A Rest Home

Former Nurse Manager, Ms C

Registered Nurse, Ms D

Nurse Manager, Ms E

General Practitioner, Dr F

A Report by the

Health and Disability Commissioner

(Case 02HDC16198)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Complainant
Mr B	Consumer
A rest home	Provider
Ms C	Provider / Nurse Manager (former) at the rest home
Ms D	Provider / Registered Nurse
Ms E	Provider / Nurse Manager at the rest home
Dr F	Provider / General Practitioner
Ms G	Licensee, the rest home
Ms H	Consumer's daughter
Ms I	Caregiver

Complaint

On 5 November 2002 the Commissioner received a complaint from Mr A about services provided to his father, Mr B. The complaint was summarised as follows:

Between May and September 2002 a rest home did not manage Mr B's deteriorating condition. In particular, the rest home:

- *did not respond appropriately to the signs of Mr B's increasing frailty, poor mobility and pneumonia*
- *did not arrange for a general practitioner to review Mr B's condition*
- *did not arrange for Mr B to be reassessed for a higher level of care*
- *did not prevent Mr B from becoming dehydrated*
- *did not arrange Mr B's admission to hospital on 28 September 2002, despite his chest pain, shortness of breath, colour and sweating.*

An investigation was commenced on 15 April 2003. On 6 June 2003 the investigation was extended to include the following individual providers:

Ms C

Between 22 April and 31 July 2002 Ms C did not manage Mr B's deteriorating condition. In particular, Ms C:

- *did not respond appropriately to the signs of Mr B's increasing frailty, poor mobility and pneumonia*
- *did not arrange for Mr B to be reassessed for a higher level of care.*

Ms D

Ms D did not provide services of an appropriate standard to Mr B. In particular, Ms D:

- *did not adequately assess Mr B's condition on 28 September 2002*
- *did not arrange Mr B's admission to hospital on 28 September 2002.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Ms E
In August and September 2002 Ms E did not manage Mr B's deteriorating condition. In particular, Ms E:

- *did not respond appropriately to the signs of Mr B's increasing frailty, poor mobility and pneumonia*
- *did not arrange for a general practitioner to review Mr B's condition*
- *did not arrange for Mr B to be reassessed for a higher level of care*
- *did not prevent Mr B from becoming dehydrated.*

Dr F
Dr F did not provide services of an appropriate standard to Mr B. In particular, Dr F:

- *did not attend Mr B despite being advised on two occasions in September 2002 that he was unwell*
- *prescribed antibiotics twice to Mr B without examining him*
- *did not record Mr B's treatment in September 2002.*

Information reviewed

- Response and relevant policies received from Ms G, licensee
- Response from Ms C, former nurse manager
- Response from Ms D, registered nurse
- Response from Ms E, nurse manager
- Response from Dr F, general practitioner
- Relevant medical records from a public hospital relating to Mr B's admission in April 2002 and September 2002
- Relevant nursing and medical records from the rest home
- Information from Mr A and Ms H

Independent expert advice was obtained from Dr Niall Holland, general practitioner, and Ms Wendy Rowe, registered nurse.

Information gathered during investigation

Admission to the public hospital – February 2002
Mr B (who was 83 years old at the time of these events) had multiple medical conditions, including Parkinson's disease. Mr B lived alone. On 16 February 2002, his son, Mr A, and daughter, Ms H, took him to the public hospital because they were concerned that he was falling more frequently, forgetting to take his medication, and seemed less able to take care of himself.

Mr B had a number of medical problems, including:

- Parkinson's disease
- Dementia/confusion
- Diet controlled diabetes
- Ischaemic heart disease
- Congestive heart failure
- Atrial fibrillation (controlled)
- Previous hemicolectomy in 1998 for cancer of the bowel
- Impaired vision (cataracts)
- Urinary incontinence (especially at night)
- Medication non-compliance (owing to confusion)
- Recent history of falls
- Psoriasis
- RIND [Reversible Ischaemic neurological deficit]

Mr B was admitted to the medical ward. While on the ward he was significantly confused. His MMSE (mini mental status exam) score was 11/28.

On 20 February Mr B was transferred to a ward for rehabilitation. The admitting doctor for the ward described his examination of Mr B as "difficult", as Mr B was unable to follow commands (because of his confusion). Mr B appeared to have "no insight" into his limitations or his inability to manage at home. Mr B's children were keen to see him go into rest home care as it was clear to them that he was no longer managing at home.

During Mr B's admission to hospital he remained dependent for all of his personal needs including transferring and walking (with a frame). There is no record of staff having concerns about Mr B's swallowing. However, it was noted that he required assistance with setting up a meal.

On 21 February a 'Not for Resuscitation Form' was completed and placed on Mr B's file (meaning that if Mr B's heart/breathing stopped, active resuscitation would not be initiated). On 22 February Mr B was assessed for his fall risk, and scored 17 (over nine is considered high risk). Despite some weeks of rehabilitation, Mr B remained significantly dependent for his personal cares and it was agreed that he would not return to his home. Mr B was assessed for rest home level care. His support needs level (SNL) was 4, which indicated that he required a high level of rest home care (SNL 5 indicates private hospital level care is appropriate).

Mr B was discharged to the rest home on 7 March 2002. His discharge summary, sent to his general practitioner, Dr F, stated the following:

"…

Functional status at discharge

[Mr B] is mobilising with a 2 x 2 frame and one support. Although his mobility has increased he is still not safe enough to return home. Physio assessment feels that [Mr B] has probably reached his maximum level of functioning. [Mr B] needs assistance with dressing, showering and toileting."

The discharge summary noted that Mr B's MMSE had improved to 18/28.

The rest home – 7 March to 31 July 2002
Mr B was admitted to a wing at the rest home. Ms I, a caregiver, was responsible for the six residents living in this wing, including Mr B. The rest home licensee, Ms G, advised me that Ms I had developed a trusting relationship with Mr B, often assisting him in her own time while he was a resident at the rest home. Ms G stated:

"[Ms I] had been looking after [Mr B] since the first day he entered the rest home. They had developed trust and friendship over time. [Ms I] was willing to assist [Mr B], in her own time, for example, taking [Mr B's] cat to the vet, spending extra time talking to him and helping him to read personal documents. …"

Ms C was the nurse manager of the rest home at the time of Mr B's admission until 9 July 2002. Ms C described Mr B as follows:

"On admission a full physical assessment of [Mr B] was completed and a residential care plan was developed. The complaint from [Mr A] identifies a period from 22 April to 31 July 2002. I left [the rest home] on the 9th of July 2002. For the period between 22 April to 9 July 2002 [Mr B's] condition did not show signs of increasing deterioration. There were some signs of improvement and his mobility improved so that he was able to use his walking frame safely with a caregiver walking alongside.

…

Most of the time he was able to feed himself with occasional assistance. Staff encouraged fluid intake. He showed no signs of dehydration. He was alert and able to hold a good conversation. He was able to request assistance and he would make his needs known to staff when necessary."

Ms C advised that because of Mr B's multiple medical problems she was aware that he was likely to need a higher level of care in the future. However, she stated that Mr B at no stage met the criteria for level five care, being "[the] constant supervision or assistance of two persons to provide care". Accordingly, she did not arrange for his reassessment for a higher level of care.

Ms G informed me that Mr B required assistance with showering, dressing and personal cares. He was able to feed himself with the assistance of caregivers, and drank using a special feeding cup or through a straw.

Ms G stated:

> "He was orientated to time, place & person. He had some short term memory loss but was normally mentally alert and could articulate his needs and concerns."

Because of Mr B's Parkinson's disease, and other ailments, his health fluctuated on a daily basis. Some days he would be frailer, would have difficulty walking and be prone to falls. On other days he could manage a walk down to the beach. The notes for this period reflect Mr B's "good days" and "bad days".

From March to July Dr F visited the rest home and saw Mr B every month, and more frequently when requested. Ms C advised:

> "His visits were documented in the medical progress notes. I considered [Dr F] had an excellent rapport with [Mr B] at all times. I did not experience any problems or difficulties in communicating with [Dr F]."

In April Mr B's tremor and excessive salivation (due to Parkinson's) troubled him and he was seen by Dr F, who prescribed Dispel 25mg. On 1 May he was "well" but on 10 May he had a fall (with no injuries). On 3 June he had a sore throat and flu-like symptoms but by 11 June his condition had improved. On 26 June Dr F saw him on a routine visit to the rest home. Dr F noted that Mr B had a dry cough (which he asked the staff to observe) but was otherwise well.

On 4 July Ms C recorded that Mr B seemed to be managing well and was making good progress, despite his many medical problems. His mood was "bright", he was assisting caregivers with his personal cares as much as he was able, and was "mobilising outside to the beachfront".

August to 27 September 2002
Ms E, a registered nurse, commenced employment at the rest home on 1 August 2002 as the Nurse Manager.

Aside from ill-fitting dentures and some urinary frequency, Mr B was well during the month of August. Dr F saw him on a routine visit on 28 August.

On 6 September Mr B was noted to be "well" and he had managed to walk to the beach. However, on 11 September he was "unwell, shaky", and had been incontinent three times. His temperature was 39°C, but his blood pressure and pulse were normal. A urine specimen was taken and Dr F was informed of Mr B's condition. The next day Mr B's temperature was 38.2°C. He was coughing green/yellow sputum and was complaining of chest pain when breathing. Dr F was again telephoned, and he ordered antibiotics (amoxycillin 500mg three times a day for five days). Mr B was also given paracetamol to reduce his temperature.

Two days later (14 September) Mr B appeared to be better. His temperature was normal, and he was eating, drinking and mobilising. However, the next day, 15 September, he was

described as feeling unwell, his temperature was 36.4°C and his pulse was 70. There is a note in the nursing record that fluids were to be "pushed". On 19 September Mr B was improved but still sounding "chesty". Ms E telephoned Dr F, who ordered a further five days of amoxycillin.

Dr F advised me that he had utmost respect for Ms E's clinical abilities and professional experience, so when she telephoned him on 12 September he was confident in her assessment and prescribed antibiotics accordingly. He was unable to attend personally because of other commitments. When Ms E telephoned him again on 19 September it was clear that Mr B was improving, although he needed further antibiotics, and Dr F judged a visit not to be warranted.

Mr B's condition seemed to improve. On 26 September he had routine blood tests. On 27 September Mr B was reported as having had a good day; he was eating well and had been for a walk. His blood test (white blood cell count 5.18 b/l) was normal. However, later that afternoon he was noted to be pale and shaky with very little appetite.

Ms E examined Mr B. His temperature was slightly elevated but his pulse, blood pressure and respiration rate were all within normal limits. Ms E wrote in the short-term nursing plan and handover communication book that Mr B would be for a medical review in the morning if his condition did not improve and, as his urine was concentrated, fluids were to be "pushed". That evening she telephoned the rest home (sometime between 7.30pm and 8pm) to check on Mr B's condition. She instructed the staff to push fluids and monitor his condition closely, and ring her if there was any deterioration.

Ms E stated:

> "Throughout the two month period that is the subject of this complaint I took all reasonable steps to ensure that [Mr B] was not dehydrated. During our induction programme for all new staff, staff are made aware of the importance of fluid intake in the elderly. All staff are provided with a copy of the job description and the aims and objectives of their role. These both clearly state the requirements for regular fluid intake. Staff are also informed of our nutrition and hydration policy. … The importance of hydration and nutrition is covered in the ACE training and in our rest home inservice training."

28 September

In the early morning of 28 September, Mr B's notes show that he was not well and complained of pain in his right lung when breathing. A caregiver assisted him to cough to bring up phlegm. However, the caregiver noted: "[Mr B is] not a good colour at all."

Mr A visited his father early in the morning (7.30am) on his way to work. He advised me: "My father in my opinion was far from well. I wanted to phone an ambulance immediately but was told by [Ms I] … that I couldn't, that I had to wait 25 minutes for [Ms D] to arrive." Mr A advised me that his father had chest pain, was short of breath, sweating, and a "peculiar colour". He believes that if he had not called unexpectedly early to see his father, "he would not be here today".

Ms G advised me that it was the first time Mr A had visited his father so early in the morning. Ms I (who knew Mr B well) had informed her that Mr B generally looked "a lot better" after he had had his breakfast and a wash. Ms I advised that she knew Mr B was not well, but she did not consider his condition was an emergency situation (requiring an ambulance). Because the duty registered nurse, Ms D, was due to start work at 8.30am, she thought Ms D should assess the situation first.

Ms G explained to Ms I that "the rest home was responsible to give professional advice and opinion; however, if the family insisted on calling the doctor or ambulance, it was their right to do so and we must respect that". Ms G counselled Ms I about not becoming over-involved with residents' family affairs.

Mr A telephoned his sister, Ms H, and told her of his concerns about not being able to telephone for an ambulance. Ms H, a registered nurse, offered to speak to Ms I, but Ms I refused. Mr A then telephoned an emergency medical service (which provides after-hours medical services) and described his father's condition. They advised him to telephone for an ambulance.

Mr A advised me that when he told Ms I that he was going to telephone for an ambulance she "shouted" that he could not telephone for an ambulance. However, he told her that it was "my call and my responsibility" and telephoned for an ambulance.

At approximately 8.30am, before the ambulance arrived, Ms D arrived at work. Ms D usually worked at the rest home in the weekends. Mr A advised me that Ms D did not want Mr B to go to hospital and indicated to him that calling an ambulance was "a waste of everyone's time".

Ms D advised me that when she arrived at work that morning she walked into a highly charged potential medical emergency. Mr A was very upset about events and told her that his father had chest pain, and that he had called an ambulance. Ms D stated:

> "Chest pain can denote very serious life threatening conditions that can threaten the person's cardiac and respiratory function immediately, immediate emergency assessment and action is to be taken to ensure [the] person's basic life support systems remain stable until further medical intervention arrives."

Ms D advised that an emergency assessment required the following to be checked:

- assessment of level of consciousness, level of responses
- assessment of patient's airway
- assessment of breathing status
- assessment of circulation status
- data gathered from person involved
- data gathered from family
- data gathered from staff caring for the person.

With the ambulance on its way, Ms D advised that she had only a short time to perform an emergency assessment, and therefore did not have time to gather equipment for the assessment, discuss the situation with staff, or refer to Mr B's notes.

Ms D assessed Mr B in his room and noted that he was able to respond to her questions and did not appear to have trouble speaking. When she asked him about his chest pain he indicated that he had pain in the base of his thoracic cavity, and moved his hand across his diaphragm. He did not complain of any shortness of breath or breathing difficulties and did not cough or bring up sputum. There were no obvious loud breathing sounds. His pulse was 70 beats per minute and his temperature appeared to be normal, although as Ms D did not have a thermometer she placed her hand on Mr B's face. Mr B appeared to be pale, but there was no evidence of cyanosis (lack of oxygen in the blood). Ms D concluded that Mr B was generally unwell but not in any immediate danger.

Ms D stated:

> "I explained to him [Mr A] that this was not an emergency situation at that point. This did not mean that there was nothing wrong with [Mr B], nor did it mean that [Mr B] did not need an ambulance and/or follow-up medical intervention ….
>
> [Mr A] was within his rights to contact medical services if he felt the need to."

Ms D told me that in normal circumstances she would carry out a full assessment of the patient and then arrange a transfer to hospital, or contact the general practitioner, if required. However, because of the limited time available for Mr B's assessment, she had been unable to complete a full assessment. Knowing that an ambulance was on its way, she focused on maintaining Mr B's condition.

The ambulance arrived at 8.38am. Ms D explained to the ambulance staff that Mr B had recently had a chest infection, which could be why he was unwell.

Ambulance transfer to hospital

Mr B's pulse was 90 beats per minute on arrival, his blood pressure was 110/60 (low/normal) and his blood sugars were 5.1 (normal). His air saturation rate was 92% (poor) which improved to 95% after oxygen was administered.

The ambulance Case Slip stated the following:

> "Unwell
>
> History of chest infection last week – has been on antibiotics. Visited by son at rest home who he told had chest pain. On arrival, after questioning, chest pain is only on coughing. Conscious and alert. Pt [patient] states he feels something is wrong and feels very week. O/E [on examination] skin hot and dry. Lung field clear, monitor shows NS. Travelled well with no further deterioration on route. Pt aware of surroundings, time, place. Son states 'not talking as well as yesterday' and very concerned.

*Rest Home felt he did not need to go to hospital but patient requested transport.

*Some delay due to speaking with son and patient re care at rest home and transportation to hospital."

Admission to the public hospital

Mr B was assessed in the emergency department of the hospital. He was noted to be coughing green sputum, and complaining of being short of breath and "thirsty++". He said that he had had diarrhoea for several days (since taking the antibiotics) and had lost his appetite. Mr B's pulse was 90 and he was pale. His oxygen saturation levels were low (86% without oxygen, 93% with oxygen).

Mr B denied having any chest pain. He was febrile and had reduced mobility.

Mr B was administered IV fluids, and had blood tests taken to determine whether an infection was present. He was transferred to a medical ward with notes stating "? Pneumonia, dehydrated++". His daughter, Ms H, informed the doctor that she had noticed that her father's condition had deteriorated over the last two weeks.

Mr B settled on the ward. Early the next morning the nursing notes record: "Mouth dry, drinking water well through a straw. Pt [patient] needs help turning." Mr B's blood tests showed that he had a streptococcus infection. His antibiotics were reviewed on the post-acute ward round and he was commenced on IV Augmentin.

On the morning of 30 September Mr B was reviewed by the medical team. His diagnosis was recorded as: "Probable bilateral pneumonia. Slow to improve." Mr B's appetite was poor and he was being encouraged to take fluids. He was pale and the medical team considered he was anaemic.

Mr B was referred to the social worker, dietician and physiotherapist. The physiotherapist saw Mr B later that day and queried whether he was aspirating (inhaling food and fluids). She referred Mr B to a speech language therapist for assessment.

On 1 October Mr B was again reviewed by the medical team and noted to be improving. However, he continued to require full assistance with his personal cares and mobility. Mr B was assessed by the speech language therapist, who suspected that he might be aspirating. She arranged to review him later in the week.

By 3 October Mr B's condition had improved sufficiently for him to commence oral antibiotics. On 4 October he was seen again by the speech language therapist, who recommended that he be fed thickened fluids and puréed food only, in an upright position, because of his "severe oral and pharyngeal dysphagia". She recorded that his swallowing difficulties were adversely affecting his nutrition and fluid intake. On 7 October the speech language therapist reviewed Mr B again and confirmed that he needed to remain on thickened fluids/puréed foods because of the risk of aspiration.

On 7 October Mr B was transferred to another ward for rehabilitation. However, he remained significantly dependent for all of his personal cares and mobility and was assessed as requiring private hospital level care (SNL 5). He was discharged to a private hospital on 17 October 2002. Mr B's Discharge Summary stated that he might need subcutaneous fluids overnight because his oral intake had reduced.

Subsequent events
Mr A met with Ms G about his concerns regarding the care provided to his father. However, he remained dissatisfied with the explanations he received. Mr B states that Ms G told him that it was common practice for residents not to receive a drink before they went to bed. Mr B considers this to be an unacceptable practice that needs review. Mr B was not willing to meet Ms G again via Advocacy Services.

Ms G advised me that Mr B's recollection of her comments was incorrect. She stated:

> "I said, 'I have not had a chance to fully investigate the situation. But generally speaking, residents may LOOK dehydrated first thing in the morning . … It is common practice in rest homes that we do not wake residents up during the night to give them fluids. Quite often the last cup of tea they had would be at suppertime, which is around 7.30pm.'"

Independent advice to Commissioner

Nursing advice
The following expert advice was obtained from Ms Wendy Rowe, an independent registered nurse:

> "I have been asked to provide an opinion to the Commissioner on case number 02/16198, and I have read and agree to follow the Commissioner's Guidelines for Independent Advisors. I am a registered comprehensive nurse with 18 years of nursing experience. I have spent most of my career working in the acute medical/rehabilitation areas, and the past 3 years in the private sector. I have a Bachelor of Nursing and a Master of Arts. I currently work in a large aged care facility.
>
> **Supporting Information**
> - [Mr A's] letter of complaint, notes of meeting with advocacy service and action notes of [Mr B's] conversation with investigation officer marked 'A' (1-21)
> - Response and medical records provided by the rest home marked 'B' (22-119)
> - Response from registered nurse [Ms D] marked 'C' (120-130)
> - Response from registered nurse [Ms C] marked 'D' (121-134 pages)
> - Response from registered nurse [Ms E] marked 'E' (135-139)
> - Response from [Dr F] marked 'F' (140-145)
> - Medical notes from [the public hospital's] admission in February 2002 marked 'G' (146-225)

- Medical notes from [the hospital] admission in September 2002 marked 'H' (226-388)
- Action note dated 3 October 2003 of conversation with [Ms H] ([Mr B's] daughter) marked 'I' (page 389).

Expert Advice Required
To advise the Commissioner whether, in my professional opinion, registered nurses [Ms D], [Ms C], [Ms E] and [the rest home] provided services to [Mr B] of an appropriate standard.

Did [Ms D] provide services of an appropriate standard on the 28th of September 2002?

- Documentation from [Ms D] indicates that she did adequately assess [Mr B] on arrival at work on the 28th of September 2002 (pages 122-126). [Ms D] did not start work until 0830am.
- The circumstances required that [Ms D] complete an emergency assessment of [Mr B] without time to gain additional information about his condition. The actions she took were efficient and effective. She also [sought] advice from the on call Manager.
- [Mr B's] son [Mr A] had already initiated the ambulance to take [Mr B] to hospital. [Ms D] was not in a position to stop this transfer as the ambulance had already been called for by [Mr A].

How did [Ms C] manage [Mr B's] deteriorating condition between 22 April and 31 July 2002?

- Progress notes indicate [Mr B's] general condition was stable between April-August 2002 whilst under the care of [Ms C].
- There is no indication in the progress notes that a reassessment was appropriate at this time. He was seen by the general practitioner 6 times during this period.
- Although [Mr B] was frail and had varied mobility he did not show any signs of pneumonia during this period of time.

How did [Ms E] manage [Mr B's] deteriorating condition during August and September 2002?

- Adequate care planning and evaluation by [Ms E].
- Good documentation on care plan (pages 113 & 114) and long/short term care plan (page 101).
- Evidence of assessment in clinical progress notes, although entries are few (entries 11/09/02 & 12/09/02, page 110).
- [Ms E] contacted the general practitioner to review [Mr B's] condition (12/09/02, page 110).
- [Mr B] had good and bad days where his ability to mobilise changed depending on his mood and Parkinson's. He suffered a series of chest infections that did not respond to antibiotics and resulted in the development of pneumonia. There is no

evidence from the care plan and progress notes that [Mr B] needed to be reassessed for a higher level of care. This may have been necessary in the near future.
- Long/short term care plan outlines the need to keep [Mr B] hydrated (page 110).
- [Ms E] indicates in her letter that [Mr B's] son shouted at him a lot, this is not documented in the clinical notes at any point (page 135).

Additional advice given on the following questions:

Was [Mr B's] care plan adequate and appropriate at all times throughout his stay at [the rest home]?

- There is no evidence of a nursing assessment being completed on [Mr B].
- [Mr B's] care plan reflects a list of problems with no evidence of assessment completed (pages 113 &114).
- No speciality assessments completed by the rest home e.g. falls assessment, continence assessment, pressure area assessment, or pain assessment.
- Long/short term care plan is appropriate to use as a short-term plan to be situated in the resident's notes. The information on this plan is appropriate (page 101).
- The care plan is completed by a caregiver with additional information written by the registered nurse. The registered nurse has signed and dated the care plan without adequately outlining the evaluation undertaken. The intervention/care part of this plan is in fact an assessment.
- The registered nurse needs to take responsibility for planning care based on a robust assessment process. Caregivers are a vital component of this process, but should be guided by the registered nurse.
- [Mr B's] care plan is inadequate, however the care he received was appropriate based on the information available in the care plan and the entries in the progress notes.

Are [the rest home's] policies adequate and appropriate? In particular, is the rest home's procedure for admitting patients into hospital appropriate?

- No dates for review on some polices and procedures so unclear as to when they were completed.
- No evidence of research base for policies written. e.g. […]
- The emergency policy (page 121) is appropriate.

Were [Mr B's] changing needs (frailty, hydration and mobility) identified and appropriate strategies in place at all times during his stay? In particular, was [Mr B's] hydration being appropriately managed?

- There is evidence in the progress notes that [Mr B's] changing needs were being met by the staff. Care plan states that fluids needed to be encouraged. [Mr B's] progress notes request for fluids to be pushed (page 109, entry 17/09/02).
- Entry in progress notes for 27/09/02 also states to push fluids (page 107).
- Short/long term care plan states on the 27/09/02 the goal to prevent dehydration.

- [Mr B] fed himself most days so hydration was adequate. Fluids are obtained through food and drink. He did not begin to show signs of becoming dehydrated until 27/09/03. At this stage he needed encouragement to drink and eat. His hydration was appropriately managed.

Is there any clinical evidence that [Mr B] had been suffering from aspiration pneumonia (or had difficulty swallowing) prior to 27 September? If so, when?

- No evidence in progress notes that [Mr B] was suffering from aspiration pneumonia prior to 27 September 2002. He did however have multiple medical problems.
- [Mr B] had difficulty sometimes feeding himself due to his Parkinson's and did not always eat well. This would be reasonable for his condition. No mention in progress notes of difficulty to swallow.
- Care plan does not indicate any difficulties in this area.

How are the symptoms of aspiration pneumonia recognised and prevented?

- Aspiration pneumonia is due to inhalation of foreign material into the lungs, usually vomit.
- Usually occurs during an anaesthetic and the patient is generally unconscious at the time.
- Signs and symptoms include a change in pulse rate and colour.
- Patients require prompt suctioning, oxygen therapy and antibiotics (Mosby Nursing Dictionary, 5th Edition, 1999).

Please comment on the liaison between [Dr F] and the rest home staff throughout [Mr B's] stay. Was it adequate? In particular, was [Dr F] given timely and adequate information about [Mr B's] condition at all times?

- [Dr F] was given adequate information from the registered nurses that worked in the resthome. He was contacted by phone and saw [Mr B] as required. [Dr F's] letter also confirms that he felt well informed about [Mr B's] condition at all times (pages 140 &141).

What action, if any, should have been taken in light of [Mr B's] condition on 27 September? In particular, was any action necessary during the evening of 27 September when his condition worsened? Whose responsibility was this? Was there any indication that [Mr B] required a higher level of care than the rest home could offer him during his stay at [the rest home]? If so, whose responsibility was it to organise a reassessment or transfer?

[Mr B] was recovering from a chest infection prior to 27 September 2002. [Mr B] did not require reassessment at this stage as he could still maintain some independence. He was able to walk outside, feed himself and articulate his needs. [Mr B] had good and bad days and at times required assistance. He did not require the assistance of two carers and he generally had good bowel and bladder control.

- On the evening of the 27th of September 2002 [Mr B's] condition began to deteriorate. The senior caregiver on duty was responsible to make the decision to call the registered nurse. The registered nurse did phone on this evening to see how he was and to ensure the staff maintained an adequate fluid intake. The progress notes indicate [Mr B's] condition required review sometime in the near future.
- [Mr B] continued to deteriorate overnight, and again it was the responsibility of the senior caregiver to call the on-call registered nurse if they felt he needed to be assessed. [Mr B] was for review in the morning by the Doctor.

Was [Ms D's] clinical assessment of [Mr B] on 28 September reasonable in the circumstances?

- [Ms D's] clinical assessment of [Mr B] was reasonable under the circumstances. She arrived at work to be told that an ambulance was already on its way to collect a resident she had not had the opportunity to assess. She acted in a calm and professional manner with the time she had available to her to make an assessment of [Mr B]. Given more time [Ms D] may have been able to fully assess [Mr B] and make a decision about his ongoing care requirements.

Are there any other matters of relevance that you would like to bring to the Commissioner's attention?

- No evidence of an initial assessment to complement care planning process.
- No evidence of a new resuscitation status form in the progress notes at [the rest home].
- Caregivers need to be given education on how to document in the clinical notes as many of their entries use inappropriate language and have little meaning, for example such terms entered as 'great, good, doing number twos, no worries'.
- [The rest home] staff have the basis for adequate documentation and nursing care planning. Direct resident care is appropriate."

General practitioner advice
The following expert advice was obtained from Dr Niall Holland, an independent general practitioner:

"**Purpose**
To provide independent advice about whether [Mr B] received an appropriate standard of care from general practitioner, [Dr F].

Background
[Mr B] (83) suffered from Parkinson's Disease and dementia. He was transferred from [the public hospital] to [the rest home] on 22 April 2002. [Dr F] visited [Mr B] every month from April to August.

[Mr B] kept reasonable health until becoming unwell with a chest infection in September 2002. [Dr F] prescribed antibiotics for [Mr B] twice in September (on the 12th and 16th), but did not see him or record his interventions. [Mr B] improved; however, on 27

September his condition rapidly deteriorated. The next morning [Mr B's] son, [Mr A], visited early in the morning. [Mr B] complained of chest pain. [Mr A] telephoned for an ambulance. Before the ambulance had arrived registered nurse [Ms D] arrived for duty and briefly assessed [Mr B's] condition.

[Mr B] was admitted to [hospital] where he was diagnosed with aspiration pneumonia and dehydration. He was unable to return to rest home level care and now resides in a private hospital.

Complaint
[Dr F] did not provide services of an appropriate to [Mr B]. In particular, [Dr F]:

- *did not attend [Mr B] despite being advised on two occasions in September 2002 that he was unwell*
- *prescribed antibiotics twice to [Mr B] without examining him*
- *did not record [Mr B's] treatment in September 2002.*

Supporting Information
- [Mr A's] letter of complaint, notes of meeting with advocacy service and action notes of [Mr B's] conversation with investigation officer marked 'A' (1-21)
- Response and medical records provided by the rest home marked 'B' (22-119)
- Response from registered nurse [Ms D] marked 'C' (120-130)
- Response from registered nurse [Ms C] marked 'D' (121-134 pages)
- Response from registered nurse [Ms E] marked 'E' (135-139)
- Response from [Dr F] marked 'F' (140-145)
- Medical notes from [the hospital] admission in February 2002 marked 'G' (146-225)
- Medical notes from [the hospital] admission in September 2002 marked 'H' (226-388)
- Action note dated 3 October 2003 of conversation with [Ms H] ([Mr B's] daughter) marked 'I' (page 389)

Expert Advice Required
To advise the Commissioner whether, in your professional opinion, [Dr F] provided services to [Mr B] of an appropriate standard.

I note that [Dr F] is not mentioned in any specific or implied way by the complainant as being the subject of his complaint.

I note that the records include a [hospital] non-resuscitation order for [Mr B] dated 21/2/0[2]. The note indicates that this decision was agreed to by the patient, his family and the doctors. Given the overall health of [Mr B] as described in this hospital record, this appears to be an appropriate decision.

[Dr F] was visiting [Mr B] on a monthly basis. This was appropriate for his level of disability.

[Dr F] has provided two consecutive prescriptions for [Mr B] by way of phone advice. The qualified nursing staff provided an appropriate assessment by phone. The symptoms and signs described were consistent with chest infection. The patient's condition did not appear to be severe. [Dr F] prescribed Amoxycillin 500mg three times a day. This was an appropriate drug to use. He prescribed this for a total period of ten days with an initial prescription for five days and a further prescription for the balance. This was after a phone discussion with the nursing staff which indicated that the patient was improving but not completely well.

Chest infections in nursing homes are extremely common events. It is a very common practice to provide an antibiotic prescription by way of phone advice in response to early symptoms.

Given the existence of a clear indication that the patient wished to avoid heroic resuscitation efforts, the goal of treatment was to keep the patient comfortable rather than necessarily to prolong life. Even without such a non-resuscitation order, when a patient has multiple pathology which includes debilitating and progressive illnesses such as Parkinson's Disease, strokes, early dementia, heart failure, advanced cancer with high risk of metastatic disease (his resected Dukes C Carcinoma of the colon) and diminishing vision it would be usual practice to treat gently and in the expectation that a chest infection would provide a peaceful and comfortable end to life. It is not without foundation that pneumonia is termed the 'old man's friend'.

Taking all the above into consideration and considering the nursing notes, it is very clear that [Dr F] did provide care to an appropriate standard.

In addition, please advise:

- *Whether it was reasonable in the circumstances for [Dr F] to prescribe [Mr B] antibiotics twice without seeing him. In particular, did [Mr B] need to be seen in September?*

This is in part covered by my response to the first question above. I note that [Dr F] also did a blood test which indicated a normal white cell count. It is very common practice to prescribe by phone under these circumstances. The patient was under the watchful eye of qualified nursing staff with extensive experience in the care of the elderly and who knew the patient well. The doctor was monitoring the patient by phone. The patient was responding to treatment and a ten-day course is usual practice. The patient did not necessarily need to be seen.

- *Whether it was reasonable in the circumstances that [Dr F] did not make a record of his interventions in September.*

It would have been wise of [Dr F] to keep a record of the conversations at the surgery. However nursing staff generally record this advice in detail on the patient's record which is held at the home. For this reason it is very common practice to depend on this record

alone and to countersign the orders on the next routine visit to the nursing home. Therefore it was reasonable and consistent with usual practice.

- *Is there any other action/treatment that [Dr F] should have initiated prior to and during September?*

No. A chest X-ray was not indicated at this stage. Such chest infections are very common events. Empirical treatment is usual practice.

- *Is there any clinical evidence that [Mr B] had been suffering from aspiration pneumonia (or had difficulty swallowing) prior to September?*

No. The records do not indicate this. I note also that the hospital records on admission are not clear that aspiration pneumonia had occurred. Rather it was identified over a number of specialised assessments that this risk was present. It is a very common problem in the frail and elderly.

- *What causes aspiration pneumonia?*

Aspiration usually results from a loss of a timely reflex closure of the epiglottis during the swallowing process or from loss of the cough reflex when spillage into the trachea takes place. It may occur in the process of swallowing while eating or through reflux of food from the stomach. Aspiration may occur as a result of diminished consciousness, loss of coordination or loss of specific components of the complex reflexes involved in swallowing without aspiration.

The cause is usually a general debility when multiple illnesses are present as was the case with this patient. [Mr B] had also had a number of strokes. These may have impaired a component of his swallowing reflexes. With the onset of dementia, coordination of swallowing often becomes more difficult. Parkinson's disease may also impair the necessary motor control.

Aspiration pneumonia occurs when the body reacts to the foreign material in the airway by mounting an inflammatory response in an effort to clean up the airway.

- *How are the symptoms of aspiration pneumonia recognised and prevented?*

The symptoms of aspiration may be very subtle. Initial symptoms in the frail elderly may be nil or no more than mild respiratory stridor after eating. It may occur some time after the meal and be unobserved. Spilling of feeds may be apparent but does not necessarily indicate a risk of aspiration.

The symptoms of aspiration pneumonia may include fever though not necessarily in the elderly. A raised respiratory rate may be present. Cough may be present. Sometimes the only indication is noisy breathing or a general loss of health. Rattling sounds may be heard on listening to the chest.

- *How is aspiration pneumonia treated?*

Aspiration pneumonia is very common in the late stages of life. Often it is treated simply with the introduction of thickened foods to minimise spillage into the airway and feeding and nursing in an upright position to maximise the benefit of gravity to keep food in the stomach.

Depending on the level of resuscitation wished for by the patient, established aspiration pneumonia may be: not treated, treated conservatively with oral antibiotics and comfort care or treated vigorously by admission to hospital for full IV therapy resuscitation.

- *What was the likelihood of aspiration pneumonia being diagnosed if [Dr F] had seen [Mr B] in September?*

Unless the doctor had a high index of suspicion that aspiration was occurring it is unlikely that he would have diagnosed this. I note that the hospital discharge summary does not conclude that this was aspiration pneumonia. While they did detect swallowing difficulty, this was not necessarily deemed to be the cause of the pneumonia. His infection was with Streptococcus pneumonia, which is the most common infectious cause of pneumonia.

- *Please comment on the liaison between [Dr F] and the rest home staff throughout [Mr B's] stay. Was it adequate? In particular, was [Dr F] given timely and adequate information about [Mr B's] condition at all times?*

From my perusal of the records, liaison appeared to be very adequate and there appeared to be thorough assessment and timely and appropriate contact and information provision by the nursing staff. This accords with the best of my experience in providing nursing home care. It is not always my experience that staff prepare themselves for phone calls to the doctor by recording all the necessary vital signs.

- *Would you have expected [Dr F] to have been notified of [Mr B's] deterioration during the day and evening on 27 September?*

This depends on a number of things including the arrangements for after hours cover with the nursing home, the understanding between all parties as to the level of intervention that was desired and the severity of the symptoms. I see no indication that urgent attention was required that day. [Mr B] was on treatment for infection and a fluctuating course was to be expected. His level of distress was not great or inconsistent with the presumed diagnosis. Heroic intervention would not normally have been indicated, unless this had been the expressed intention of the patient.

- *Prior to 27 September, was there any indication that [Mr B] required a higher level of care than the rest home could offer him? If so, whose responsibility was it to organise a reassessment or transfer?*

No.

- *How serious was [Mr B's] condition on transfer to [hospital]? Could his condition have been safely managed in the rest home?*

I can see no indication from the notes for urgent transfer to hospital. If he had been my patient, I would have expected to be contacted by the senior nursing staff to visit to assess him and to discuss the next step in his management. This would normally include a discussion with the family either directly or through the nursing staff as to the wisdom of referral to hospital and the expectations regarding the degree of intervention desired.

Given that he had early dementia, I would make this decision in conjunction with the family, drawing to their attention his previously indicated wish to avoid resuscitation. If the family were adamant that they wanted hospital admission I would concur.

However if my advice was sought as to the best option for the patient, in this case I would probably have initially advised comfort care and minimal intervention with oral antibiotics and fluids either sub-cut or orally.

I would have advised the family that if death were the outcome then this could be seen as a blessing, given the likelihood that his life held the prospect of a steady deterioration in quality with the loss of dignity associated with advancing dementia and Parkinson's disease."

Response to Provisional Opinion

Ms G responded to my provisional opinion on behalf of the rest home. She stated the rest home had taken my nurse advisor's comments about documentation "positively". She advised that the rest home's documentation policies and procedures had been recently reviewed and noted that their new system had been highly commended by accreditation auditors.

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.*

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

…

4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

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

Opinion: No breach – Ms C

Management of deteriorating condition March – July 2002
Ms C was the nurse manager in charge of the rest home during Mr B's admission, until 9 July 2002.

Ms C advised me that Mr B's condition, under her charge, did not deteriorate. There was some improvement in his condition during this time and accordingly there was no need to seek a reassessment of his care level. She was aware that Mr B would need a reassessment of his care level at some point in the future because of his multiple medical problems. However, at no stage did he require continual supervision or assistance from two people for personal cares or to mobilise (indicating the need for private hospital level care).

Mr B's nursing and medical records from this period record that he had "good" days and "bad" days. Some effort was made to correct his dentures, which were causing him problems when eating. My nurse advisor considered that Mr B's condition was largely stable during this period. There was no evidence that Mr B suffered from swallowing problems or pneumonia while under Ms C's care.

I have reviewed Mr B's notes and am satisfied there was no indication that he suffered from pneumonia or swallowing difficulties (which could lead to aspiration) while under Ms C care, or that his condition warranted reassessment. He was being regularly reviewed by Dr F at appropriate intervals. It appears from the nursing and medical records that Mr B's condition changed in September, when Ms C was no longer working at the rest home. Accordingly, in my opinion, Ms C did not breach the Code in relation to her management of Mr B's care.

However, I note my nurse advisor's comments regarding the lack of comprehensive nursing assessment documentation. Proper documentation is essential to the provision of good care. I draw Ms C's attention to my advisor's comments and recommend that she review her record-keeping practice.

Opinion: No breach – Ms E

Management of deteriorating condition/dehydration
Ms E was nurse manager at the rest home from 1 August 2002. Mr B's condition was stable during August (with the usual "good" days and "bad" days). However, on 11 September he was unwell and had a temperature. A urine specimen was taken and she telephoned Dr F. When Mr B was still not well the next day, 12 September, Ms E updated Dr F, who ordered five days of antibiotics.

Mr B initially improved but his condition fluctuated; on 15 September he was unwell and on 19 September he was sounding "chesty". Ms E again contacted Dr F, who ordered a further five days of antibiotics. Mr B seemed to improve and in the morning of 27 September he managed to walk to the beachfront. Routine blood tests were reported as normal; however, by the afternoon he was unwell. Ms E reviewed him and recorded that if his condition did not improve by the next day he should be medically reviewed, and that fluids were to be "pushed". She telephoned later that evening to check on his condition.

Mr B was not well overnight (in pain and needing assistance when coughing) and when Mr A visited early in the morning on 28 September, he was alarmed by his father's condition. Mr B was admitted to hospital with suspected pneumonia and dehydration, necessitating IV fluids.

In the circumstances, my nurse advisor concluded that Ms E responded appropriately to Mr B's fluctuating health needs during the time he was under her care. My advisor commented that Mr B did not require reassessment, although it was likely he would in the near future. She considered Ms E's care planning and evaluation was adequate and appropriately documented. In particular, Mr B's hydration needs were recorded in the long/short term care plan, and the progress notes mentioned the need for fluids to be "pushed". My nurse advisor stated:

> "He [Mr B] did not show signs of becoming dehydrated until 27/01/03. At this stage he needed encouragement to drink and eat. His hydration was appropriately managed."

When Mr B's condition deteriorated on 12 and again on 19 September (with what seemed to be a relapse of his chest infection), Ms E appropriately updated Dr F. Dr F commented that because of his work load he could not personally review Mr B but was satisfied with the quality of Ms E's clinical assessment skills and the information she provided him. Both my nurse advisor and my general practitioner advisor considered the liaison between Dr F and Ms E/the rest home to be adequate in the circumstances.

Mr B's condition during the evening of 27 September and early morning of 28 September did not improve. However, the caregiver on duty did not inform Ms E of this. I note that on 27 September Ms E recorded in Mr B's notes that if his condition had not improved by the next day a medical review should be sought. I consider this to be an appropriate plan.

I am satisfied that Ms E adequately managed Mr B's care, particularly in September, and liaised appropriately with Dr F. Mr B had multiple medical problems which would

eventually have caused him to require private hospital care. However, there is no evidence that he needed the assistance of two people on a daily basis while he was at the rest home. Accordingly, in my opinion, Ms E did not breach the Code.

Opinion: No breach – Ms D

Assessment – 28 September 2002
Ms D arrived at work on 28 September at 8.30am to a highly charged situation and a potential medical emergency. Mr A and Ms I had had an altercation over his wishing to call an ambulance for his father. Mr A told Ms D that his father had chest pain.

Ms D advised me that in the short time available to her she did not have time to perform a full assessment, obtain equipment for the assessment, liaise with other care staff, or refer to Mr B's notes. Accordingly, Ms D focused on undertaking an emergency assessment and maintaining Mr B's condition until the ambulance arrived.

My nurse advisor commented that the standard of Ms D's assessment was reasonable in the circumstances:

> "She acted in a calm and professional manner with the time that she had available to her to make an assessment of [Mr B]. Given more time [Ms D] may have been able to fully assess [Mr B] and make a decision about his ongoing care requirements."

Ms D concluded that Mr B did not require an emergency transfer to hospital via ambulance, although she recognised that Mr B was unwell. My general practitioner advisor concurred with Ms D's assessment of Mr B's clinical situation not requiring an urgent hospital admission (discussed further below).

Admission to hospital – 28 September 2002
When Ms D arrived at work at 8.30am Mr A informed her that an ambulance was already on the way. In the time before the ambulance arrived (approximately eight minutes) Ms D briefly assessed Mr B. When the ambulance staff arrived, she briefed them on Mr B's recent chest infection. Ms D was of the view that an urgent ambulance transfer was not indicated but does not dispute that Mr B was not well, and that Mr A was within his rights to call for an ambulance if he wished.

My general practitioner advisor agreed with Ms D's assessment of Mr B's condition. My advisor did not consider that Mr B's condition required urgent hospital admission. It would have been appropriate to ask for Mr B's general practitioner to review him and advise on future management. I am satisfied that such a review would have taken place, as I note that Ms E had recorded that Mr B was for medical review if his condition had not improved by the next day.

Ms D was not involved in the decision to call an ambulance and, although she considered that an urgent transfer was not necessary, she did not prevent it from taking place. Accordingly, in my opinion, Ms D did not breach the Code.

Opinion: No breach – Dr F

Management of chest infection
Mr B's condition deteriorated on 12 and 16 September 2002 when he had two chest infections. On both occasions nursing staff at the rest home contacted Dr F and notified him of Mr B's symptoms. Dr F prescribed two five-day courses of antibiotics for Mr B, but did not visit him, arrange for an X-ray, or make a record of his treatment. My general practitioner advisor, Dr Holland, stated that he considered Dr F provided adequate care to Mr B at all times during his residence at the rest home. Dr Holland stated: "[Dr F] was visiting [Mr B] on a monthly basis. This was appropriate for his level of disability."

My advisor considered it unlikely that, had Dr F seen Mr B in September, he would have diagnosed aspiration pneumonia. Mr B's symptoms were consistent with a chest infection. Dr Holland noted:

> "Chest infections in nursing homes are extremely common events. It is very common practice to provide an antibiotic prescription by way of phone advice in response to early symptoms."

My advisor did not consider that other interventions, such as a chest X-ray, were warranted in the circumstances. Mr B was being cared for by nursing staff with extensive experience in the care of the elderly, who were trusted by Dr F, and who knew Mr B well. Dr F was monitoring Mr B's condition by telephone, and his illness was not life-threatening. He did not necessarily need to see Mr B.

In hospital, Mr B was diagnosed with streptococcus pneumonia, a common infection. Mr B was subsequently assessed as being at risk of aspiration. My advisor could find no evidence that Mr B had suffered from aspiration or swallowing problems prior to his admission to hospital. He advised: "Taking all the above into consideration and considering the nursing notes, it is very clear that [Dr F] did provide care to an appropriate standard."

I am satisfied that Dr F provided care to Mr B of an adequate standard. The liaison between Dr F and Ms E was appropriate. Mr B's condition was not immediately life-threatening and he appeared to be responding to treatment. My advisor commented that conservative treatment was indicated given Mr B's many comorbidities. The goal of treatment for a patient like Mr B is to maintain comfort rather than prolong life.

I am guided by my advisor's comments. In particular, I note that Mr B had multiple pathology, which included debilitating and progressive Parkinson's disease, early dementia, heart failure and advanced colon cancer. I am advised that the usual practice would be to

treat gently, in the expectation that a chest infection would provide a peaceful and comfortable end to life. Accordingly, in my opinion, Dr F did not breach the Code in his management of Mr B's chest infections.

Documentation
Dr F did not record his telephone interventions with Mr B in September. My advisor considered that Dr F would have been wise to keep a record of his conversations at the surgery. However, my advisor noted that it is very common practice to rely on the nursing staff to record advice in the patient's rest home notes, and to countersign orders on the next routine visit to the rest home. He stated: "Therefore it was reasonable and consistent with usual practice."

Good documentation is an essential component of good quality care. I note Dr F's acknowledgement that he was "remiss" in this respect. However, I am guided by my advisor's opinion that in the circumstances, Dr F's action of not recording his interventions (although not ideal) was reasonable and consistent with common practice. Accordingly, I do not find Dr F in breach of the Code in relation to this aspect of Mr B's care.

Vicarious liability

Employers are responsible 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. As none of the staff at the rest home have breached the Code, the question of vicarious liability does not arise.

Other comment

Documentation
My nurse advisor commented that while Mr B's care provision was adequate, she considered that the rest home would benefit from improved documentation of residents' care. In particular, she stated that caregivers would benefit from education on how to document in clinical notes.

Recommendations

I recommend that the rest home review the documentation of residents' care in light of my nurse advisor's comments.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand and the Medical Council of New Zealand.

- A copy of this report, with details identifying the parties removed, will be sent to Residential Care New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.