Ms A

Rest Home

A Report by the

Health and Disability Commissioner

(Case 02/17106)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Registered Nurse, Provider
Mrs B	Complainant, Mrs D's niece
Mrs C	Complainant, Mrs D's niece
Mrs D	Consumer
Ms E	Managing Director, Rest Home
Ms F	Caregiver
Rest Home	

Complaint

On 15 November 2002 the Commissioner received a complaint from Mrs B and Mrs C concerning the services provided to their aunt, Mrs D, by Ms A and the Rest Home. The complaint was summarised as follows:

Ms A
On 9 and 10 November 2002, Ms A did not provide Mrs D with services of an appropriate standard. In particular, Ms A did not respond appropriately to Mrs D's period of unconsciousness and did not:

- *investigate the possible causes of her unconsciousness;*
- *adequately monitor her diabetic state;*
- *seek medical attention for Mrs D in a timely fashion; and*
- *inform Mrs D's night caregiver that Mrs D was a diabetic patient.*

The Rest Home
The Rest Home did not inform Mrs D's family members who held power of attorney about Mrs D's "slight turn" on or about 6 November 2002.

An investigation was commenced on 9 June 2003.

Information reviewed

I have reviewed the following information:

- Letters from a law firm on behalf of Mrs B and Mrs C (15/11/2002, 14/03/2003, 13/06/2003)
- Letter of 13 November 2002 from Mrs C to Ms E, Rest Home
- Report from the Ambulance of 10 November 2002

- Admission letter to the Public Hospital from the Rest Home undated but presumably from 10 November 2003
- Letter of 4 April 2003 from the Ministry of Health to a legal firm
- Letter of 10 July 2003 from Ms A with the following attachments:
  - Appendix 1 – Summary of service provided to Mrs D at the rest home over the period of concern
  - Appendix 2 – Summary of Mrs D's condition over relevant period
  - Appendix 3 – Relates to decision to call an ambulance and reasons why a doctor was not called
  - Appendix 4 – Ms A's experience and qualifications and staff in-service education record
  - Appendix 5 – Additional comments about Ms A's specific knowledge and experience of aged care
    - Ms A's response to the complaints made about Mrs D's care (letter 15/11/2002)
    - Letter of 10 July 2003 from Ms E, Managing Director of the Rest Home
    - Mrs D's Lifestyle/Care Plan
    - Mrs D's Progress Notes from 29 October 2002 to 10 November 2002
    - Mrs D's Blood Sugar record from 26 August 2002 to 6 November 2002
  - Appendix 6 – The Rest Home policies on:
    - Competent Care
    - Introducing new policy
    - Care planning
    - A deleted reporting policy – now updated
  - Appendix 7 – Same as Appendix 2
  - Appendix 8 – Registered Nurse Job Description
  - Appendix 9 – New Registered Nurse Job Description
  - Appendix 10 – Staff Orientation and In-service Education at the Rest Home
  - Appendix 11 – The Rest Home Induction Plan
  - Appendix 12 – The Rest Home's Orientation Programme
  - Appendix 13 – Ms A's In-service Education Record
  - Appendix 14 – Policy – Management of diabetes
  - Appendix 15 – Policy – Deterioration of Residents Condition
  - Appendix 16 –Diabetes Trust Workforce Development Circular
  - Appendix 17 – Example of record of consultation with next of kin or agent
- Letter of 31 July 2002 from a dietician at the District Health Board to a Doctor with advice about nutrition
- Letter of 19 September 2002 from a dietician at the District Health Board advising that Mrs D had been discharged from the service
- Resuscitation Status note from the District Health Board and dated 28 April 2003
- ECG Record from the District Health Board for Mrs D, dated 28 April 2003
- Mrs D's Nutritional Assessment documentation from the District Health Board, dated 23 July 2002

- Referral form from general practitioner to dietician, dated 23 July 2002
- All medical and nursing records relating to Mrs D's admissions to the Public Hospital from 10 November 2002 to 9 May 2003. For the period 10 November 2002 and 19 November 2002 this includes:
  - nursing assessments
  - examination and progress forms
  - nursing transfer form to another Rest Home
  - access management assessment 11 November 2002
  - prescription forms 19 November 2002
  - yellow card medication summary
  - X-ray chest result of 14 November 2002
  - lab results
  - IV fluid order form
  - medication administration signing forms
  - fluid balance form
  - vital signs form 10 November to 18 November 2002
  - diabetic recording chart
- Public Hospital – discharge and coding summary dated 6 May 2003
- District Health Board Patient Information form dated 28 April 2003
- Various medical and nursing notes relating to Mrs D's admission to a Retirement Home and Hospital
- Letter of 13 November 2002 from Mrs B to the District Heath Board
- District Health Board Discharge Summary to a Doctor of 20 November 2002
- Patient Information form of 10 November 2002 which records that Mrs B holds Enduring Power of Attorney for Mrs D.
- Letter from legal firm to Mrs D regarding the Enduring Power of Attorney, dated 23 August 1996
- Copy of Enduring Power of Attorney for Mrs B in relation to Mrs D, dated 8 August 1996
- The Rest Home clinical records for Mrs D between 11 July 2001 and 10 November 2003, including:
  - medication instructions
  - medical notes
  - lab reports
- The District Health Board consent for use of restraint form for cot-sides signed by Mrs B dated 10 November 2002
- File note of conversation between Commissioner's investigator and Ms F, dated 24 November 2003

Independent expert advice was obtained from Ms Lesley Spence, registered nurse.

Information gathered during investigation

In November 2002, Mrs D, an 88-year-old woman suffering dementia and diabetes, was a resident of the Rest Home. Because of Mrs D's condition, her niece, Mrs B, had held an enduring power of attorney for Mrs D's personal care and welfare since 8 August 1996. Mrs C, another of Mrs D's nieces, was named as a substitute attorney for personal care and welfare. Mrs B and Mrs C advised that they regard their responsibility in looking after their aunt as a joint endeavour.

Mrs D was on Diamicron, an antihyperglycaemic medication, for her diabetes. Her care plan indicated that her blood sugar level should be measured four times a day on Mondays and Wednesdays. A review of Mrs D's blood sugar records taken in accordance with this plan indicates that her diabetic state was stable between 26 August 2002 and the time of the last test, recorded at 7.30am on 6 November 2002.

On the morning of 6 November 2002 it was recorded in the nursing notes that Mrs D was vomiting, had diarrhoea and "may have had a TIA [transient ischaemic attack, a temporary disruption of the circulation to part of the brain, which can cause dizziness, weakness and unconsciousness] this morning". Mrs D's family were not advised of this. The notes later in the same day record that Mrs D had "no problems", but diarrhoea was noted several more times over the following three days.

Ms A, registered nurse, cared for Mrs D on the afternoon of 9 November 2002. Ms A was on duty over the weekend of 9 and 10 November 2002. During this time she was required to be present at the rest home during the day and available on call after hours. Ms A advised that her shift was supposed to end at 4.30pm, but that on 9 November 2002 she remained at the Rest Home until 6.00pm to assist a caregiver because two other staff had failed to arrive for work. Ms A advised that she fed Mrs D soup, sandwiches and a cup of tea during her shift.

After Ms A had left for the evening two caregivers helped Mrs D wash, dress, eat supper and go to bed. One recorded in Mrs D's notes that she looked tired. At approximately 9.30pm the other caregiver went to give Mrs D her evening medication, but was unable to rouse her. She called Ms A, who attended at around 9.45pm.

Ms A took Mrs D's blood pressure and pulse and measured her blood sugar level. Ms A also advised that she reviewed Mrs D's nursing notes and saw the reference to the possible TIA on 6 November 2002. The notes she made at this time state:

> "Staff went to give medication and noticed [Mrs D] was unconscious, frothy at the mouth, very clammy and pyjamas were damp. RN called. On examination [Mrs D] had ~~obviously~~ ? had a CVA [a stroke]. BP 111/44. P 65. Groaning when BP was taken, but unresponsive to pain and when name was called. Rang [Mrs B] who came straight here. [Mrs B] requests to sit with [Mrs D]. BP recordings stable.

B/sugar 4.9

Check regularly

Hrly BP

2 hrly turns"

Ms A advised that she observed Mrs D for the next hour. She said her respiration was regular and strong. At 11pm she rechecked Mrs D's blood pressure and pulse, both of which appeared stable and within normal limits.

Mrs B advised me that she was called by Ms A at 10pm and told that her aunt had had a severe stroke and was in a deep coma. Mrs B said she went straight to the Rest Home and found that Mrs D was clearly not aware of what was happening around her. She said Ms A advised her that she had not called a doctor as there was no point, there was nothing he could do, and that nature would determine whether Mrs D came out of the coma or not. Ms A told Mrs B that if her aunt died during the night, an undertaker would be called in the morning. Mrs B remained with her aunt until approximately 7.15am when she went home to rest. She stated that throughout her stay, Ms F, caregiver, regularly checked her aunt's blood pressure.

Ms F advised me that she probably arrived at the Rest Home shortly before 11pm. Ms F was the only staff member on duty throughout the night and was responsible for 20 residents. She explained that there had been a bout of vomiting and diarrhoea in the unit over the previous few days and she had a mountain of laundry to work through. She stated that Ms A did not say much to her before leaving for the night, but did tell her that she should keep a close eye on Mrs D and that she was unlikely to last the night. Ms F advised that Ms A told her to check Mrs D's blood pressure two-hourly throughout the night, but gave no further instructions.

Ms F said that while checking Mrs D's blood pressure she noticed her mouth was very dry. She got some glycerine mouth swabs and while using them she noticed that Mrs D would react and move a little bit.

Ms A informed me that she told Ms F to contact her immediately should there be any change in Mrs D's condition. In response to my provisional opinion, Ms A explained that she told Ms F to check Mrs D's blood pressure hourly, to swab Mrs D's mouth with glycerine swabs and certainly did not tell her that Mrs D was unlikely to last the night. Ms A left the Rest Home to go home at around 11pm.

Ms F recorded in Mrs D's progress notes:

"BP [blood pressure] taken every hour
and turned 2 hourly

hates [facing] the wall
look far better today than yesterday"

Ms A was on duty again the next morning, 10 November 2002. She said that she assessed Mrs D shortly after her arrival at 8am and that she was surprised to find that Mrs D was still unconscious. On examination she found that Mrs D's blood pressure, pulse and respirations all remained stable. She did not check Mrs D's blood sugar level. Ms A stated that she called for a general practitioner at 8.30am but was unable to get through because the telephone at the practice was engaged. Ms A advised that she had to leave Mrs D to administer medicine to 19 other residents and to deal with several other matters relating to the running of the home. She said she tried telephoning the general practitioner again at around 9.30am, but was still unable to get through.

Mrs B returned to the Rest Home at around noon. She said she found her aunt in the same condition she had left her in some hours earlier.

Ms A said that after completing her other work she telephoned a nurse at the general practitioner's at approximately 11.00am and faxed through Mrs D's progress notes for the past three days, her medication instructions and the most recent page of her medical notes. Ms A advised that at approximately midday, after still not hearing back from the general practitioner, she rang the clinic once more. She said she spoke to another nurse at the clinic, who told her that she would telephone her back shortly. Ms A said she was rung back some time later and told that the general practitioner was going to speak to a hospital registrar. Ms A sponged Mrs D, took her blood pressure and pulse, turned her again and swabbed her mouth. Ms A noticed a reaction when she swabbed Mrs D's mouth. At this point, the practice nurse rang her back and advised that the general practitioner had spoken to a registrar at the Public Hospital and that an ambulance should be called at once. There is no record of these discussions in the records of the general practitioner's clinic or at the Rest Home.

The Ambulance records indicate that an ambulance was called at 1.18pm and arrived at 1.21pm. Mrs B said she advised the ambulance officer that her aunt was diabetic and that he immediately took a blood sugar reading and inserted medication intravenously. Ambulance records indicate that at the time ambulance staff assessed Mrs D her blood sugar level was 1.9mmols (extremely low). The notes further record:

> "patient cannulated and 40mls 25% dextrose administered with immediate effect. ↑ GSC [Glasgow Coma Scale, a measure of consciousness, improved] and verbal response – normal for patient. Aware of surroundings. BSL [blood sugar level][improved to] 6.5mmols. "

Ms A advised that Mrs D's level of consciousness appeared to have changed prior to the ambulance arriving and that Mrs D had started opening her eyes.

The Emergency Department admission note from the Public Hospital records that on arrival Mrs D was "according to her niece … now back to her normal self". She was assessed as having suffered a "prolonged hypoglycaemic episode" and treated with further dextrose administered intravenously. Mrs D was admitted to the medical ward for observation and was discharged on 19 November 2002.

Independent advice to Commissioner

The following expert advice was obtained from Ms Lesley Spence, an independent registered nurse:

"**1. Should any further action have occurred as a result of the possible T.I.A. (transient ischaemic attack) which was noted on 6th November 2002?**

While it is speculation for me to comment on this, the notes only indicate '[Mrs D] may have had a T.I.A.' It would seem that it was only a very brief episode and not significant enough to have required any further comment. There were no on-going effects reported in the progress notes. In the light of [Mrs D's] dementia – it may also have been the result of a number of cognitive or communication problems – the R.N. [registered nurse] used the word may which indicated doubt about the cause of the incident.

[Mrs D] was being administered cartia probably for T.I.A. If this was the case, it would be possible for the R.N. in charge that day to assume [Mrs D] had experienced a T.I.A.

Cartia (Aspirin) is commonly used to reduce the risk of cardio-vascular or neuro-vascular problems – transient ischaemic attacks being one of them.

I do not believe there was a lack of due care on this occasion.

It is best practice however to advise next of kin about changes in a resident's condition. Older people constantly experience minor changes to their health and well-being on a daily basis. It would be unrealistic for R.N.s to advise families of every minor health incident. As [Mrs D] appeared to have a brief incident and no side effects were noted, I do not believe any blame should relate to this.

2. Could more have been done to investigate the possible causes of her unconsciousness?

R.N. [Ms A] took into account that [Mrs D] may have experienced a T.I.A. on 6/11/2002, 3 days earlier and assumed that this was a further T.I.A. or stroke.

- A T.I.A. causing a change in consciousness can last up to 24 hours but nursing best practice would intervene before waiting that long.

I consider even had the unconscious state been caused by a T.I.A., a Doctor should have been called to further assess and make decisions about hospitalization – when R.N. [Ms A] returned at 9.45 p.m. on 9th November 2002.

3. Was her diabetic state monitored appropriately?

[Mrs D's] diabetic state had been stable as indicated by the blood sugar monitoring record of 26/08/2002 to 06/11/2002 when the last 2 x weekly Blood sugar was taken at 7.30 a.m. and recorded at 6.4 mmol/L. This is within the normal range for an early morning blood sugar. Her plan of care indicated that blood sugars should be recorded four times a day on Mondays and Wednesdays – her blood sugar was only recorded once on the Wednesday 6th November 2002 prior to her illness rather than the 4 times indicated in the plan – not necessarily a major problem but in the light of [Mrs D's] diarrhoea may have helped indicate that her blood sugars may have been dropping.

The rule of thumb for a 'safe' diabetic state is 5–15 mmol/L – if below this, registered nurses should ensure the resident had sweet food – often jelly beans and protein food – usually a cheese sandwich or something similar.

On no occasion previous to the 10/11/2002 had [Mrs D's] blood sugar been lower than 5. I believe the 4.9 mmol/L reading at approximately 10 p.m. on 9/11/2002 and the cold clammy state [Mrs D] was described as being in, should have prompted R.N. [Ms A] to consider that [Mrs D] was in a hypoglycaemic state and certainly advise the caregiver to record it regularly, 2–4 hourly throughout the night.

Symptoms of hypoglycaemia can include:

- Sweating
- Tremor
- Palpitations
- Hunger
- Headache
- Confusion
- Abnormal behaviour
- Coma (unconsciousness)
- Blood sugar lower than 5mmol/L

4. Should medical interventions have been sought for [Mrs D]?

I believe a Doctor should have been called for the following reasons:

- By 11 p.m. [Mrs D] had been unconscious for approximately 2 hours (9.00 p.m. – 11 p.m., it may have been longer)
- There was no real evidence she had experienced a T.I.A. on the 6th November 2002 and that this episode could be another one.

It is noted however that T.I.A.s were on [Mrs D's] medical problem list.

- Her blood sugar was lower (although not excessively abnormal), than it had ever been before, she had had diarrhoea for 4 days and had not been eating or drinking well which would also have made her more likely to develop hypoglycaemia.
- She was cold and clammy, clear symptoms of hypoglycaemia
- A caregiver with her limited knowledge and experience was alone on night duty and had 19 other residents to be responsible for as well. She would not have had the time or skill to care for an unconscious resident – even with a relative to assist.
- An unconscious person requires close monitoring to avoid further complication e.g. aspiration of saliva/vomitus into their lungs as their cough reflex may be absent;
- Equipment such as suction or oxygen is not normally provided at dementia level of care – nor would the caregiver be capable of using it.
- There was no 'not for resuscitation' order or advance directive in place which may have changed the nursing intervention to one of symptom management rather than active care.

5. Should [Mrs D's] night caregiver have been informed that [Mrs D] was a diabetic patient?

Registered Nurses have a legal responsibility for the nursing care provided by caregivers in rest homes and dementia units.

The New Zealand Nurses Organisation Guideline for nurses working with unregulated caregivers – May 1998 – states in the paragraph about supervision, page 2; *'A nurse supervising a caregiver or caregivers has a general overall responsibility for their work. The nurse is responsible for ensuring that the work of the caregiver does not cause risk or harm to patients. It also discussed the duties and obligations of a nurse when supervising caregivers to take steps to act reasonably'*

No. 2 of these steps:
Knowing the level to which caregivers are trained, and
Ensuring the tasks caregivers do are appropriate to this level, and
Ensuring that communication occurs in a form and manner which the caregiver is likely to understand.

The [Rest Home] Nurse Job Description states Nursing and care staff are monitored to ensure safe practice.

While I believe the caregiver on duty that night would have had knowledge of [Mrs D's] diabetic state, it was clearly identified on a well written care plan, she may not have had the knowledge or experience to have interpreted [Mrs D's] symptoms as hypoglycaemia and this could not have been considered to be within her realm of practice.

It is the registered nurse's role to highlight more complex issues of nursing practice at hand over time and give explanation and instructions as to how they should be managed.

Unfortunately, R.N. [Ms A] when called to assess [Mrs D] at 9.45 p.m. did not consider that an altered diabetic state was an issue and the caregiver was not reminded about its importance.

6. Do you believe that further exploration of the care provided by other nursing staff in particular night staff is warranted?

I do not believe the night caregiver should hold any responsibility for [Mrs D's] continued unconscious state or that she did not consider that her diabetes could be a problem. She carried out the instructions required of her by R.N. [Ms A] very conscientiously. This was commented on favourably by [Mrs D's] niece [Mrs B].

I do not believe the staff member who stated [Mrs D] may have had a T.I.A. should be investigated. The management's response to this incident i.e. new policies have been developed relating to the following appears satisfactory:

- diabetes management
- deterioration of resident's condition
- the delivery of skilled care in a professional and timely way has been reviewed; e.g. if a T.I.A. is suspected the Doctor is rung after 10 minutes if the resident has not roused and an ambulance called if a Doctor can not be contacted within 45 minutes. If a T.I.A. is not suspected a Doctor is called immediately.
- The documentation relating to orientation, induction and education is of a good standard.

7. Any further aspects of care provided by staff which you consider warrant further investigation.

There may be some issues to be considered relating to the 4 days of diarrhoea [Mrs D] experienced without significant nursing or medical intervention.

6th November 2002
a.m. report, the R.N. noted that [Mrs D] had vomiting and diarrhoea++ (which indicates a significant amount) and may have had a T.I.A. (transient ischaemic attack) this morning, not eating, drinking lemonade (diabetic) with encouragement.

There was no p.m. progress note but the night caregiver reported no problems.

7th November 2002
a.m. report stated no problems – had shower ?end (the word is difficult to read) of diarrhoea.

p.m. reports diarrhoea again and didn't eat much.

Night report: had another loose bowel motion at 1.30 a.m. and 5.15 a.m.

8th November 2002
Night caregiver reported no problems, very tired, slept all night

9th November 2003
a.m. report stated diarrhoea still present – very loose after lunch. Imodium given.

p.m. report stated that [Mrs D] looked tired and all care given.

In the record of [Mrs D's] day it was recorded that R.N. [Ms A] fed [Mrs D] her evening meal: soup, sandwiches and tea. No blood sugars had been recorded since 7.30 a.m. on 6th November and was 6.4 mmol/L at this time.

It is likely given [Mrs D's] history over the previous 3 days, 6th November – 9th November 2002:

- Frequent diarrhoea
- Not eating or drinking well
- Her diabetic medication continuing

that her blood sugars could well be dropping and there would be a significant risk of her developing hypoglycaemia (low blood sugar). The recording taken by R.N. [Ms A] at 9.45 p.m. on 9th November 2002 of 4.9 mmol/L may or may not have been a true reflection of her blood sugar level – considering the symptoms she was demonstrating at the time (medical opinion could be obtained for this).

A demented diabetic resident who resists eating and sometimes drinking would be vulnerable to hypoglycaemia especially if her diabetes medication Diamicron was continued during this period.

She was given Imodium in the morning of the 9th November 2002. No diarrhoea was reported following this but that was the only specific intervention for the problems she was experiencing over the 4 days. Having only limited days of progress notes to consider, it is difficult to determine whether there was a pattern to the diarrhoea and it usually resolved following the Imodium. I believe it did justify more nursing and medical intervention in such a vulnerable resident.

8. Additional comment

Rest homes/dementia units are run on tight budgetary constraints.

Staffing being the biggest component of the budget causes challenges to management. Nurse managers staff their facilities to safe levels of practice as required by Ministry of Health Agreements and Specifications which indicate clear requirements for staffing – these are minimum levels and at present do not require Registered Nurses 24 hours/day.

Three issues arise here which are causing increasing concern for the management/professionals and consumers of rest home care.

A The budgetary constraints which rest homes work under; Government funding does not reflect the true cost of caring for seniors in rest home/hospital/dementia facilities.

B The shortage of skilled committed registered nurses to work in this specialized field of nursing.

C All rest homes experience difficulties with staffing at weekends. Often, the best planned roster is upset by staff ringing in sick and the corresponding difficulties of finding replacements and ensuring the staffing skill mix is safe.

I believe as in continuing care hospitals, registered nurses should be present 24 hours each day – and the funding should be adjusted to allow this and to compensate staff more generously for working unsociable hours.

Conclusion

R.N. [Ms A] presents as a well educated sensitive and responsible R.N. On the days in question, she stayed an additional 1 ½ hours (from 8.a.m. - 6 p.m.) to cover for staff who rang in sick thus endeavouring to provide resident safety. She returned at approximately 9.45 p.m., did not leave until 11.00 p.m. and was back on duty at 8 a.m. the next day.

Her recent education and significant experience fitted her well to be in charge of a small 20 bed dementia unit over the weekend.

On call R.N.s are necessary components of providing safety for residents in rest homes not required to have 24-hour registered nurse cover. This does increase the demands on the nurses ultimately carrying the responsibility of the care.

On 9th November 2002, R.N. [Ms A] worked from 8 a.m. to 6 p.m. She then returned at 9.45 p.m. and did not leave until 11 p.m. This constitutes a working day of 11 ¼ hours. She was also working under pressure at the end of her duty as two staff had failed to arrive (it was a Saturday) and she was supporting a senior caregiver who had just returned from maternity leave. It would have been an arduous and challenging day.

She then returned again at 8 a.m. Sunday – I assume for an 8-hour duty.

It is possible this may have affected her judgement when she returned to care for [Mrs D] at 9.45 p.m. on 9th November 2002 and where she failed to observe the symptoms of hypoglycaemia; i.e.;

Coldness
Clamminess
Drowsiness – unconsciousness
A low blood sugar

These symptoms would be found in any current nursing medical or first aid text book and is foundation knowledge in any nursing education programme (see two common references of information in Sources of Information).

I believe R.N. [Ms A], a well qualified and experienced nurse, should have responded to [Mrs D's] unconscious state at 9.15 p.m. on the 9th November 2002 by calling her Doctor or the Doctor on call.

By these actions even though she failed to diagnose the likely hypoglycaemia, [Mrs D] would have been treated up to 14 hours earlier. Treatment was provided by ambulance staff on 10th November 2002 when she was given glucose causing a dramatic improvement in her condition.

R.N. [Ms A's] judgments were not best nursing practice and while there was not a very serious outcome for [Mrs D], she experienced significant distress for a long period of time.

I consider the actions of R.N. [Ms A] in not calling an ambulance/Doctor in a timely fashion for an acutely unconscious resident to be a major nursing failure and believe there would be significant disapproval by her peers."

Response to provisional opinion

In response to my provisional opinion, Ms A stated:

> "…
>
> I acknowledge that I should have called a doctor to [Mrs D] on the evening of 9 November. I have always called a doctor previously in similar circumstances.
>
> I believe this oversight was caused by my medical condition (due to which I had already put in my notice) and the extreme pressures I was working under on that day and the day before.
>
> I wish to apologise to [Mrs D] and her family for my oversight. I am very sorry that this occurred.
>
> As mentioned above I have retired from nursing due to ill health after a 35 year previously unblemished career. I have no intention of practising again.
>
> In light of the above and the effect the investigation is having on my health I ask you to take these factors into account in deciding what action to take."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 6

Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

a) An explanation of his or her condition; and

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
c) Advice of the estimated time within which the services will be provided; and
d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
e) Any other information required by legal, professional, ethical, and other relevant standards; and
f) The results of tests; and
g) The results of procedures.

Clause 3 – Provider Compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
2) The onus is on the provider to prove that it took reasonable actions.
3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Other relevant standards

The New Zealand Nurses' Organisation "Guidelines for nurses working with unregistered caregivers" (May 1998) state:

> "A nurse supervising a caregiver or caregivers has a general overall responsibility for their work. The nurse is responsible for ensuring that the work of the caregiver does not cause risk or harm to patients."

The responsibilities of registered nurses in these circumstances include:

- Knowing the level to which caregivers are trained; and
- Ensuring the tasks caregivers do are appropriate to this level; and
- Ensuring that communication occurs in a form and manner which the caregiver is likely to understand.

Opinion: Breach – Ms A

Response to Mrs D's condition
Ms A was the registered nurse responsible for Mrs D's care during the day of 9 November and the morning of 10 November 2002 and was also on call on the night of 9 November. At around 9.30pm on 9 November a caregiver noticed that Mrs D was not conscious and called Ms A. Ms A arrived at around 9.45pm and assessed Mrs D. She was aware that Mrs D suffered from diabetes. Ms A formed the opinion that Mrs D had suffered a stroke, contacted her niece, observed Mrs D again an hour later, and advised the caregiver to take hourly blood pressure checks and call her if there was any change in condition. Ms A then went home. She did not make any arrangements to monitor Mrs D's blood sugar.

At 8am Ms A returned to the Rest Home and was surprised to find that Mrs D was still unconscious. She advised me that she attempted to telephone a general practitioner several times during the morning, but initially could not get through because the line was engaged. Eventually Ms A spoke to the practice nurse and faxed through some information about Mrs D. She was rung back some time later and advised to call an ambulance immediately. Records indicate that an ambulance was called at 1.18pm.

My independent nursing advisor, Ms Spence, advised me that when Ms A reviewed Mrs D at approximately 9.45pm on 9 November, she should have considered whether Mrs D was in a hypoglycaemic coma given that she recorded that Mrs D was damp and clammy, and had a blood sugar level of 4.9mmols. Her recent medical history included a bout of diarrhoea. A 'safe' diabetic state is between 5 and 15mmols. I accept my expert advice. In my opinion, Ms A did not adequately recognise and consider the possibility of hypoglycaemia in a patient she knew to have diabetes.

Ms Spence also advised me that irrespective of the suspected cause, Ms A should have contacted a doctor when she saw Mrs D on the evening of 9 November. Ms Spence advised that medical input was indicated because:

- By 11pm she had been unconscious for at least 2 hours
- There was no real evidence that Mrs D had suffered a TIA
- Her blood sugar was low, she had not been eating well and had suffered diarrhoea for several days, and she was cold and clammy – all factors indicating that hypoglycaemia was likely
- A caregiver with limited knowledge and experience was the only person on duty and could not be expected to care for an unconscious patient
- Secondary complications arising from unconsciousness (such as saliva/vomit aspiration) could have occurred and the caregiver could not have been expected to monitor for this and did not have the knowledge or equipment to treat it
- There was no "not for resuscitation" order or advance directive which might have changed the nursing intervention to one of symptom management rather than active care.

In overlooking the potential issue of an altered diabetic state Ms A also failed to brief the caregiver rostered to care for Mrs D overnight on the need for careful monitoring of her blood sugar, or to consider whether it was appropriate for the caregiver to be caring for Mrs D in her unconscious state.

I accept my expert advice that Ms A should have been alert to, and recognised, the symptoms of an altered diabetic state; called a doctor on the evening of 9 November; briefed the caregiver carefully on the actions she needed to take to monitor Mrs D's condition; and satisfied herself that the caregiver was able to safely care for and assess Mrs D overnight. As the registered nurse on call, Ms A had overall responsibility for the caregiver's work and the safety of the residents.

Ms A's failure to call for medical input on the night of 9 November was exacerbated by her failure to call for assistance as soon as she observed that Ms A was still unconscious on 10 November. Ms A reviewed Mrs D at 8am on 10 November and advised that she attempted to call a general practitioner at around 8.30am, but was unable to get through because the line was engaged. Ms A stated that she was subsequently busy with other duties and did not try again until sometime later, at which point she was instructed to call the ambulance. Ambulance records indicate that an ambulance was called at 1.18pm.

Ms A had worked a ten-hour shift on 9 November, was on call over the night of 9 and 10 November, and returned on 10 November for another day's work. Ms Spence advised me that Ms A's judgement may have been affected by the long hours she had worked, but that her actions in not calling an ambulance or a doctor in a timely fashion for an acutely unconscious resident was "a major nursing failure" that would be the subject of significant disapproval from her peers.

Ms Spence advised me that while Ms A's failure did not result in a serious outcome for Mrs D, she experienced significant distress for a long period of time. In response to my provisional opinion, Ms A disputed this statement and stated that Mrs D "gave the appearance of being in a deep sleep and being completely oblivious to events around her. There is no evidence of [Mrs D] suffering any pain or discomfort. … I do not believe there is any evidence at all to justify saying that [Mrs D] had 'experienced significant distress for a long period of time'."

I do not accept Ms A's submission. A period of unconsciousness would be distressing for any consumer (certainly in retrospect) and undoubtedly for family members who spent a sleepless night at home or by the bedside.

I am guided by my expert advice. In my opinion, Ms A did not provide services with reasonable care and skill and in accordance with professional standards and therefore breached Right 4(1) of the Code.

Opinion: No breach – [Rest Home]

Mrs D's "slight turn" on 6 November 2002
Mrs B and Mrs C told me that they were not advised of Mrs D's "slight turn" on 6 November 2002. As the holder of an enduring power of attorney for Mrs D's personal care and welfare, Mrs B was entitled to receive information about her aunt's condition, as Mrs D did not have the capacity to receive that information herself.

My expert advised me that it is best practice to advise next of kin about changes in a resident's condition. However, Ms Spence also advised that older people experience minor changes to their health and well-being on a daily basis and that it would be unrealistic for rest homes to advise families of every minor health incident.

Under clause 3 of the Code providers are required to take reasonable steps in the circumstances to comply with the Code. I accept my expert advice that Mrs D's symptoms on 6 November appeared short-term and minor, and no side-effects were noted. In my opinion, it was reasonable for the Rest Home not to inform Mrs B about Mrs D's condition on 6 November in these circumstances. Accordingly, the Rest Home did not breach Right 6(1) of the Code.

Care provided by Ms A
Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

The Rest Home employed Ms A, an experienced and well-trained registered nurse, and provided her with appropriate training, including a management of diabetes course in 1997. The rest home had appropriate policies and guidelines in place for the treatment of residents with diabetes and the management of a resident whose condition deteriorated, and ensured that caregivers were aware of their responsibility to contact a registered nurse when necessary.

On 9 November 2002 Ms A worked a 10-hour day, was on call for the night of 9 and 10 November, and returned to start another day's work at 8am on 10 December. Clearly, the long hours worked by Ms A may have impacted on her judgement. It appears that Ms A was required to work some of these hours because of the absence of other staff. While it is not ideal to have a single nurse responsible for all nursing care over an extended period, as Ms A was required to, I do not believe that this amounts to a failure by the Rest Home to ensure that Ms A complied with the requirements of the Code.

In the circumstances the Rest Home had taken such steps as were reasonably practicable to ensure nursing staff provided services with reasonable care and skill. Accordingly, the Rest Home is not vicariously liable for Ms A's breach of Right 4(1) of the Code.

Other comment

Ms F
Ms F, the caregiver, acted only under the supervision of Ms A. The New Zealand Nurses' Organisation "Guidelines for nurses working with unregistered caregivers" (May 1998) states: "A nurse supervising a caregiver or caregivers has a general overall responsibility for their work. The nurse is responsible for ensuring that the work of the caregiver does not cause risk or harm to patients." The responsibilities of registered nurses in these circumstances include:

- knowing the level to which caregivers are trained; and
- ensuring the tasks caregivers do are appropriate to this level; and
- ensuring that communication occurs in a form and manner which the caregiver is likely to understand.

In this case, Ms A had responsibility for Mrs D's care. Ms F could not be expected to have had any specialised knowledge of Mrs D's diabetic state or the warning signs of hypoglycaemia. She had an obligation to contact Ms A when concerned about a resident's well-being and she met this obligation. Any further care the caregiver provided could only have been at Ms A's instruction.

Mrs D's diarrhoea
In the days prior to this incident, Mrs D suffered a bout of diarrhoea. My advisor noted that Mrs D would have been vulnerable to hypoglycaemia while suffering diarrhoea. It would have been good nursing practice to have arranged better assessment and intervention in Mrs D's care prior to the events of 9 and 10 November 2002.

Follow-up

- In light of Ms A's advice that she has retired from nursing practice, I propose to take no further action in relation to her.
- A copy of this report will be sent to the Nursing Council of New Zealand and the Ministry of Health.
- A copy of this report, with all details identifying the parties removed, will be placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.