mrs A experienced an acute deterioration in her health on 13 June 2022, registered nurses (RNs) at Bethesda did not document the completion of a full assessment for sepsis or acute cellulitis as required by the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (the Standard)[1] and Bethesda's 'Acute Deterioration Frailty Care Guides' (the Guides). This included assessing vital signs, hydration, delirium, and pain and reviewing care goals with the resident and her family after the assessment. In addition, on 13 June 2022, Bethesda staff should have discussed Mrs A's treatment options and the risks and benefits of her being transferred to hospital. In failing to document a full assessment and discuss treatment options, Bethesda breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), which states that consumers have the right to have services provided with reasonable care and skill.

4. I have also made an adverse comment about the oversight provided by RNs to Enrolled Nurses (ENs) caring for Mrs A and made an educational comment on the standard of communication by RNs when escalating clinical concerns regarding Mrs A's condition to Bethesda's General Practitioner (GP).

## Recommendations

5. Bethesda has advised the Health and Disability Commissioner (HDC) that it has reflected on the care provided to Mrs A and has implemented the following changes since this event:

   - hired more permanent staff, including RNs and healthcare assistants (HCAs), reducing its reliance on casual and agency nurses;
   - implemented a continuous training and education plan for nursing staff. As at February 2026, five nursing staff had attended a clinical assessment course to strengthen their assessment and clinical decision-making skills;

[1] https://www.standards.govt.nz/shop/nzs-81342021. These standards set out the foundations required to achieve safe, high-quality health and disability services and are applied to the residential aged care sector.

*Names have been removed (except Bethesda Care and Retirement Village and the clinical advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

- implemented a formal on-call support system whereby a clinical manager or clinical coordinator is available 24/7 to assist nursing staff with emergencies and complex clinical decisions;
- nursing staff are more confident and proactive in contacting the GP when urgent situations arise. In addition, the expectation that residents requiring antibiotics need to be referred to the GP in a timely manner and that they must follow up with the GP within the same shift if they have not received a response has been reinforced with staff; and
- strengthened nursing capability in recognising and responding to acute deterioration, including use of the Guides and a sepsis screening tool. This includes completing a thorough clinical assessment, discussing goals of care with the resident's family (including hospitalisation versus palliative/comfort care) and consulting with the GP for further advice and management.

6. I acknowledge and support these changes and recommend that Bethesda:

a) Provides education to staff on appropriate escalation processes for acute deterioration in residents. This should include training on the following topics:

i. the STOP and WATCH tool.[2]

ii. escalation of clinical concerns to RNs; and

iii. the use of the ISBAR tool[3] when escalating concerns to Bethesda's GP.

Bethesda is to provide evidence of education occurring on the above topics in the form of education materials and staff attendance records, including the percentage of staff who have attended training sessions. This education is to be completed, and the relevant evidence forwarded to HDC, within six months of the date of this report.

b) Use an anonymised version of this case for wider education of ENs and RNs. The case study presentation should detail the actions/decisions taken and highlight the importance of oversight that RNs are required to provide to ENs in situations of acute deterioration of a resident's health. Evidence confirming the content and delivery of the presentation is to be provided to HDC within six months of the date of this report.

[2] The Stop and Watch tool encompasses the following: S – Seems different than usual; T – Talks or communicates less; O – Overall needs help; P – Participates less in activities; A – Ate less, difficulty swallowing medication; N – No bowel motion >three days, diarrhoea; D – Drank less; W – Weight change; A – Agitated or more nervous than usual; T – Tired, weak, confused or drowsy; C – Change in skin colour or condition; H – More help walking, transferring, toileting.

[3] ISBAR stands for Identification, Situation, Background, Assessment and Recommendation. The ISBAR tool is used to create a structured approach to communication between healthcare workers. It is useful when reporting changes or deterioration in a patient's health and can be used when changing over shifts or transferring between health services.

## Background

*Relevant medical history*

7. Mrs A was aged 77 at the time of the events and had multiple comorbidities, including a history of recurrent urinary tract infections (UTIs) and chronic oedema (swelling caused by a build-up of fluid in the body's tissues) in both legs, and had also previously experienced suspected cellulitis of the right leg. These conditions had previously been managed effectively by staff at Bethesda.

8. Mrs A's medical history also included a cerebrovascular accident/stroke, which occurred in 2018 and affected her speech and mobility; hypertension (high blood pressure); and type 2 diabetes mellitus. Mrs A required one person to assist her with activities of daily living.

9. Mrs A had a long-term care plan and an advance directive, which had been updated in May and June 2022, but no enduring power of attorney (EPOA) for her personal care and welfare.[4] Mrs A's documented wishes were to be kept comfortable at Bethesda once she needed end-of-life care, to avoid hospitalisation if her health deteriorated, and that she was 'not for resuscitation'. Mrs A's family was regularly involved in her care and were aware of these documents; her long-term care plan noted that they respected her wishes.

*Summary of events from 10 to 19 June 2022*

10. On the morning of Friday 10 June 2022, Mrs A's daughter visited her at Bethesda and noticed that she was feeling unwell and her right leg had started to swell. The daughter raised her concerns with staff, who examined the swollen leg and attributed the swelling to Mrs A's history of oedema. This assessment was not documented.

11. On 11 and 12 June 2022, progress notes state that Mrs A was eating and drinking normally, participating in activities of daily living, and generally stable and well. No concerns were noted.

<u>Monday 13 June 2022</u>

12. On the morning of 13 June, Mrs A's care was overseen by an EN. Before lunch, an HCA noticed that Mrs A was shivering and complaining of feeling cold. This was escalated to the EN, who took Mrs A's temperature, which was 37.5°C (normal).[5] Mrs A was given Panadol, and her temperature reduced to 36.2°C. At 12.45pm, another HCA alerted the EN that Mrs A was still shivering. At this point, Mrs A's blood pressure was noted as 159/85mmHg (normal),[6] but the shivering meant her pulse could not be taken, and her respiratory rate was not measured. Progress notes indicate that Mrs A also appeared

[4] An advance directive is a legal document that outlines a person's preferences for medical and health care and designates a person to make such decisions on their behalf if the person is unable to communicate their wishes. It does not bind healthcare providers. An EPOA is a legal document that allows a person to appoint someone they trust to make personal care and welfare decisions on their behalf if they become unable to make such decisions due to illness, injury or cognitive decline. This does legally bind healthcare providers.

[5] Normal body temperature is around 37°C.

[6] For most people, ideal blood pressure is 120/80mmHg. High blood pressure is a reading of 140/90mmHg or higher, and low blood pressure is a reading of 90/60mmHg or less.

confused and was assisted by two RNs during an episode of vomiting. Lower abdominal pain, frequent urination, and smelly urine were also documented.

13. Bethesda said ENs are responsible for observing, documenting and supporting a resident, whereas RNs are responsible for decision-making, clinical assessments, and escalation of concerns. It said that RNs, including a clinical coordinator, directly assisted the EN with Mrs A's care, which was documented. Clinical records do not indicate what clinical assessments the RN and clinical coordinator undertook. The progress notes do not include a record of an RN completing an assessment of Mrs A, as outlined as necessary in Bethesda's Guides. This would have included taking additional observations such as oxygen saturation and respiratory rate, reviewing hydration status, assessing for delirium and reviewing pain using the OLDCART tool.[7] The Guides state that, once this assessment is completed, goals of care should be reviewed and the resident and their family asked what they want to happen, including preferences around hospitalisation. A plan can then be developed based on the assessment and discussion.

14. The EN contacted Mrs A's daughter to inform her of Mrs A's condition. The daughter raised concerns about Mrs A's legs and the risk of cellulitis and requested that she be seen by Bethesda's GP, Dr B, on his usual Wednesday rounds (two days later).

15. On the afternoon of 13 June, Mrs A's care was handed over to an RN, who was informed she had been unwell that morning. Mrs A's temperature had increased again to 39°C (high), and the RN gave her a cold wash to help reduce her temperature. Although Mrs A was no longer shivering at this point, a note was made to continue monitoring her temperature throughout the day. A urine dipstick was performed in the evening, which indicated a UTI. A urine sample was taken and sent to the laboratory to confirm this finding. Mrs A's right leg was also observed to be red and swollen. She was given codeine for leg pain, and her leg was elevated in bed to reduce the swelling. The RN then updated Dr B, although clinical notes do not record what information was conveyed to him at this time or whether the ISBAR tool was used to communicate with him. Dr B told HDC that he queried whether Mrs A had an infection and planned to review her on 15 June.

16. Overnight, Mrs A reported pain, and Panadol was administered. Her temperature was recorded as 37.1°C (normal). No other concerns were noted.

<u>Tuesday 14 June 2022</u>

17. On 14 June, Mrs A continued to report feeling unwell, including experiencing persistent leg pain, shivering, and nausea. Her right leg continued to be red, swollen, and warm to the touch, and she had a temperature of 38.9°C (high), and staff informed Dr B. Again, no ISBAR tool was used to communicate with Dr B, and further RN assessment in accordance with the Guides did not occur. Panadol and codeine were given to manage Mrs A's fever and pain. In addition, Dr B charted trimethoprim (an antibiotic) in response to the likely UTI. Vital signs recorded at 2.42pm show that Mrs A's temperature had reduced to 37.5°C (normal), pulse was 80 beats per minute (bpm) (normal), blood

[7] OLDCART is a symptom evaluation tool that stands for O – Onset, L – Location, D – Duration, C – Character, A – Aggravation or associated symptoms, R – Relievers, T – Treatment.

pressure was 120/60mmHg (normal), oxygen saturation was 98% (normal),[8] and respiratory rate was 20 breaths per minute (normal).[9] She remained in bed and had reduced food and fluid intake over the day.

18. A short-term care plan and infection log were created for the management of Mrs A's suspected UTI, which advised staff to administer the antibiotic and encourage Mrs A to drink more fluids. Staff were also advised to elevate Mrs A's legs.

19. Mrs A's daughter was updated with the above information and that Dr B would see Mrs A the following day as planned; however, no discussions regarding Mrs A's advanced care wishes or the risks and benefits of hospital transfer were documented. Bethesda noted in their response to HDC that several factors influenced their decision to initially manage Mrs A's infections on site: her previously stated wishes to avoid hospitalisation, her history of having similar conditions managed effectively at Bethesda, the presence of COVID-19 in the community, and the risk of catching COVID-19 in hospital.

20. In the late evening, the RN noted that Mrs A was in an 'unstable' condition, with pain in her right lower leg, which was also 'very red, swollen and warm' to touch. Codeine was given to Mrs A for her pain, and antibiotics were administered for her infection. Her temperature was recorded as 36.9°C (normal), but no other vital signs or assessment findings were recorded.

*Subsequent events – 15 to 29 June 2022*

21. At 3am on the morning of 15 June, Mrs A was noted as being 'comfortable' and 'settled'. Between 15 and 18 June, Mrs A's health fluctuated, and Bethesda staff continued to monitor her.

22. On Wednesday 15 June, Dr B examined Mrs A and noted that she had been experiencing confusion over the previous 24 hours but that she was alert and had good food intake at the time of assessment. Mrs A's temperature was recorded as 37.5°C (normal). Dr B diagnosed Mrs A with cellulitis of the right calf and requested another urine sample be taken and sent to the laboratory, which was done in the afternoon. Dr B then changed Mrs A's antibiotic to flucloxacillin, as he stated in his response to HDC that this was a more effective antibiotic for cellulitis. An RN created a short-term care plan for the management of Mrs A's cellulitis, and this advised staff to administer flucloxacillin.

23. Also on 15 June, another RN called Mrs A's daughter to update her on Mrs A's condition and to let her know that Dr B had prescribed her stronger antibiotics. Again, no discussions occurred regarding potential hospitalisation.

24. Progress notes record that Mrs A generally ate and drank well over the next few days and participated in activities. However, she continued to report feeling unwell, and staff observed that her right leg was still swollen, red, painful, and warm to the touch. Mrs A

[8] For most people, a normal blood oxygen level is 95–100%; anything below 95% is considered low.
[9] Normal respiratory rates for an adult at rest are between 12 and 16 breaths a minute. Fewer than 12 breaths or more than 25 breaths per minute while resting is considered abnormal.

was given further medication to manage her symptoms, including Panadol and codeine, as well as the flucloxacillin.

25. On Friday 17 June, Bethesda received the laboratory results for Mrs A's urine test. The results showed growth of bacteria. Dr B stated in his response to HDC that he was not advised of the results of the urine test on 17 June but was not surprised at this because Mrs A appeared at the time to be 'clinically improved'. He also stated that his prescribed course of treatment and choice of antibiotic would have remained the same even if he had been made aware of the results at the time because he had not received correspondence from Bethesda staff suggesting Mrs A was still experiencing urinary symptoms. Dr B advised that using antibiotics to treat asymptomatic bacteriuria[10] in older patients is rarely appropriate according to the Best Practice Advocacy Centre guidelines.[11]

26. On the morning of Sunday 19 June, Mrs A complained of leg pain. An RN contacted Dr B and requested liquid morphine be charted. At 1pm, Mrs A was noted to be experiencing chills and rigors.[12] Vital signs taken at this time showed Mrs A had a temperature of 37.3°C (normal), heart rate of 111 bpm (high), respiratory rate of 28 breaths per minute (high), and oxygen saturation level of 92% (low). At 1.30pm, her temperature had risen to 38°C (high), heart rate was 108 bpm (high), respiratory rate was 24 breaths per minute (high), and oxygen saturation was 93% (low). Mrs A was administered Panadol, and an EN contacted Mrs A's daughter to update her on Mrs A's condition. The daughter requested that Mrs A be transferred to hospital. The EN contacted Dr B, who agreed that Mrs A should be transferred to hospital, and an ambulance was called at 2.06pm. While waiting for the ambulance to arrive, an EN monitored Mrs A, and she was given codeine and 4L of oxygen therapy to maintain oxygen saturation levels.

27. The ambulance arrived at 4.37pm to transfer Mrs A to Middlemore Hospital. She was admitted with a primary diagnosis of right leg cellulitis and a secondary diagnosis of cystitis. Mrs A was treated with intravenous antibiotics and discharged to Bethesda on 29 June 2022.

**Responses to provisional opinion**

28. Mrs A's daughter was given an opportunity to comment on the 'background' section of the provisional opinion but, to date, has not done so.

29. Bethesda was given an opportunity to comment on the provisional opinion, and its comments have been incorporated into the report where relevant.

30. In their response, Bethesda emphasised the mitigating factors, outlined above, that influenced their approach to caring for Mrs A when she became unwell and that their

[10] The presence of bacteria in the urine without any urinary symptoms.

[11] A pragmatic guide to asymptomatic bacteriuria and testing for urinary tract infections in people over 65 - Best Tests July 2015.

[12] A sudden feeling of cold with shivering, accompanied by a rise in temperature, often with copious sweating, especially at the onset or height of a fever.

decision to manage her infections on site in the first instance was based on prioritising her wishes and wellbeing.

31. Bethesda also noted that Mrs A had no EPOA in place at the time of the events and that this could make it challenging to make decisions about Mrs A's care. Although Mrs A's daughter was the primary family contact involved in decision-making when Mrs A was unwell from 10 to 19 June 2022, other family members were also involved in her care at other times and later expressed differing views on how Mrs A's care was managed over this period.

**Analysis**

32. Bethesda is responsible for providing services in accordance with the Code. Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill. I have sought advice from in-house aged care advisor, Ms Hilda Johnson-Bogaerts, to determine whether Bethesda breached the Code (see **Appendix A**).

*Assessment of Mrs A's condition: Bethesda – breach*

33. There is a concern as to whether Mrs A was appropriately assessed on 13 and 14 June 2022 when she experienced an acute deterioration in her health.

34. Criteria 3.2.4 and 3.2.5 of the Standard stipulate that providers are responsible for ongoing assessments when a consumer's health changes.

35. Ms Johnson-Bogaerts advised that severe shivering and feeling cold are signs of sepsis and require further investigation. Ms Johnson-Bogaerts expressed concern that, when Mrs A was showing these symptoms on 13 June 2022, along with symptoms of a UTI and cellulitis, the RN did not appear to follow Bethesda's Guides and investigate further for indicators of sepsis or acute cellulitis.

36. The first step in the Guides is 'STOP and WATCH', which outlines several signs to look for in residents to recognise acute changes in health. If these signs are observed, the next step in the Guides is for an RN to perform an assessment and review, which includes taking observations and consulting the sepsis screening tool to review warning signs indicating serious illness or sepsis. Once this has been done, the RN is to consult with a GP or Nurse Practitioner (NP) using the ISBAR tool to report findings.

37. The Guides do not outline the number of signs that need to be observed to trigger the RN to perform a further assessment and review. However, the progress notes from 13 June 2022 indicate that, along with shivering and feeling cold, Mrs A also exhibited some of the signs listed under 'STOP and WATCH', which indicated acute deterioration. These included eating and drinking less than normal and appearing confused. She also showed symptoms of infection (UTI and cellulitis) and had vomited.

38. Bethesda noted that Mrs A was not diagnosed with sepsis after being transferred to Middlemore Hospital. However, this information is known in hindsight. When Mrs A was unwell on 13 June, it was not confirmed that she did not have sepsis.

39. When Mrs A was first observed shivering and feeling cold, an HCA alerted an EN, who took Mrs A's temperature. Later in the afternoon, another HCA alerted the EN and RNs that Mrs A was still shivering and appeared unwell. At this point, her vital signs were taken but the progress notes only include blood pressure and temperature records (and a note that the pulse could not be taken because of the shivering). Other vital signs listed under the RN review in the Guides, such as respiratory rate, were not taken. In addition, the RN did not follow the assessment pathway in the Guides, such as reviewing Mrs A's hydration status, assessing for delirium, reviewing pain levels (although pain medication was given as required), or reviewing goals of care (which is discussed later in this report).

40. On 14 June 2022, Mrs A continued to show signs of acute deterioration, including shivering, nausea, and a high temperature. Progress notes recorded at 12.58pm state that Mrs A was shivering and had a temperature of 38.9°C (high). The RN who recorded these observations did not document any further assessment or vital signs. This was a second opportunity to follow the Guides and perform a full assessment of Mrs A, and this opportunity was again missed.

41. For the above reasons, I accept Ms Johnson-Bogaerts's advice that RNs failing to document a complete assessment of Mrs A for sepsis or acute cellulitis, in accordance with the Standard and Bethesda's Guides, on 13 and 14 June 2022 represents a moderate to significant departure from accepted standards of care.

*Timeliness of Mrs A's transfer to hospital: Bethesda – breach*

42. Mrs A's daughter expressed concern in her complaint to HDC that Mrs A was not transferred to hospital before 19 June 2022.

43. Bethesda stated that the decision not to transfer Mrs A to hospital on 13 June 2022, when she first became unwell, was made based on her documented wishes to avoid hospitalisation unless absolutely necessary and to be cared for and kept comfortable at Bethesda. Additionally, Bethesda said Mrs A's symptoms were consistent with her previous history of UTIs and cellulitis, which had been effectively managed by Bethesda staff. Bethesda also noted the high levels of COVID-19 in the community at the time of the events. They said that, in June 2022, aged care facilities were encouraged to care for residents on site wherever possible to reduce their risk of catching COVID-19 in hospital. Each of these factors were important considerations when staff were making decisions about Mrs A's care and meant that caring for her at Bethesda, in accordance with her wishes and guidance to the sector at the time, was a priority.

44. Ms Johnson-Bogaerts acknowledged that Mrs A's documented wishes to avoid hospitalisation were a significant consideration in decisions about her care. However, Ms Johnson-Bogaerts noted that her wishes related to end-of-life care. In practice, an important distinction is often made between a 'gradual or terminal deterioration where the focus is on comfort and palliation' and 'acute, potentially life-threatening conditions that may be reversible or partially reversible with timely medical intervention'. On 13 June 2022, when Mrs A's health declined, it would have been clinically appropriate to assess whether this was a potentially reversible illness where hospital treatment would be beneficial or 'a deterioration consistent with end-of-life care'. Ms Johnson-Bogaerts

noted that such assessments are complex and require shared decision-making and discussion, and clinical judgement.

45. Acknowledging Mrs A's communication difficulties, Ms Johnson-Bogaerts stated that she would have expected RNs caring for her on 13 June 2022 to have had a discussion with her and her family that was then documented. This conversation would have outlined their clinical assessment of Mrs A's condition, the risks and benefits of transfer to hospital, and how to approach the situation in relation to her previously stated wishes to avoid hospitalisation. Other factors that influenced Bethesda's decision-making regarding hospitalisation, including previously managing similar episodes at Bethesda and the risk of Mrs A catching COVID-19 in hospital, could also have been discussed with her family. There is no documented evidence of such a conversation taking place. If it had, this would have provided an opportunity to review Mrs A's wishes regarding hospitalisation considering her condition at the time.

46. As noted above, a full assessment of Mrs A's condition in accordance with the Standard and Bethesda's Guides is not documented as having been completed on 13 June 2022 when Mrs A's health deteriorated. This suggests that Bethesda staff did not fully appreciate the seriousness of Mrs A's condition and consider that hospital care may be required. This failure to appreciate the seriousness of Mrs A's condition can be seen again on 19 June 2022 when, despite several of her vital signs being outside of normal range, it was Mrs A's daughter, and not an RN, who suggested Mrs A be transferred to hospital.

47. I acknowledge that Bethesda's staff were considering her previously expressed wishes and risk to her health of being transferred to hospital in the context of COVID-19 in the community in 2022 and took steps to manage her condition on site as outlined in this report. However, I accept Ms Johnson-Bogaerts's advice that Mrs A's wishes related to end-of-life care and that the timeliness of Mrs A's transfer to hospital represents a moderate departure from the accepted standard of care. Bethesda staff should have discussed Mrs A's treatment options and the risks and benefits of her being transferred to hospital on 13 June 2022. Mrs A was reported to be experiencing confusion on 13 June 2022. If she was unable to fully engage in such a conversation, a conversation could have been had with her family, who were regularly involved in her care.

<u>Finding</u>

48. For failing to comprehensively assess Mrs A on 13 and 14 June and discuss the risks and benefits of hospitalisation with Mrs A or her family, I find that Bethesda breached Right 4(1) of the Code.

*Clinical oversight of ENs: Bethesda – adverse comment*

49. In her advice, Ms Johnson-Bogaerts noted that, although ENs caring for Mrs A on 13 June 2022 appropriately documented her concerning symptoms once they were alerted to them by an HCA, the records do not show these being escalated to an RN until later in the day. Mrs A was observed shivering and feeling cold before lunch time. RN oversight is not mentioned in the progress notes until 12.45pm when Mrs A was assisted by two RNs because she had vomited. Progress notes recorded at 3.42pm by the RN show that she was updated on Mrs A's condition as part of the afternoon handover.

50. In the EN job description that Bethesda provided to HDC, the key tasks and duties include 'undertaking the preliminary aspects of health assessments under guidance of a registered nurse' and 'understands the enrolled nurse role and boundaries in relation to scope of practice within the registered nurse's delegation.' The job description for RNs includes 'demonstrates accountability for directing, monitoring and evaluating nursing care that is delegated to ENs and HCAs.'

51. Ms Johnson-Bogaerts stated that the 'lack of evidence of timely escalation to an RN and the apparent delay in RN clinical oversight' indicates that supervision of ENs on 13 June 2022 was 'not optimal'. Ms Johnson-Bogaerts advised that this was a moderate departure from the accepted standard of care and has suggested reinforcing escalation expectations for ENs when they observe acute deterioration in residents.

52. In their response to HDC, Bethesda emphasised that RN oversight did occur when Mrs A became unwell on 13 June 2022, despite a lack of explicit documentation of RN assessment and instructions provided to ENs.

53. In my view, it appears that, on 13 June 2022, RNs were aware of Mrs A's deterioration as evidenced by the support they provided to her. Therefore, this indicates that the care was escalated and some RN oversight was provided. However, I agree with Ms Johnson-Bogaerts that the level of clinical oversight provided to the ENs was insufficient. This is evidenced by a lack of documented RN assessment (as discussed above) and a lack of evidence around what instructions were provided to the EN around monitoring Mrs A. Therefore, I am critical about the level of EN oversight on 13 June 2022.

*Escalation of clinical concerns to Dr B —educational comment*

54. Ms Johnson-Bogaerts advised that the communication between Bethesda staff and Dr B regarding Mrs A's condition on 14 June 2022 represented a mild departure from accepted practice. The email to Dr B included in the progress notes mentions that Mrs A appeared unsettled, had a temperature of 38.9°C and was observed shivering. It mentions that she is prone to UTIs and had a dipstick test that showed '+ leukocytes.' The email requests antibiotics to be charted in MediMap. This email refers to an earlier email that was sent to Dr B on 13 June 2022 regarding Mrs A's condition but not included in the progress notes.

55. Although Ms Johnson-Bogaerts acknowledged that an email was sent to Dr B to update him on Mrs A's condition, the information included in the email was limited and may not have allowed Dr B to fully understand Mrs A's condition. A structured communication tool such as the ISBAR is recommended for escalating information on a resident's condition to a clinician, particularly when their health has deteriorated and communication is time sensitive. Use of the ISBAR tool supports relevant clinical information to be communicated in a clear and structured way.

56. I accept Ms Johnson-Bogaerts's advice and note that she recommends that good clinical practice in residential aged care settings is to use a structured communication framework such as the ISBAR tool to escalate clinical concerns to a GP or other clinician. I encourage Bethesda to consider embedding this in their practice and ensuring staff are confident using the ISBAR tool.

**Conclusion**

57. For the reasons outlined above, I consider that Bethesda has not provided services to Mrs A with reasonable care and skill. Accordingly, I find Bethesda in breach of Right 4(1).

58. I make an adverse comment regarding the oversight RNs provided to ENs.

59. I make an educational comment regarding Bethesda's standard of communication when escalating clinical concerns to Bethesda's GP.

**Distribution**

60. A copy of this report with details identifying the parties removed, except Bethesda Care and Retirement Village and the clinical advisor, will be sent to HealthCERT at the Ministry of Health and Health New Zealand | Te Whatu Ora Counties Manukau and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
**Deputy Health and Disability Commissioner**

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

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

## CLINICAL ADVICE – AGED CARE

**CONSUMER** : [Mrs A]

**PROVIDER** : Bethesda Care and Retirement Village

**FILE NUMBER** : C22HDC01543

**DATE** : 10 December 2023

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Bethesda Care and Retirement Village. 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. Specifically, I have been asked to review the provided clinical documentation and advise:
    a. whether on 13 June 2022, when [Mrs A] presented with symptoms of acute deterioration, this was appropriately managed and escalated to the GP
    b. if the June 2022 COVID-19 restrictions in the facility are considered to be appropriate in the circumstances, specifically in terms of resident–family interactions.

3. **Documents reviewed**
    - Provider response dated 23 August 2022 and 23 June 2023
    - Progress notes, Physio notes
    - Lab test results
    - Resident information
    - Policy acute deterioration (frailty care guides)

4. **Review of clinical records**

    At the time of the events [Mrs A] was a 77-year-old resident at Bethesda where she lived since May 2018 to receive hospital-level care. Her medical history includes STEMI [ST-elevation myocardial infarction; heart attack] 2018, atrial fibrillation, cerebrovascular accident, hypertension, diabetes, and frequent UTI. [Mrs A] was assessed as having an unsteady gait and would mobilise using an electric chair during the day and a wheelchair in the afternoon. She would also mobilise using a gutter walking frame with the assistance of one person.

    **Appropriateness of management of acute deterioration**

    The physio review notes from 17 May 2022 include that [Mrs A] reported to have leg cramps and swelling of lower limbs but no redness and no elevated

temperature. Tight hamstrings meant that the physio recommended range-of-motion exercises and stretches in bed and for the nurse to review with the GP if ongoing magnesium would be indicated.
Reviewing the clinical notes by care staff of 12 June 2022, these are unremarkable and include no indication of being unwell, with normal food and fluid intake and participation in activities in the care home.

The notes of 13 June 2022 include that, after a normal morning, [Mrs A] was observed shivering and complaining of feeling cold before lunch. Temp was 37.5°C, and after taking her regular Panadol was 36.6°C, urine was reported to be clear but smelly. [Mrs A] complained of leg cramping pain. Later there was an episode of vomiting and vital signs showed blood pressure of 159/85mmHg, temp 36.2°C, with the pulse not able to be taken due to shivering. The nurse's recommendation was to continue monitoring and collect urine. Family was notified and reported to be unhappy about the situation.

The afternoon nurse reported that temp after 3pm was reco[r]ded to be 39°C with a cold wash as intervention. The RN reported that [Mrs A] complained of pain in her lower abdomen as well as having a swollen and red leg. PRN [as needed] codeine was given for pain relief. The urine dipstick was positive for leukocytes, indicating a potential UTI. A urine sample was taken to be sent to the lab. The notes include that an email was sent to the GP – no response. Notes of 14 June 2022 include a similar situation with elevated temperature, shivering, and feeling cold, and that her leg was swollen and felt warm to touch as well as having symptoms of a UTI.

The provider forwarded their Policy for acute deterioration, which used the Health Quality & Safety Commission Te Tāhū Hauora frailty care guides.

Severe shivering and feeling cold is a sign of sepsis and needs further investigation by the RN for additional indications and to compare these with baseline. Indications of sepsis are a medical emergency needing immediate escalation to the GP/NP or contact with emergency services.

Additional observations to be taken and escalated include respiration rate, oxygen saturation, temperature, pulse, observation of skin colour and appearance, breathing, and alertness. It is best to assume sepsis and be wrong than to be cautious and miss sepsis because of its high mortality rate, with early intervention being key. When the RN escalates a sudden deterioration, it is good practice to use a handover tool such as ISBAR to communicate with the GP/NP and establish with the GP/NP the frequency of further monitoring and a threshold for further escalation. This should be accompanied by informing the resident and their family/EPOA about the situation and plan.

I am concerned that the RN who assessed [Mrs A] on 13 and 14 June 2022 did not investigate further to assess for indicators of acute cellulitis or sepsis when [Mrs A] was shivering severely and was feeling cold and showed symptoms of infections, both UTI and swollen red leg. They did not treat the situation with the

urgency it required. They did not follow the organisation's policy and adopted frailty care guide for acute deterioration.

In conclusion, I consider the management of the acute deterioration on 13 and 14 June 2022 to have been inadequate in terms of assessment of the situation, clinical critical reasoning, and medical escalation by the RNs. **My peers would consider, in the situation, the management of the acute deterioration to have been moderately to significantly deviating from accepted practice.**

**Appropriateness of COVID-19 restriction in place relating to family–resident interactions**

During June 2022 and until September 2022, New Zealand was in code orange of the COVID-19 protection framework (traffic lights). Aged care providers were to follow specific guidelines to ensure safety in aged care facilities. This included guidance for testing and isolation, the correct and safe use of PPE [personal protective equipment] and adhering to the six principles of safe visiting and social activities. Additional vaccination was strongly recommended (Six Principles for Safe Visiting and Social Activities in Aged Residential Care).

I did not find specific information on how Bethesda Care was managing visitors at the time in the provided documentation and recommend that the family concerns be compared with the required implementation of the six principles dated May 2022, which can be downloaded following the above provided link.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
**Nurse Advisor (Aged Care)**
Health and Disability Commission

On 23 December 2025, Ms Johnson-Bogaerts provided further advice at the request of HDC:

**Independent clinical advice to Health and Disability Commissioner**

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| **Complaint:** | **Mrs [A]/Bethesda Care and Retirement Village** |
| **Our ref:** | **22HDC01543** |
| **Independent advisor:** | **Ms Hilda Johnson-Bogaerts** |

I have been asked to provide clinical advice to HDC on case number **22HDC01543**. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

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| Qualifications, training and experience relevant to the area of expertise involved: | I am an RN with extensive experience in residential aged care, dementia care, end-of-life care, and clinical governance within the New Zealand aged care sector.<br><br>I hold a Master of Health Sciences, postgraduate qualifications in business administration, and a Certificate in Clinical Governance. My clinical and professional background includes senior leadership roles in aged care, with responsibility for clinical oversight, quality and risk management, workforce capability, policy development, and models of care. |
| Documents provided by HDC: | 1. Clinical advice dated 10 December 2023<br>2. Bethesda Care and Retirement Village's response dated 14 August 2025<br>3. Advanced Directive and progress notes for Mrs [A] covering the period 6 June 2022 to 19 June 2022<br>4. Long-term care plan for Mrs [A], including end-of-life care and hospitalisation preferences<br>5. Bethesda Care and Retirement Village Enrolled Nurse position description<br>6. Bethesda Care and Retirement Village RN position descriptions |
| Referral instructions from HDC: | 1. Does any of the new information provided change your initial advice? |

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| | 2. Did [Mrs A] need to be transferred to hospital on 13 June 2022, given her documented wish that she remain in the care home?<br>3. Was Mrs [A]'s care appropriately escalated to the GP?<br>4. Was there appropriate clinical oversight of Enrolled Nurses (ENs) that provided care to [Mrs A] on 13 June 2022?<br>5. Any other comments you wish to make. |

| **Question 1: Does any of the new information provided change your initial advice?** | |
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| List any sources of information reviewed other than the documents provided by HDC: | Nil |
| Advisor's opinion: | No. Having reviewed the additional information provided; my initial clinical advice remains unchanged. |
| What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material. | |
| Was there a departure from the standard of care or accepted practice?<br><br>• No departure;<br>• Mild departure;<br>• Moderate departure; or<br>• Severe departure. | |
| How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted. | |
| Please outline any factors that may limit your assessment of the events. | |
| Recommendations for improvement that may | |

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| help to prevent a similar occurrence in future. | |

| **Question 2: Did [Mrs A] need to be transferred to hospital on 13 June 2022, given her documented wish to remain in the care home?** | |
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| List any sources of information reviewed other than the documents provided by HDC: | Nil |
| Advisor's opinion: | In reviewing whether [Mrs A] required transfer to hospital on 13 June 2022, I have considered her documented advance care preferences, the nature of her acute presentation, and accepted nursing and clinical practice in residential aged care.<br><br>Mrs [A]'s long-term care plan includes a clearly documented preference relating to end-of-life care, namely her expressed wish not to be transferred to hospital should her health further deteriorate. Such preferences are an important component of person-centred care and should guide clinical decision-making.<br><br>However, the interpretation of "further health deterioration" requires careful clinical judgement and is context dependent. In practice, a distinction is often made between:<br><br>• gradual or terminal deterioration where the focus is on comfort and palliation, and<br>• acute, potentially life-threatening conditions that may be reversible or partially reversible with timely medical intervention.<br>On 13 June 2022, [Mrs A] experienced an acute infection that evolved or could evolve into a potentially life-threatening situation. In such circumstances, it is clinically appropriate to assess whether the acute condition represents an irreversible decline consistent with end-of-life care or whether it is a potentially reversible episode that may benefit from hospital-level assessment and treatment. This distinction is not always clear-cut and requires clinical reasoning, discussion, and shared decision-making.<br><br>In my view, I would have expected the RNs involved in Mrs [A]'s care to undertake a documented discussion with [Mrs A] and her family (acknowledging Mrs [A]'s communication difficulties), outlining their clinical assessment, the risks and benefits of hospital transfer, and how this situation was being interpreted in light of her previously stated wishes. Such a |

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| | conversation would support informed, person-centred decision-making and ensure alignment between the care team and the family.<br><br>I did not find evidence in the clinical documentation that such a discussion occurred, nor that there was documented agreement with [Mrs A] or her family regarding the interpretation of her advance care wishes in this specific acute context.<br><br>Additionally, it is my clinical experience that people's wishes regarding treatment and hospital transfer can change in the moment, particularly when faced with an acute illness that potentially is reversable. Best practice therefore includes revisiting advance care preferences when circumstances change, rather than relying solely on previously documented statements without reassessment.<br><br>In summary, while Mrs [A]'s documented preference not to be transferred to hospital is a significant consideration, the acute and potentially reversible nature of her condition on 13 June 2022 and the days following this warranted clear clinical reasoning, discussion, and documentation. The absence of evidence of such a process represents a gap in the clinical record and decision-making framework. |
| What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material. | In providing my advice regarding the decision to transfer [Mrs A] to hospital on 13 June 2022, I have considered the following relevant standards and professional guidance. I note that there is no single standard that prescribes when a resident must or must not be transferred to hospital; rather, expectations are derived from broader principles of clinical judgement, escalation, and person-centred care.<br><br>Health and Disability Services Standards (NZS 8134:2021) The *Ngā Paerewa Health and Disability Services Standard NZS 8134:2021* sets overarching requirements for safe, quality health and disability services. Relevant principles include:<br><br>• services being responsive to a consumer's changing health needs,<br>• care being planned and delivered in a manner that promotes safety and minimises harm, and<br>• consumers' preferences being respected within the context of clinically appropriate care. |

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| | While the standard supports the use of advance care planning, it does not remove the obligation on clinicians to respond appropriately to acute clinical deterioration.<br><br>Advance Care Planning guidance (New Zealand) **New Zealand advance care planning guidance describes advance care plans as tools to guide clinical decision-making, not as rigid directives**. The guidance recognises that clinical circumstances may arise that were not anticipated when preferences were documented, and that discussion, reassessment, and clinical judgement are required in such situations.<br><br>Nursing Council of New Zealand – Code of Conduct and Scope of Practice<br><br>The *Code of Conduct for Nurses* requires nurses to provide safe and competent care, recognise and respond to changes in a person's health status, and communicate effectively with consumers, families, and other health professionals.<br><br>The RN scope of practice includes responsibility for clinical assessment, decision-making, and escalation of care, including determining when a resident's needs exceed the capacity of the facility. |
| Was there a departure from the standard of care or accepted practice?<br><br>• No departure.<br>• Mild departure;<br>• Moderate departure; or<br>• Severe departure. | Moderate departure |
| How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted. | |
| Please outline any factors that may limit your assessment of the events. | |

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| Recommendations for improvement that may help to prevent a similar occurrence in future. | |
| **Question 3: Was [Mrs A]'s care appropriately escalated to the GP?** | |
| List any sources of information reviewed other than the documents provided by HDC: | |
| Advisor's opinion: | In considering whether escalation to the General Practitioner (GP) was appropriate, I reviewed the available clinical documentation, including the content of communication sent to the GP as per progress notes.<br><br>While an email was sent, the information contained within it was limited and did not clearly convey a comprehensive clinical picture of Mrs [A]'s condition at that time. Based on the documentation available, it is not evident that the GP received sufficient information to fully understand the progression or severity of Mrs [A]'s deterioration, nor the clinical concerns prompting escalation.<br><br>Good clinical practice in residential aged care requires that acute deterioration be escalated to a GP using a structured communication framework, such as the ISBAR tool (Identify, Situation, Background, Assessment, Recommendation). ISBAR supports clear, concise, and clinically relevant communication, particularly in time-critical situations, and assists the receiving clinician to make informed decisions regarding further assessment or treatment.<br><br>In this case, there is no evidence in the documentation that ISBAR, or an equivalent structured communication approach, was used when escalating Mrs [A]'s condition to the GP. The absence of a clear assessment, current observations, and explicit clinical concerns limits confidence that the escalation met expected standards of practice.<br><br>In summary, while escalation to the GP did occur, the quality and structure of the communication appear insufficient to ensure safe and effective clinical decision-making. The lack of documented use of a structured tool such as ISBAR, combined |

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| | with limited evidence of assessment and evaluation of treatment effectiveness, represents an area for improvement. |
| What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material. | As above |
| Was there a departure from the standard of care or accepted practice?<br><br>• No departure;<br>• Mild departure;<br>• Moderate departure; or<br>• Severe departure. | Mild deviation |
| How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted. | |
| Please outline any factors that may limit your assessment of the events. | |
| Recommendations for improvement that may help to prevent a similar occurrence in future. | Use of ISBAR tool to escalate and communicate to GP plus follow-up observations assessing the effectiveness of interventions with GP |
| **Question 4: Was there appropriate clinical oversight of Enrolled Nurses (ENs) that provided care to [Mrs A] on 13 June 2022?** | |
| List any sources of information reviewed other than the documents provided by HDC: | |
| Advisor's opinion: | In considering whether there was appropriate clinical oversight of the Enrolled Nurses (ENs) who provided care to [Mrs A] on 13 |

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| | June 2022, I reviewed the EN's clinical documentation in the progress notes, the RN notes, and the scope and responsibilities outlined in the EN job description.<br><br>The EN documentation records significant clinical observations, including elevated temperature, shivering, vomiting, and [Mrs A] appearing confused. These signs are consistent with acute clinical deterioration and are recognised red flags in older people, particularly in the context of suspected infection. The notes also indicate that family were notified, with documentation that Mrs [A]'s daughter was unhappy with the situation.<br><br>However, the EN notes from the morning shift do not indicate that these clinical findings were escalated to an RN at the time they were observed. There is no documentation demonstrating RN review, assessment, or direction in response to the symptoms recorded by the EN during that period.<br><br>The RN documentation later in the afternoon indicates that the RN received handover, suggesting that information was eventually transferred; however, this appears to have occurred after a period during which [Mrs A] was already exhibiting symptoms.<br><br>Reviewing the EN job description and scope of practice, the EN role includes providing competent and efficient nursing care while working under the supervision and direction of an RN. While ENs are expected to recognise and report changes in a resident's condition, responsibility for clinical assessment, decision-making, and escalation rests with the RN.<br><br>In my opinion, the clinical findings documented by the EN on the morning of 13 June 2022 warranted prompt escalation to, and review by, an RN. The absence of documented escalation or escalation for RN oversight represents a gap in clinical oversight and does not align with expected standards of practice in residential aged care.<br><br>In summary, while the EN appropriately documented concerning clinical observations, the lack of evidence of timely escalation to an RN and the apparent delay in RN clinical oversight indicate that supervision of the EN role on that day was not optimal. This represents an area for improvement, particularly in reinforcing escalation expectations and documentation when ENs identify acute deterioration in residents. |

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| What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material. | |
| Was there a departure from the standard of care or accepted practice?<br><br>• No departure;<br>• Mild departure;<br>• Moderate departure; or<br>• Severe departure. | Moderate departure |
| How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted. | |
| Please outline any factors that may limit your assessment of the events. | |
| Recommendations for improvement that may help to prevent a similar occurrence in future. | The absence of documented RN review and oversight in the presence of significant clinical symptoms indicates that expected supervision arrangements were not clearly demonstrated in the clinical record. This represents an area for improvement in ensuring that EN practice is appropriately supported by RN oversight, particularly during acute deterioration. |
| **Question 5: Any other comments you wish to make.** | |
| List any sources of information reviewed other than the documents provided by HDC: | |
| Advisor's opinion: | |

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| What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material. | |
| Was there a departure from the standard of care or accepted practice?<br><br>• No departure;<br>• Mild departure;<br>• Moderate departure; or<br>• Severe departure. | |
| How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted. | |
| Please outline any factors that may limit your assessment of the events. | |
| Recommendations for improvement that may help to prevent a similar occurrence in future. | |

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| By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged. |
| Name: Hilda Johnson-Bogaerts |
| Date of Advice: 23 December 2025 |