Bupa Care Services NZ Limited

A Report by the

Health and Disability Commissioner

(Case 15HDC00420)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A aged 77 years at the time of these events in 2014, was admitted to a rest home for one week of respite care. Mr A had been diagnosed with castrate resistant metastatic prostate cancer,[1] and had a long-term, large sized, urethral catheter in situ.

2. Prior to admission, staff from Needs Assessment and Support Coordination (NASC) gave information to the rest home that set out that Mr A had ongoing issues with his catheter blocking, which would require hospital-level care, and that he had a large bladder mass severely obstructing urine flow.

3. Mr A was previously known to the rest home, having spent 11 nights there for respite care several months earlier. A short stay nursing assessment and support plan had been completed for Mr A in at that time, but this was not updated on his next admission, nor was a specific catheter care plan initiated.

4. At approximately 9pm on the day he was admitted (Day 1[2]) Mr A complained of dysuria.[3] A nurse noticed that his catheter had not drained any urine and performed bladder irrigation. This expelled blood clots and the catheter began draining well.

5. Around 1am on Day 2 Mr A complained of pain and was given pain relief. At 4.45am caregivers reported to the nurse that Mr A's urine was bypassing the catheter and was "bleeding a little". The nurse noted that no urine had drained into the catheter bag since 1am. She attempted bladder irrigation without success, and therefore removed Mr A's catheter. The nurse said that she did not attempt to recatheterise Mr A because blood was evident and the clot was on the tip of the catheter. There was also no correct sized catheter in stock at the rest home.

6. Mr A vomited during the morning shift on Day 2. The nurse recorded that she witnessed Mr A passing a "reasonable" amount of urine. At 4pm a nurse inserted a correct sized catheter, which Mr A's daughter had supplied. A small amount of urine passed. Mr A continued to pass low levels of urine. He refused dinner and drank minimal fluids. No formal fluid balance monitoring occurred. Mr A experienced abdominal pain overnight. He was provided pain relief and bladder irrigation, which drained a small amount of urine.

7. On the morning of Day 3 Mr A vomited on several occasions. His low urine output continued. That afternoon Mr A's daughter, who had been expressing concerns about her father's deterioration, took her father to hospital. He was admitted and diagnosed with hyponatremia[4] and acute kidney injury, secondary to bladder obstruction and dehydration. Mr A's condition was managed with bladder irrigation, intravenous hydration and blood transfusion. Sadly, Mr A died in hospital on Day 7. The cause of death was presumed myocardial infarction (heart attack) resulting from his underlying prostate cancer.

[1] Where cancer has spread to parts of the body other than the prostate and therefore cannot be treated with hormone therapy or by surgically removing the testicles.
[2] Relevant dates are referred to as Day 1-7 to protect privacy.
[3] Pain or difficulty urinating.
[4] A condition that occurs when the levels of sodium in the blood are abnormally low.

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Findings

8. Bupa Care Services NZ Limited breached Right 4(1)[5] of the Code of Health and Disability Services Consumers' Rights (the Code) as it failed in its duty to ensure that Mr A received services of an appropriate standard while at the rest home, in the following ways:

- Care management plans, namely the short stay nursing assessment and support plan, were not updated on admission to reflect Mr A's current clinical presentation.
- Appropriate plans were not established on admission to manage the regular and known problem of Mr A's catheter blocking.
- Bladder irrigation was performed several times without first seeking medical advice, as required by Bupa's policy, and without documenting the amount of saline fluid used.
- Mr A's catheter was removed without seeking medical advice, and he was not recatheterised promptly.
- No formal fluid balance chart was commenced, and the monitoring of Mr A's fluid balance was infrequent and inadequate.
- Concerns about Mr A's condition were not escalated to the on-call manager by nursing staff, and they did not seek medical advice.

Complaint and investigation

9. The Commissioner received a complaint from Mrs B about the services provided by the rest home to Mrs B's late father, Mr A. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mr A (dec) by Bupa Care Services NZ Limited from Day 1–Day 3.*

10. An investigation was commenced on 6 August 2015. This report is the opinion of Health and Disability Commissioner Anthony Hill.

11. The parties directly involved in the investigation were:

Mrs B	Complainant/consumer's daughter
Bupa Care Services NZ Limited	Provider

12. Further information was received from:

District health board	Provider
Medical centre	Provider
District nursing service	Provider
RN C	Provider/Clinical Manager
RN D	Provider/registered nurse
RN E	Provider/registered nurse

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

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RN F	Provider/registered nurse
RN G	Provider/registered nurse
RN H	Provider/registered nurse
RN I	Provider/registered nurse

13. Others mentioned in this report:

Ms J	Needs assessor

14. In-house nursing advice was obtained from registered nurse (RN) Dawn Carey (**Appendix A**).

Information gathered during investigation

Background

15. Mr A, aged 77 years at the time of these events, was taken to the rest home for one week of respite care. Previously Mr A had been diagnosed with castrate resistant metastatic prostate cancer, and had a long-term size 20 French urethral catheter in situ.[6]

16. The rest home is a facility owned and operated by Bupa Care Services NZ Limited (Bupa). It is funded through a district health board (the DHB). At the time of these events residents requiring either rest home or hospital level care were accommodated together at the rest home.

17. The region does not have an after-hours general practitioner (GP) service. Staff at the rest home are able to telephone a local GP practice and be transferred to an on-call nurse practitioner/registered nurse for advice. Bupa told Mrs B that when a resident's condition is considered serious, staff are expected to ring an ambulance.[7] It said that "when calling the [ambulance], staff are asked if the person's breathing is compromised or if it is life threatening. If the answer is no, the call is triaged …" Bupa said that depending on workload, it could take "up to several hours" for an ambulance to arrive.

Rest home staffing

18. With the exception of RN D, who had completed a competency assessment programme for overseas nurses in 2014, each of the nurses involved in Mr A's care had a number of years' nursing experience in the aged care sector in New Zealand and/or overseas.

19. Bupa advised that each of the nurses involved in Mr A's care had up-to-date competencies in catheter management and insertion.

[6] The French scale refers to the circumference of the catheter in millimetres. Any subsequent references to catheter size in this report refer to the French scale.

[7] This is reflected in Bupa's written policy, "Doctors — Contacting after hours", which states: "For **Urgent and unexpected medical events** — e.g. … acute illness — the GP/[nurse practitioner (NP)] should be contacted immediately (… informing the senior nurse first) … In some situations — (ie obvious fracture) OR at the discretion of the senior nurse an ambulance may be called immediately rather than the GP/NP."

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Relevant policies/procedures

20. Bupa has written policies in place for catheterisation and catheter care,[8] including procedure information sheets for bladder irrigation, male catheterisation and catheter removal. Regarding bladder irrigation, the policy states:

> "• Routine irrigation is not indicated due to the risk of increased infection and trauma to the bladder.
> - Bladder irrigation is carried out following consultation between medical and nursing staff.
> - The procedure is carried out by a Registered Nurse who is deemed competent in the procedure …"

21. The information sheet for bladder irrigation includes the instructions to "[c]hart the amount of fluid inserted and the amount and type returned".

22. Bupa's policy regarding fluid balance charts states:[9]

> "… Staff will commence a Fluid Balance Chart … where required … but always in the event [that] … [t]he RN is concerned about a resident/client's fluid intake and/or output …
>
> - It is the responsibility of the staff caring for the residents/clients to **accurately** complete the fluid balance chart during their shift
> - Registered nurses have overall accountability to ensure that care giving/[resident care assistant] staff are completing the fluid balance charts accurately during their shift
> - Registered nurses must regularly evaluate the need for on-going monitoring of fluid balance …" (Emphasis in original.)

23. Bupa said that, in all its care homes (including the rest home), the nurses are required to note to the oncoming staff and managers any issues or concerns about a resident. These are to be recorded in a book known as the "Facility Managers report". If a resident becomes unwell (or continues to be unwell), Bupa expects nursing staff to contact the on-call manager for advice.

Preadmission

24. A needs assessor, Ms J, contacted the rest home requesting that Mr A be given a bed at the rest home for one week. Mr A was previously known to the rest home, having spent 11 nights there for respite care several months earlier. Clinical Manager (CM) RN C (who is also a registered nurse) said that Ms J informed her that Mr A had ongoing issues with his catheter blocking, and that he had a pending oncology appointment. RN C told HDC that she was not informed of any specific changes in Mr A's clinical management, and was unaware that Mr A was in increased pain and passing blood clots, or that his catheter was size 20. However, the last record of Mr A's catheter size changing was prior to Mr A's first admission to the rest home, when the district nurse increased his catheter size from 16 to 20.

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[8] Last reviewed February 2012.
[9] The policy was last reviewed in December 2013.

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25. RN C said she recalls that the focus of her conversation with Ms J was around the ability of Mr A's daughter, Mrs B, to cope with her father's care at that time, and that admission to the rest home was to provide carer support. Ms J told RN C that Mr A would likely require hospital-level care, and she intended to present him to the DHB team for assessment prior to admission to confirm this. It was agreed that Mr A would bring a blister pack of his own medications for the week.

26. The Needs Assessment and Service Coordination (NASC) emailed information to the rest home prior to Mr A's admission. This included a urology clinic letter, which reported frequent haematuria,[10] clots and clot retention over the previous few weeks (which had largely been self-resolving), and that Mr A had a large bladder mass obstructing the right vesicoureteric junction (VUJ)[11] and severely narrowing the left VUJ. RN C told HDC that she accepted the referral based upon her prior knowledge of Mr A, her discussion with Ms J, and the written information provided by NASC. In response to the provisional opinion, RN C said that not all information was received prior to or at the time of accepting Mr A for admission, and the picture presented was not that of a deteriorating man.

27. On the evening prior to Mr A's admission, RN C faxed a request to Mr A's GP to complete a medication prescription sheet and provide Mr A's current medical history. This was provided by the GP on Day 1.[12] RN C told HDC that an email received from NASC the same day confirmed that Mr A required hospital-level care but that she did not get the impression from this information that Mr A was acutely unwell. RN C said that she may have seen this email after Mr A's admission that day, but the email would not have prompted further questioning at that point because he appeared well. None of the documentation sent to the rest home included specific guidance for staff on how to manage Mr A's catheter.

Admission to the rest home — Day 1

28. Mr A was admitted to the rest home in the afternoon.[13] The short stay nursing assessment and support plan documents from Mr A's previous admission were not updated. A catheter care plan was also not commenced at this time.

29. RN H was responsible for Mr A's care that evening. She said that Mr A ate dinner at 5pm, and she emptied 350 millilitres (mls) from his catheter bag at 7.30pm. At 9pm she went to check on Mr A. He complained of dysuria, and she noticed that his catheter had not drained any urine. RN G performed bladder irrigation[14] at RN H's request. The irrigation expelled blood clots and the catheter began draining well. RN G documented this in the progress notes, but her entry did not include the volume of saline used to perform the procedure. RN G said that she reported back to RN H and returned to the other residents she was caring for.

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[10] Blood in the urine.

[11] The vesicoureteric junction is the point at which the ureter enters the bladder.

[12] The initial medication prescription sheet provided did not match the medication Mr A brought with him. RN C said the anomalies were looked at by the GP, and an updated prescription sheet was provided.

[13] RN C told HDC that she was not on duty between Days 2-5 inclusive, and therefore was not involved in Mr A's care throughout this period. Her cover was provided by the facility manager.

[14] Manual bladder irrigation involves disconnecting the drainage bag from the catheter tubing and flushing saline through the tubing into the bladder via a catheter tipped syringe, and then drawing back the fluid. The process may also be termed "bladder washouts".

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RN H said she checked on Mr A at 10.50pm and noted that he was asleep. RN H also told HDC that Mr A's catheter was draining well.[15]

Day 2

30. At around 1am on Day 2, Mr A complained of pain. RN E said she gave Mr A 30mg codeine and 1g Panadol, which gave him slight relief, and also emptied his catheter bag, although she does not remember how much she emptied at this time. RN E advised that at 4.45am caregivers reported to her that Mr A had passed a lot of urine urethrally (ie, urine was bypassing the catheter) and was "bleeding a little". RN E said she checked and noticed that there had been no urine in the bag since she had last emptied it at 1am. RN E attempted bladder irrigation without success, and therefore removed Mr A's catheter, noting that it had a blood clot at the tip. The removal appeared to provide Mr A with instant relief. RN E documented this information in the progress notes at 5.30am. The entry does not include the volume of saline used for the bladder irrigation.

31. RN E told HDC that she did not attempt to reinsert a catheter because blood was evident and the clot was on the tip of the catheter. She said she looked through Mr A's nursing file prior to removing the catheter, but found no action plan for catheter care if it was blocked, and she did not telephone anyone for advice.

32. RN E said she helped Mr A shower at about 7am. He told her that it stung when he passed urine but that there was no pain like he had felt overnight.

33. RN D began her shift at 6.45am. She told HDC that it was a busy shift as it was a public holiday and she was the only registered nurse on duty (when normally there would be two on morning shift), and the residents had a number of visitors. However, an extra caregiver was on shift. RN D said that during handover RN E informed her of Mr A's abdominal pain, poor urine output and unsuccessful bladder irrigation, and that she had removed Mr A's catheter. RN D told HDC that they had a brief discussion about whether she would be able to replace the catheter, as she was the only registered nurse on duty. RN D does not recall whether RN E advised her that Mr A was catheterised with a size 20 urethral catheter or the reason for this.

34. RN D said that Mr A vomited his morning medications at breakfast. She assessed his vital signs at 9.45am and recorded them in the progress notes.[16] She also wrote that Mr A was "[passing] urine urethrally with no trouble [and the] PM RN [was] to catheterise if required".

35. RN D told HDC that she observed Mr A pass "a reasonable amount of urine" into a urine bottle, and recalls that there were blood clots present. She said that a caregiver later informed her that Mr A had passed urine and accepted fluids, and RN D checked Mr A before lunch and again witnessed him pass "a reasonable amount of urine" with no complaint of pain. These observations were not documented in the progress notes.

36. RN D told HDC that she had time to read Mr A's clinical notes after the lunch medication round, which was when she became aware that Mr A had prostate cancer and ongoing

[15] RN H's check of Mr A at 10.50pm is not recorded in the progress notes.
[16] Temperature 36.7°C, heart rate (HR) 84, respiratory rate (RR) 22 and blood pressure (BP) 128/78mmHg.

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problems of catheter blockage. RN D telephoned Mrs B at around 1.30pm and informed her that Mr A's catheter had blocked during the night and had been removed, and that Mr A had vomited that morning. RN D told Mrs B that the rest home did not have a size 20 catheter in stock. Mrs B recalls RN D saying that the next available size was only 14mm, and the nursing staff had chosen not to reinsert this size.[17] Mrs B had a spare size 20 catheter at her home, and told RN D that she would bring it in.

37. At around 2.30pm Mr A reported pain in his lower abdomen, and RN D administered codeine phosphate as prescribed. RN D finished her shift at 3.15pm. She told HDC that during the nursing handover she passed on information to the afternoon staff regarding Mr A's pain and the analgesia provided, that his catheter had been removed, and that she had not replaced it initially because he was passing urine "reasonably". She also told the afternoon staff about his urinary output, and that he had vomited, his vital signs were stable, he had eaten lunch, and that Mrs B would visit shortly to provide a size 20 catheter.

38. Mrs B arrived with the catheter during handover. Mrs B told HDC that she asked a nurse to reinsert the catheter but the nurse did not do so, saying that Mr A had been to the toilet that morning. Mrs B told HDC that she helped her father to the toilet but he was unable to pass urine and, on one occasion, he vomited violently over the floor.[18] RN F told HDC that it was nearing the end of handover when she was informed that Mr A had vomited. She went to his room immediately to assess his condition. RN F said that when she arrived, Mrs B had cleaned up most of the vomit and she was therefore unable to assess the amount and content of the vomit. At around 3.45pm RN F and Mrs B assisted Mr A to the toilet, but again he was unable to pass urine.

39. At 4pm RN F inserted the catheter that Mrs B had supplied, but only a small amount of urine passed. RN F told HDC that it took about five minutes for 10ml of urine to pass, at which time she inflated the catheter balloon and connected the drainage bag. RN F encouraged Mr A to drink fluids. Mrs B told HDC that she advised RN F several times that she would normally empty her father's catheter bag at least twice during the day, and "she felt things were not right". Mrs B also said she told RN F that her father had deteriorated visibly after he was admitted to the rest home. RN F documented in the progress notes: "Daughter [Mrs B] very concerned about [Mr A]."

40. Mr A did not eat his dinner that evening and refused other food; however, he tolerated his dinnertime medications. RN F said that at 6pm Mr A had passed 25ml of urine by catheter, so she filled his water jug and encouraged him to empty it by bedtime. She said Mr A reported that he was not in any abdominal discomfort. Mrs B said she left the rest home at 8.30pm and, before leaving, told RN F again that her father's catheter was not running as it had been normally.

41. RN F said that Mr A was checked several more times to monitor his urine drainage and, each time, slightly more urine had drained. These observations are not documented in the

[17] Bupa said that there is significant risk of infection and trauma to the bladder by catheterising with a smaller size. RN C said that "it is possible that a catheter of the correct size could have been sourced earlier if more information about [Mr A's] needs [had been] known prior to [his] admission".

[18] Mrs B said her father felt anxious about vomiting because he had been told by staff that he must make it to the toilet next time.

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progress notes. She encouraged him to drink more water. RN F telephoned Mrs B before her shift ended to reassure her that Mr A was settled and asleep. RN F said:

> "I advised her that there had been no more episodes of vomiting and that the catheter had only drained 50ml of blood stained urine. I remember [Mrs B] telling me that this was normal for him. I also advised her that I would be asking the night staff to monitor his output throughout the night."[19]

Day 3

42. RN E told HDC that Mr A had a settled night until around 3am, when he complained of being unable to pass urine. RN E noted frank haematuria[20] and that Mr A had not passed urine since the 50ml previously recorded at 10.15pm. RN E said that on examination Mr A's abdomen was hard but not distended. She attempted five bladder washouts but did not document the volume of saline used. She noted visible blood clots but no urine returned, and gave him two glasses of water and 1g Panadol.

43. At 3.50am Mr A was given a warm cloth for his abdomen. At 4.30am he was still in pain. RN E gave him codeine and performed five bladder washouts (again, the volume of saline used was not documented). RN E noted returned blood, large clots, and only around 50ml of urine. At 6am RN E recorded Mr A's total urine output overnight as 400ml.

44. At morning handover RN E informed RN D that Mr A's catheter had been reinserted, but he had needed frequent bladder washouts, had very low urine output and visible blood clots, and was experiencing pain and taking analgesia. RN E said she also notified the day staff that Mr A "could benefit from either a visit by his own GP or be taken to [a 24-hour clinic]", which provided 24-hour urgent accident and medical care.[21] RN D said: "[RN E] did not mention that [Mr A] needed urgent medical or GP review." RN E recorded in Mr A's progress notes: "[Query] for GP review or medical review [Day 3]."

45. RN D told HDC that Mr A tolerated his breakfast and medications that morning but vomited at around 10.30am. RN D noticed that the vomitus consisted mainly of Mr A's medications (Vitamin C tablet distinguished by its colour). She said that Mr A had three other episodes of vomiting that morning, and the vomit she viewed appeared to be mainly saliva. Mr A did not eat lunch but RN D said that he drank a full glass of lemonade in her presence. RN D recorded Mr A's observations at 10.30am[22] and 12.45pm.[23] She noted that Mr A's catheter was draining well (although blood clots were present) and his approximate total urine output by 1.45pm was 500ml.[24]

46. RN D said that when writing her notes at 1.45pm she noticed that in the last entry in the clinical notes, night shift staff had queried whether Mr A should have a medical review on Day 3. She told HDC that she felt that transfer to hospital was not indicated because she considered that Mr A was stable, and he was mobilising well, drinking and eating

[19] RN F recorded this information in the progress notes at 10.15pm.
[20] The term "frank" is used to differentiate that the blood in the urine is visible rather than microscopic.
[21] This is approximately 30 minutes' drive from the rest home.
[22] Temperature 36.8°C, HR 78, RR 20, BP 108/51mmHg, oxygen saturation 96%.
[23] Temperature 36.8°C, HR 84, RR 20, BP 134/90mmHg, oxygen saturation 96%.
[24] RN D told HDC that she emptied the bag at breakfast and was aware that caregivers had emptied it on two other occasions during this shift at Mr A's request.

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satisfactorily overall and had good urine output. On later reflection, she said she should have monitored Mr A more closely and considered admission to hospital for assessment.

47. RN G told HDC that she was working the afternoon shift and, following the handover by morning staff, Mrs B came to the nurses' station and said she felt that her father had deteriorated since coming to the rest home and she wanted him seen by the GP as soon as possible. RN G informed Mrs B that the rest home does not have a GP available on public holidays and suggested that her father could be sent to hospital instead. RN G's colleague, RN I, suggested that it could be quicker for Mrs B to take him in her own car rather than wait for an ambulance transfer. Mrs B felt that her father should go to hospital and agreed that he go by car.

48. Before they left, RN G took Mr A's observations, which were in the normal range.[25] Mr A's urine output since 1.45pm had been approximately 100ml. RN G said that while Mr A looked unwell, he appeared to be stable. She told HDC that she assisted Mr A into a wheelchair and took him to the car, which he got into without assistance.

49. Mrs B told HDC that prior to his admission to the rest home her father was mostly independent: he showered himself, made his own breakfast and gardened. However, when she went to see her father that afternoon, he was vomiting as she arrived, and the vomit was by then a charcoal colour. Mrs B said that her father's catheter bag had very little urine in it. She took him for a walk, as this sometimes assisted the flow of urine. She told HDC that he was weak and could no longer walk on his own. When they returned to his room, Mr A vomited again. At this stage, Mrs B went to the nurses' station to ask for a doctor.

50. Mrs B recalls being told that "she would be lucky to get a [doctor] on a public holiday and that it would be too expensive". She said that she asked about calling an ambulance and was advised against it because the previous day it had taken four hours for one to arrive.

51. At around 4.30pm, Mrs B's daughter drove Mr A and Mrs B to the public hospital.

Subsequent treatment at the public hospital

52. Mr A arrived at the Emergency Department (ED) with the presenting complaint of vomiting and lower abdominal pain. He was triaged as category four, meaning he was to be seen within one hour. Mr A was assessed by a doctor, had a three-way catheter inserted, and was admitted to the acute oncology ward. Whilst in the ED, 4200ml of bloody urine was emptied from Mr A's catheter.

53. Mr A's blood tests indicated that he had hyponatremia and acute kidney injury. These conditions were both assessed as being new issues secondary to bladder obstruction and dehydration. Over the next few days Mr A's condition was managed with bladder irrigation, intravenous hydration and blood transfusion.

54. Sadly, on Day 7, Mr A died. The cause of death was presumed myocardial infarction due to metastatic cancer in the bladder, and haematuria, resulting from his underlying prostate cancer.

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[25] Documented observations were temperature 36.5°C, BP 102/62mmHg, oxygen saturation 97%, HR 83.

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Further information

55. Mrs B wrote a letter of complaint to Bupa. Bupa investigated Mrs B's concerns and provided her with a written response. In this letter, Bupa acknowledged the following matters:

- Mr A's history presented a picture of a gentleman who was at high risk of complete blockage to his ureters and had the potential to become unwell very quickly.
- In accepting Mr A for respite care, the manager did not identify any clinical risks that might require further investigation and a management plan prior to his admission.
- It was unfortunate that a catheter care plan was not commenced when Mr A was admitted, as this care plan may have helped staff when planning his care.
- Mr A's urine output should have been monitored formally when his catheter was removed and re-inserted, given his history of the catheter blocking.
- The attending nurses did not monitor Mr A's condition adequately.
- At no time during Mr A's stay was the manager called and advised of Mr A's condition.
- It was not appropriate for the nurses to suggest the family take Mr A to hospital themselves, as it was Bupa's responsibility to advocate for him.

56. Bupa's letter also included the following apology to Mrs B:

> "The nurses all agreed that they should have considered seeking medical advice sooner or arranged your father's transfer to hospital for further assessment when earlier attempts to unblock the catheter were unsuccessful. They fully understand that their lack of planning regarding the management of ongoing issues especially when you raised concerns caused distress to both you and your father and they sincerely apologise for not acting sooner."

57. In addition, Bupa told HDC:

> "We acknowledge that staff failed to recognise [Mr A's] deteriorating condition and act on this accordingly and sincerely apologise to [Mrs B] and her family. It is not the standard of care we aspire to and we sincerely apologise for this."

58. Bupa also said that it considers that it would have been appropriate for the urology team to have provided a care plan covering catheter management and instructions for the event of a blocked catheter. In response to the provisional opinion, RN C told HDC that she also agrees that this would have been very beneficial as it would have brought further focus to Mr A's condition, his subsequent care planning and management.

59. RN E told HDC:

> "I should have rung an ambulance on the night of [Day 1] … and [I] certainly would have done [so] if [Mr A] had been a permanent resident with such significant changes in health status and I certainly should have rung and [obtained] advice from ED/Urology prior to removing the catheter. This I truly regret, but at the time [I] thought I had done what was best for [Mr A] that night."

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Actions taken since complaint

60. Bupa said that it is has taken the following actions to reduce the risk of a similar event happening:

- Each of the nurses involved was asked to complete a formal reflection on their involvement in Mr A's care and how their practice would be different in the future.
- An audit was completed of the clinical records of the other residents at the rest home with catheters to ensure each had a catheter care plan and was being managed according to this care plan.
- Bupa undertook a review of the documentation of other respite clients at the rest home to ensure relevant information had been gathered about the resident in a timely manner.
- Managers were in the process of creating individualised performance development plans for all the rest home registered nurses involved in Mr A's care to ensure that the clinical decision-making skills of the nurses are improved.
- A case review meeting was held, which reiterated the type of information staff are expected to bring to their managers' attention.
- Education was provided to the nurses about using ISBAR,[26] a verbal communication tool for handing over key information on a resident's condition.
- The rest home is now stocked with a small number of size 20 catheters.

Responses to provisional opinion

61. A response to the "information gathered" section of the provisional opinion was provided by Mrs B on behalf of Mr A's family.

62. Bupa provided a response to the provisional opinion, in which it acknowledged the concerns raised by Mr A's family regarding his care whilst a resident at the rest home, and apologised that the standard of care fell short of what it expects. It stated: "This matter has resulted in considerable reflection and review within Bupa and we have worked to put better systems and processes in place." In addition to the actions stated above, Bupa said that a number of measures have been taken:

- The clinical manager is receiving mentoring from the care home manager.
- An experienced unit coordinator has joined the rest home.
- The unit coordinator and the care home manager are working closely to ensure the clinical manager continues to be supported and appropriately advised on what is required to ensure residents receive quality care. This includes meetings three times a week between the clinical manager and the care home manager to discuss any clinical concerns with residents, and actions to be undertaken, and to confirm that the clinical manager has visited the residents and that all relevant documentation has been completed.

[26] ISBAR stands for Introduction, Situation, Background, Assessment and Recommendation.

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- Clinical meetings with all nurses on duty are taking place every Monday and Friday to ensure consistency and completeness in nursing care, and that plans are in place for residents potentially requiring higher levels of care during the weekend period.
- Bupa is undertaking quarterly internal audits of the rest home to ensure that the above practices are implemented and the care and documentation practices are improving.
- A more rigorous admission process has been implemented to highlight and address concerns earlier.
- RN C stated that the practice of staff escalating concerns to the on-call manager has been reinforced through additional documentation and training to ensure that appropriate escalation occurs.

63. RN C told HDC that at the time she accepted Mr A for admission, she did not consider it necessary to put in place any additional measures, and expected staff to follow the normal policies and procedures regarding catheter management. RN C said that, upon reflection, she would now ensure a catheter plan was in place for any respite resident who was admitted with a catheter.

Opinion: Bupa Care Services NZ Limited — Breach

Introduction

64. The New Zealand Health and Disability Services (Core) Standards (NZS) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, to provide timely, appropriate, and safe services to consumers.[27] Bupa had overall responsibility for ensuring that the staff at the rest home provided Mr A with services of an appropriate standard, and that complied with NZS and the Code. Mr A was let down by several aspects of the care provided to him by several staff at the rest home during his stay. I accept RN Dawn Carey's advice that "when this case is considered in total the care provided demonstrates an overall moderate departure from accepted standards of nursing".

Admission

65. Mr A was accepted for hospital-level respite care, and he was admitted to the rest home that afternoon. A short stay nursing assessment and support plan had been completed about six weeks earlier during Mr A's first admission to the rest home. When RN C was contacted by NASC the day prior to Mr A's admission, she was informed that Mr A had ongoing issues with his catheter blocking and had a pending oncology appointment. RN C told HDC she was unaware of any specific changes in Mr A's clinical condition, and unaware of the size of his catheter at this time. However, documentation emailed to the rest home reported frequent haematuria, blood clots and clot retention, and identified a large mass in Mr A's bladder that was obstructing his urine flow significantly. Mr A's catheter size was last changed by the district nursing service prior to his first admission to the rest home. As Mr A had spent 11 days at the rest home previously, I consider it reasonable to expect that RN C should have been aware of the size of Mr A's catheter on his second admission.

[27] NZS 8134.1.2:2008, Standard 2.2 published by the Ministry of Health.

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66. My in-house nursing advisor, RN Dawn Carey, noted that a size 20 catheter “typically indicates issues with haematuria and potential obstruction from clot formation”. RN Carey is critical that RN C, as Clinical Manager, “did not ensure that an appropriate plan was in place to manage the regular and known problem of [Mr A’s] catheter blocking”. I agree with RN Carey’s criticism. In my view, the information available to RN C was sufficient for her to consider that such issues with Mr A’s catheter might arise, and to ensure that an appropriate plan was established.

67. RN Carey further advised that she is critical of RN H, the nurse responsible for caring for Mr A at the time of admission on Day 1, because RN H did not update the short stay nursing assessment and support plan to reflect Mr A’s current clinical needs. I accept RN Carey’s advice. Mr A’s admission documentation should have reflected his current clinical presentation.

Bladder irrigation

68. Bupa’s policy on bladder irrigation provides that it should be carried out by a registered nurse, following consultation with medical and nursing staff. It further states that the amount of fluid inserted and the amount and type returned should be charted.

69. Mr A received manual bladder irrigation by RN G on the evening of Day 1, and by RN E in the early hours of the morning on Day 2, and twice on Day 3. On each of these occasions the nurses did not either seek advice from the GP’s on-call nurse practitioner or consult with medical staff, nor did they record the volume of saline used to flush into the bladder. RN Carey said that, in her experience, up to 500ml of fluid may be used when performing manual bladder irrigation.

70. RN E advised that the bladder irrigation she performed on Day 2 and the first bladder irrigation on Day 3 were both unsuccessful. RN Carey advised:

> “Unrelieved obstruction can result in the person experiencing vasovagal symptoms such as sweating, increased heart rate and lowered blood pressure …”

71. Recording the amount of fluid used assists with accurate monitoring of a person’s fluid balance, and RN Carey advised that she was mildly critical that the saline volumes used for the bladder irrigations were not recorded.

72. I am critical that the nurses did not follow the required policy and procedure by seeking medical advice before carrying out bladder irrigations, and charting the amount of fluid used and returned.

Removal of catheter

73. On Day 2 RN E removed Mr A’s catheter at around 5.30am. She said that this appeared to provide Mr A with instant relief. RN E told HDC that she did not attempt to reinsert the catheter because blood was evident and the clot was on the tip of the catheter.

74. I am critical that RN E removed Mr A’s catheter without first seeking medical review, given Mr A’s longstanding catheter use, recent history of haematuria and frequent obstruction requiring a size 20 catheter, and because the rest home did not have the correct size of catheter in stock for immediate replacement. RN Carey stated:

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> "In my opinion, the total of this information — size of catheter, previous intervention and result — should have resulted in the RN attempting further manual bladder irrigation and to have ideally sought advice from the [Emergency Department] before removing [Mr A's] [urethral catheter]."

75. RN Carey advised that once the catheter had been removed, Mr A ought to have been recatheterised promptly, and she disagreed with RN E's clinical reasoning for not reinserting a catheter. I accept RN Carey's advice that the presence of a blood clot on the tip of the catheter does not mean that recatheterisation of Mr A should not have occurred promptly.

Fluid balance monitoring

76. Bupa's policy on fluid balance monitoring states that staff are to commence a fluid balance chart where required and must do so when the registered nurse "is concerned about a resident/client's fluid intake and/or output". It requires registered nurses to "regularly evaluate the need for on-going monitoring of fluid balance".

77. The nurses caring for Mr A documented little in the progress notes regarding Mr A's fluid input and output, and no formal fluid balance chart was commenced. Bupa acknowledged that formal monitoring of Mr A's urine output would have been appropriate. In RN Carey's opinion, a period of fluid balance monitoring should occur following manual bladder irrigation, removal of a urethral catheter, and insertion of a urethral catheter. I accept that advice and consider that the monitoring of Mr A's output and fluid intake by multiple nurses was inadequate over his admission period (Day 1–Day 3).

Escalating concerns

78. Bupa states that it expects staff to contact the on-call manager for advice if a resident becomes unwell or continues to be unwell. The on-call manager was not contacted by staff regarding the fact that Mr A was in pain and required numerous bladder washouts, nor was she contacted regarding the removal of Mr A's catheter.

79. RN Carey's advice is that medical assistance should have been requested on Day 3 given Mr A's deteriorating condition.

80. Over the course of approximately two days, Mr A reported pain associated with urinating, he vomited on at least six occasions, and he had low urine output. Mrs B raised concerns about her father's visible deterioration on Day 2 and again on Day 3. I consider that the combination of these factors should have prompted the rest home nursing staff to seek medical review or advice from the on-call manager. I note that Bupa acknowledges that this would have been appropriate.

Conclusion

81. Bupa had overall responsibility for ensuring that the staff at the rest home provided Mr A with services of an appropriate standard, and that complied with NZS and the Code. As this Office has noted previously:[28]

[28] See Opinion 10HDC01286 (18 November 2013). See also 12HDC01091 (13 June 2014). Available at www.hdc.org.nz.

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"That responsibility comes from the organisational duty on rest home owner/operators to provide a safe healthcare environment for residents. That duty includes ensuring that staff comply with policies and procedures, and that any deviations from good care are identified and responded to. It includes responsibility for the actions of its staff."

82. In my view, Bupa failed in its duty to ensure that Mr A received services of an appropriate standard while at the rest home, in the following ways:

- Care management plans, namely the short stay nursing assessment and support plan, were not updated on admission to reflect Mr A's current clinical presentation.
- Appropriate plans were not established on admission to manage the regular and known problem of Mr A's catheter blocking.
- Bladder irrigation was performed several times without first seeking medical advice as required by Bupa's policy, and without documenting the amount of saline used.
- Mr A's catheter was removed without seeking medical advice, and he was not recatheterised promptly.
- No formal fluid balance chart was commenced, and the monitoring of Mr A's fluid balance was infrequent and inadequate.
- Concerns about Mr A's condition were not escalated to the on-call manager by nursing staff, and they did not seek medical advice.

83. I therefore conclude that Bupa failed to provide services with reasonable care and skill to Mr A, and breached Right 4(1) of the Code.

Recommendations

84. In my provisional opinion, I recommended that Bupa Care Services NZ Limited:

a) Provide a written apology to Mr A's family. This was to be sent to HDC within three weeks of this report being issued, for forwarding to Mr A's family.

b) Provide staff at the rest home with further education/training and report back to HDC with evidence of that training within three months of this report being issued. This education should encourage:

1. robust assessment of residents on admission;
2. appropriate monitoring of bladder irrigation;
3. appropriate catheter removal;
4. appropriate fluid balance monitoring; and
5. a clear understanding of the procedure for escalating concerns about residents to the facility manager, GP and/or DHB, particularly during public holidays.

c) Use this report as a basis for staff education at other Bupa facilities, focusing particularly on the breach of the Code identified, and provide evidence of that education to HDC within three months of this report being issued.

85. In its response to the provisional opinion, Bupa provided HDC with a written apology for Mr A's family, which has been forwarded. In addition, Bupa told HDC that the following actions were completed at the rest home in May 2016:

- A workshop was held about catheter care, including bladder irrigation, removal, fluid balance monitoring and documentation. Bupa provided HDC with attendance records and said that another session is planned for June 2016.
- A workshop was held about admission assessments, monitoring deteriorating residents and escalation of concerns. Bupa provided HDC with attendance records and notes on the content of the workshop.
- The current care home manager attended a meeting with Aged Residential Care regarding ongoing issues with respect to GP coverage after hours and during public holidays. RN C also said that she is working on a cross-discipline project team to try to find a better solution for all Aged Care Facilities within the district to help ensure that additional resources are available generally, and for situations such as Mr A's.

86. Bupa told HDC that it used the findings from this report as a case study (anonymised) for staff education at the Bupa Qualified Nurse Forums for 2016, which provide study and training days for all registered and enrolled nurses in its care homes nationally. In particular, this case was considered with respect to critical thinking skills including identifying and acting on clinical deterioration.

87. Bupa said that it will continue to use this report as a basis for staff education, and is happy to provide HDC with updates and evidence of this training.

88. In light of the actions Bupa has taken in response to the provisional opinion, I recommend that Bupa report back to HDC within three months of the date of this report with evidence of the further staff training related to the issues identified in this report.

Follow-up actions

89. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be sent to the DHB and HealthCERT, and they will be advised of the name of the rest home.

90. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited, will be sent to the Nursing Council of New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: In-house nursing advice to the Commissioner

The following expert advice was obtained from RN Dawn Carey on 20 July:

"1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mrs B] about the care provided to her late father, [Mr A] by [the rest home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information on file: complaint and correspondence from [Mrs B]; responses from Bupa Care Services (BCS) including correspondence to [Mrs B], care file for [Mr A], [the DHB's] care plan report … [DHB] clinic letters — dated […]; [public hospital] clinical notes.

3. Background and complaint
[Mr A] aged 77 years, was admitted to [the rest home] on [Day 1] for seven days of respite care services. He had previously had respite care at [the rest home]. [Mr A] had been living with his daughter, [Mrs B], since July 2014 and had recently been assessed as requiring hospital level care due to his long-term 20 French (Fr.) urethral catheter (IDC) frequently becoming obstructed. He had a diagnosis of castrate resistant metastatic prostate cancer.

During the early hours of [Day 2], [Mr A's] IDC became blocked and it was removed. [Mrs B] complains that staff did not insert a new IDC for some hours despite her father being unable to pass urine, experiencing pain and vomiting. [Mr A] was recatheterised at approximately 4pm on [Day 2]. [Mrs B] reports expressing concern to the nursing staff about the volume of urine collecting in her father's catheter bag being less than usual. On [Day 3], [Mrs B] requested that her father be seen by a Doctor as he was continuing to have vomiting episodes. She reports that nursing staff were unsupportive telling her that this would be too expensive due to the public holiday and that an ambulance would take hours to come. After contacting her daughter, [Mrs B] transported her father to [the] Emergency Department (ED) in a private vehicle. At [the public hospital], [Mr A] was recatheterised and admitted to a ward. On [Day 7], [Mr A] died on the ward following a probable heart attack.

4. I have been asked to review the nursing care provided to [Mr A] and to respond to the following questions:
   - Should [the rest home] have removed [Mr A's] catheter or sought a medical review prior?
   - Did [the rest home] staff appropriately monitor [Mr A's] urine output?
   - Was it appropriate for a nurse to attempt to reinsert [Mr A's] catheter given his complex urinary problems?
   - Should additional medical assistance have been requested on [Day 3], due to [Mr A's] deteriorating condition?
   - Would you expect a rest home to have access to a GP 24/7?
   - Was the overall care provided by [the rest home] from [Days 1-3] appropriate?

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5. [Mrs B] initially complained direct to [the rest home] and an internal investigation was undertaken by the [the rest home] Manager and BCS Quality Assurance Co-ordinator. Following completion of the investigation, BCS responded to [Mrs B]. A copy of their correspondence with [Mrs B] as well as a further response to the Commissioner has been provided and reviewed. For the purposes of brevity I have not detailed the response in my advice but note that it is consistent with the contemporaneous notes. BCS acknowledge that the care provided to [Mr A] was not consistent with their expectations and apologise for this. They report remedial actions that are aimed at reducing the likelihood of a similar experience happening to another resident.

6. Review of clinical records
   i. [Day 1] progress notes (PN) entry reports [Mr A's] admission to [the rest home]. The short stay nursing assessment and support plan (SSSP) that were completed during his first respite care stay — [several months earlier] — were again utilised for this admission. The SSSP reports [Mr A] having metastatic prostate carcinoma and an IDC in place. A new short stay admission record (SSAR) identified *ongoing issues with IDC* as [Mr A's] reason for admission on [Day 1]. His temperature, pulse and BP vital signs are recorded. I note that the admission form does not require the recording of a new resident's respiration rate. [Mr A's urology clinic letter] accompanied him to [the rest home]. This reports his cancer diagnosis and his issues with haematuria and clot retention. It also details the presence of a large bladder mass which was causing obstruction to his right vesico-ureteric junction (VUJ) and severely narrowing his left VUJ. PN entry reports [Mr A] complaining of pain and his catheter not draining. Manual bladder irrigation was done which resulted in large blood clots being released. Following this [Mr A's] IDC is reported as draining well.

   ii. [Day 2] PN entry *05.30 very unsettled night ... c/o pain in lower abdomen ... CG came to me at 04.45am and said [Mr A] was bleeding a little and bypassing ++. No urine in bag since emptied 01.00hrs. Bladder washout not successful. IDC removed ...* Day shift documentation reports [Mr A] vomiting after his morning medications had been given. His vital signs are reported and excepting slight tachypnoea (respiration rate 22) are unremarkable. As [Mr A's] respiration rate was not recorded on admission, I am unsure whether tachypnoea is normal for him. It is also reported that [Mr A] was … *passing urine urethrally with no trouble ...* At approximately 4pm, [Mr A] was *recatheterised with size 20 as unable to pass urine. Small amount of urine in bag ... Daughter [Mrs B] very concerned ... [Mr A] vomited at 15.00hrs ...* At 10.15pm the RN reports *catheter draining small volume 50mls red blood ... [Mr A] reports no discomfort ...*

   iii. [Day 3] PN entry *03.15 ... frank haematuria noted and no more volume since [10.15pm]... BWOx5 [manual bladder irrigation] lots of clots — no urine returned ... ?for GP review or medical review ... 04.30 bladder irrigation done again x5. Blood and large clots all that came back — maybe 50mls urine ... BP120/64 P72 ... 06.00 Output in night bag 400mls all up ...* During the morning, [Mr A] is reported as initially being fine ... *Around 10.30 he started vomiting. Mainly meds (vit C). Obs taken ... temp 36.8°c, P78, Resp 20, BP*

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108/51mmHg ... vomiting x3 times small ... At 12.45pm [Mr A's] vital signs were checked again and were consistent with earlier recordings other than his BP — 134/90mmHg — which had improved. [Mr A's] catheter was reported as ... draining well. Blood clots present. Total urine output=500mls.

iv. At 4.45pm, nursing staff report *Daughter concerned that [Mr A] has deteriorated since coming here ... Decided to take him (by own) car to [ED] @ 16.15hrs. Paperwork given of diagnosis and meds.* The [rest home] RN utilised [Mr A's] urology clinic letter as part of the transfer paperwork that accompanied [Mr A] to [the public hospital]. A hand written addition to the bottom of the clinic letter reports *[Day 3] Daughter concerned over deterioration since admission to [the rest home]. Obs @ 16.30 temp 36.5, BP 102/62, Ox 97% Air, P83.* This entry is signed by [the rest home] RN.

v. At [the public hospital] ED, [Mr A] was assigned triage category 4. Nursing assessment reports … coffee ground vomit on arrival, passing frank blood in IDC bag. A three-way IDC was inserted so that continuous bladder irrigation could be maintained. Blood tests results indicated hyponatremia and acute kidney injury, which were both assessed as new issues secondary to obstruction and dehydration. [Mr A] was admitted to the ward where management included bladder irrigation, intravenous hydration and blood transfusion. On [Day 7], [Mr A] complained of acute central chest pain and became unresponsive. Due to his metastatic disease, resuscitation was not attempted and he died.

7. Comments

i. When someone has an IDC in place, obstruction of urine flow can be caused by IDC issues — kinked tubes, encrustation — or by physiological conditions — such as stones, tumours, trauma, or post urological surgery. Signs and symptoms of obstruction are reduced/lack of flow through the IDC, suprapubic pain as the bladder fills and cannot empty and urine bypassing the IDC. The management of obstruction is based on clinical assessment and is essentially a trouble shooting process. Although contentious, manual bladder irrigation is a method frequently used to try and resolve obstruction. This involves disconnecting the drainage bag from the catheter tubing and flushing normal saline fluid through the tubing into the bladder via a catheter tipped syringe and then drawing back the fluid. In my experience, manual irrigation uses sequential 'flushes' until the urine runs clear or is clot free and uses up to 500millilitres (mls) of fluid. Unrelieved obstruction can result in the person experiencing vasovagal symptoms such as sweating, increased heart rate and lowered blood pressure. The inability to relieve an obstruction requires a change of IDC. If obstruction is presumed due to encrustation or if the IDC is due for changing, it is usual that the IDC is changed without an attempt at irrigation.

8. Clinical advice

i. Should [the rest home] have removed [Mr A's] catheter or sought a medical review prior?

I have reservations about the RN removing [Mr A's] IDC without prior consultation or consideration of whether a new IDC could be reinserted straight away. I base this opinion on [Mr A] having a longstanding need for urethral catheterisation. I note that [the rest home] nursing documentation

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reported the presence of his IDC when he stayed there [previously]. [Mr A] also had a large (20Fr.) catheter in place. Such a size typically indicates issues with haematuria and potential obstruction from clot formation[1]. I note that [the rest home] did not hold a stock of large urethral catheters at the time of [Mr A's] stay. The PN entry from the previous shift, referred to [Mr A's] IDC becoming obstructed with blood clots and requiring irrigation. I would expect this information to have been presented as part of the verbal nursing handover from the afternoon to night shift. In my opinion, the total of this information — size of catheter, previous intervention and result — should have resulted in the RN attempting further manual bladder irrigation and to have ideally sought advice from [the ED] before removing [Mr A's] IDC. I would be less critical if the RN had recatheterised [Mr A] promptly, albeit from the [rest home's] stock of smaller IDCs.

In my opinion, the removal of [Mr A's] IDC is a mild–moderate departure from the accepted standards of nursing assessment and management.

ii. **Did [rest home] staff appropriately monitor [Mr A's] urine output?**
No. In my opinion, documentation post manual bladder irrigation, post removal of IDC or insertion of IDC should include a period of fluid balance monitoring. This was not done in this case and even where PN documentation refers to input/output, I consider it to be inadequate. In my opinion, the fluid management provided was a mild–moderate departure from accepted standards.

iii. **Was it appropriate for a nurse to attempt to reinsert [Mr A's] catheter given his complex urinary problems?**
I consider it reasonable for a nurse assessed as competent in catheterising males to attempt to reinsert [Mr A's] IDC.

iv. **Should additional medical assistance have been requested on [Day 3], due to [Mr A's] deteriorating condition?**
In my opinion, yes.

v. **Would you expect a rest home to have access to a GP 24/7?**
In my experience, GPs are required to have adequate 'after hours' processes in place so that all registered patients can access advice 24/7. Based on the provider response it appears that the after hours service available to [the rest home] residents was in the first instance telephone advice from a nurse, which was not utilised. Had the decision making of the RN (section 8i) been more circumspect I would not have been critical of the failure to utilise all available resources to support [Mr A] to receive appropriate and timely health care. I agree with the provider that it is appropriate that they work with the DHB to determine how to access after hours health care for their residents. I also agree that contacting the oncall hospital Geriatrician is a reasonable and appropriate measure.

[1] [Relevant guidelines]

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vi. **Was the overall care provided by [the rest home] from [Day 1]–[Day 3] appropriate?**

In my opinion, no. I consider that there were a number of mild–moderate departures in the care provided to [Mr A] at [the rest home]. In addition to the previously identified departures, I also consider that it was inappropriate for a Clinical Manager to accept [Mr A] for respite care after being informed that … *he had ongoing issues with his catheter blocking …* and to not consider that such issues may arise and to ensure that an appropriate management plan was in place.

In my opinion, when this case is considered in total the care provided demonstrates an overall moderate departure from accepted standards of nursing[2].

The following further advice was received from RN Carey on 13 November 2015:

"Thank you for the request that I provide additional clinical advice in relation to the complaint from [Mrs B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. This advice should be read in conjunction with my advice dated 20 July 2015.

1. I have reviewed the following documentation available on file: clinical advice dated 20 July 2015; additional response from Bupa Care Services (BCS) dated 11 September 2015 including staff statements, job descriptions, relevant policies and procedures, urinary catheter competency assessment document.

2. I have been asked to review the additional BCS response and advise whether it causes me to amend my clinical advice and to comment specifically on the care provided by the individual registered nurses. I have also been asked to consider the appropriateness of the following matters:

    - The acceptance of [Mr A] into respite care.
    - The admission process undertaken on [Day 1], a new short stay assessment plan appears to have not been completed.
    - The relevant training of staff including the competency assessment for male catheterisation and bladder irrigation. Is it normal practice for a nursing colleague to be the assessor?
    - The submitted BCS policies, guidelines and procedures which were in place at the time.

3. Review of additional responses and information
    - **The acceptance of [Mr A] into respite care** — In my opinion, [Mr A's] health needs could and should have been successfully managed by BCS. My criticism of his acceptance for respite care is due to the lack of a plan to manage his known and regular occurring problem of his catheter blocking.

[2] Nursing Council of New Zealand (NCNZ), *Code of Conduct for Nurses* (Wellington: NCNZ, 2012) Standards New Zealand (NZS), *8134.1:2008 Health and Disability Services (Core) Standards* (Wellington: NZS, 2008).

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- **[RN C] — Clinical Manager:** I have reviewed [RN C's] statement plus job description. [RN C] reports that the [DHB's] Care Plan Report plus her prior knowledge of [Mr A] informed her decision to accept him for Hospital Level respite care. She details the information that was forwarded to her as part of [Mr A's] referral to [the rest home] and I note that it is consistent with initial response received from BCS. [RN C's] response includes extracts from the information given to her; *... catheter is getting blocked more often — not every day, but more frequently than a month ago ...*

  The Clinical Manager job description details the key tasks and responsibilities. These include … *clinical and care staff are supported and assisted to ensure that optimal care is provided to residents within the facility.*

  I continue to consider it inappropriate that [RN C] accepted [Mr A] for respite care and did not ensure that an appropriate plan was in place to manage the regular and known problem of his catheter blocking.

- **The admission process undertaken on [Day 1], a new short stay assessment plan appears to have not been completed.**
  In my experience it is not uncommon for assessment plans to be used to span consecutive admissions especially when the interval between is short. Also admission documentation can be shared across the RN team with completion usually required within 24 hours of admission.

  While I consider it reasonable to utilise the previous short stay nursing assessment (SSNA) and support plan (SP) for [Mr A], it was necessary to check that the documented findings remained accurate with appropriate amendments being made. Typically the completion of such a check is demonstrated by the RN signing and dating the document. I note that the SSNA and SP include a designated space for this action but that these are blank. In my opinion, the received responses would suggest that changes had occurred since [Mr A's] previous admission [several months earlier] and that these should have been reflected in his SSNA and SP.

- **[RN H]** — The response from [RN H] identifies that she was responsible for caring for [Mr A] on [Day 1].

- If [RN H] decided to utilise the SSNA and SP…for [Mr A's] [second] admission, I am critical of the failure to update these documents. I would consider this to be a mild–moderate departure from accepted standards of nursing care in relation to admission assessment. If [RN H] did not hand over that [Mr A] had admission documentation that required checking/completion, my criticism relates solely to her.

- **[RN G]** — The response from [RN G] reports that on [Day 1], she performed manual bladder irrigation. I note that the need for irrigation and the result is documented in [Mr A's] contemporaneous progress notes by [RN G]. I am mildly critical that [RN G] did not record the volume used as part of the manual bladder irrigation procedure performed on [Day 1].

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On [Day 3], [RN G] reports working an afternoon shift. ... *After handover* [Mrs B] *came to the nurses' station and said that she felt her father was deteriorating and she wanted her father to be seen by the GP as soon as possible.* [RN G] reports explaining that due to the public holiday there was no GP available and suggested that [Mr A] be sent to the public hospital for assessment. ... *The other RN who was on duty with me, and who was also in the nurses' station ... suggested that [Mrs B] transport her father to the hospital herself because it would be quicker than calling an ambulance and waiting for it to arrive to fetch the resident. [Mrs B] agreed ...* [RN G] reports assessing [Mr A] and checking his vital signs. She remarks that these were within the normal range and that there was approximately 100mls urine in his catheter bag. ... *While [Mr A] looked unwell he appeared stable. I assisted to put [Mr A] into a wheelchair and took him to the car. [Mr A] got into the car without assistance and appeared to be sitting comfortably in the car ...*

I consider it appropriate that on [Day 3], [RN G] assessed [Mr A] following [Mrs B's] concerns. While I note that his recorded systolic blood pressure was lower than his trend, I do not consider that it contraindicates [Mr A's] transfer to hospital via public car.

- **[RN E]** — The response from [RN E] reports that she worked night duty on [Day 1] and [Day 2]. She reports removing [Mr A's] IDC and not re-catheterising him *... due to the blood evident and the clot being on the tip of the catheter ...* I consider that [Mr A's] IDC blocked and the attempts at bladder irrigation were not effective due to presence of the blood clot. I do not consider this to mean that re-catheterisation should not have occurred and disagree with [RN E's] clinical reasoning.

  I have found no cause to amend my criticism of the decision to remove [Mr A's] IDC and continue to view this as mild–moderate departure from accepted standards of nursing assessment and management. I am also mildly critical of the failure to record the volumes used as part of the manual bladder irrigations.

- **Fluid balance monitoring** — I continue to hold the opinion as expressed in 8(ii) of my previous advice. This criticism pertains to [RN H], [RN E], [RN F], and [RN D].

- **The relevant training of staff including the competency assessment for male catheterisation and bladder irrigation. Is it normal practice for a nursing colleague to be the assessor?**
  In my opinion, the submitted competency assessment is appropriate and consistent with accepted standards. It is also not unusual for a peer colleague to hold the authority to assess practical competencies.

- **The submitted BCS policies, guidelines and procedures which were in place at the time.**
  Appropriate and consistent with standards.

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

4. Clinical advice
Following a review of the additional information and documentation I have determined no cause to amend the criticisms as expressed in section 8 of my previous advice on this case. I note the changes that BCS report making in response to their investigation into [Mr A's] care and consider them to be appropriate."

The following further advice was received from RN Carey on 23 February 2016:

"Thank you for the request that I provide further clinical advice in relation to the complaint from [Mrs B]. In preparing the advice on this case I have reviewed my previous clinical advice — 13 November 2015 and 20 July 2015. To the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. This advice should be read in conjunction with my previous advice on this case.

I have been asked to consider and comment on the following:

i. If the Commissioner was to make a finding of fact that [Mr A's] catheter was size 20 Fr at the time of his first admission to [the rest home for respite care], would this cause you to add to, or amend your original advice?

   I would then be more critical of the Clinical Manager for not ensuring that there was an adequate clinical management plan in place when she accepted [Mr A] for respite over the [public holiday] period. I would consider her lack of critical thinking to be a mild–moderate departure from accepted standards of nursing assessment[3]. In all other respects I continue to hold the opinions as expressed in my previous advice dated 13 November 2015.

ii. Do you have any further comments regarding the care provided to [Mr A] at [the rest home] in light of this new information?

   No."

[3] Nursing Council of New Zealand (NCNZ), *Code of conduct for nurses* (Wellington: NCNZ, 2012).

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