Registered Nurse, Ms C

A Rest Home

A Report by the

Health and Disability Commissioner

(Case 03HDC14664)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mr A	Consumer (deceased)
Ms B	Complainant, Mr A's daughter
Ms C	Provider, Registered Nurse and Manager, Rest Home
Mrs D	Caregiver and co-licensee Rest Home
Mr D	Co-licensee, Rest Home
Ms E	Senior caregiver
Ms F	Senior caregiver

Complaint

On 30 September 2003 the Commissioner received a complaint from Ms B about the care provided to her father, Mr A, by a rest home. The following issue was identified for investigation:

- *The circumstances and appropriateness of the rest home's management of Mr A's deteriorating condition on 20 and 21 September 2003.*

An investigation was commenced on 13 November 2003.

On 22 March 2004 the investigation was extended to include Ms C, the Manager of the rest home. The following issue was identified for investigation:

- *The circumstances and appropriateness of Ms C's management of Mr A's deteriorating condition on 20 and 21 September 2003.*

Information reviewed

- Information from the rest home
- Information from the New Zealand Police
- Information from the Ambulance Service
- Clinical records from the rest home, and two public hospitals
- Information from Ms C
- Information from Ms E
- Information from Ms F
- Transcript of interview with Mr and Mrs D with Commissioner's staff on 17 September 2004
- Information from Health Ed Trust
- Independent expert advice was obtained from Ms Jan Featherston, registered nurse.

Information gathered during investigation

Ms B complained that the staff at the rest home provided an inadequate service to her 68-year-old father, Mr A, who suffered from diabetes. Specifically, she claimed that on 20 and 21 September 2003, staff at the rest home failed to respond appropriately when Mr A became unconscious because of a low blood sugar level, and that he should have been admitted to hospital at an earlier stage.

The Rest Home
The rest home is owned by Mr and Mrs D, who are the licensees. Mrs D also worked as a caregiver at the rest home. In September 2003 there were 32 beds, of which 15 or 16 were occupied on 20 and 21 September. On each shift, care was provided by two caregivers, one of whom was recognised as the senior caregiver. These staff are neither enrolled nor registered nurses. The measurement of blood pressure, temperature, pulse and blood glucose level was always performed by the caregivers. All drug administration was performed by caregivers. Owing to the recent opening of a rest home in a nearby town, a number of residents at the rest home had transferred, resulting in more than usual empty beds. Mr A was due to transfer to the rest home in the nearby town on Monday 22 September.

Ms C
Ms C commenced at the rest home as manager and sole registered nurse in April 2001, having previously worked in a number of rest homes and nursing homes. She qualified as a general nurse in January 1960. Ms C worked at the rest home from Monday to Friday, 8am to 4.30pm, and any queries of a clinical nature outside these hours were directed to her by telephone. If she was unavailable, staff would be instructed to contact Mrs D. She informed me, "I myself am a diabetic and well aware of treatment."

Ms C's job description set out the following requirements:

> "B.2. To plan with the owners an inservice education programme for the home to meet the needs of the staff. …
> B.5. To provide on the job training to staff as appropriate to ensure the residents receive a high standard of care at all times. …
> C.6. To educate staff in the safe administration of drugs and drug side effects."

Ms C left the rest home at the end of March 2004 to work in a rest home in a city.

Mr A
Mr A had been a resident at the rest home since 29 October 1998, having been admitted on his 64th birthday. He suffered from Parkinson's disease, hypertension and diabetes. By September 2003, Mr A required significant nursing assistance for his hygiene needs, mobility and eating, and suffered occasional urinary incontinence. He also experienced

regular transient ischaemic attacks,[1] which were recorded on a chart that measured their frequency and duration.

Mr A's diabetes was controlled by a daily injection of Protophane insulin, 20 units, given before breakfast. Blood glucose levels[2] were measured twice a day, at 8am and tea time. His blood pressure was measured three times a week: on Monday, Wednesday and Friday.

Ms C wrote a care plan for Mr A that covered a number of aspects of care, and this was kept in the patient's file in the office. Ms C stated that she reviewed the care plans every three months or as required. Although the care plans were available to all staff, Ms C stated that "[the caregivers] never used to read the care plans".

The nursing interventions described on Mr A's care plan relating to the management of his diabetes stated:

- "Administer all medications as charted
- BD BMs [twice daily blood glucose measurements]
- Report any other unusual problems quickly"

The table[3] below shows the blood glucose measurements for Mr A from 13 to 20 September 2003:

Date	Morning BM (mmol/l)	Evening BM (mmol/l)	Other (mmol/l)
13 Sept	8.3	11.8	
14 Sept	8.3	10.7	
15 Sept	6.4	8.2	
16 Sept	6.4	6.1	
17 Sept	4.3	7.8	
18 Sept	2.9	6.4	
19 Sept	3.1	4.8	
20 Sept	2.3	2.7	2.5 (at 8pm)

Mr A's blood sugar levels from 1 May to 21 September can be seen in Appendix 1.

Information from Diabetes New Zealand states that a blood glucose level of 4mmol/l or under can be described as hypoglycaemic – a low blood glucose level that needs to be raised immediately by ingesting sweet food or drink.

Ms C stated that she checked Mr A's blood glucose levels every day:

[1] Transient ischaemic attacks: brief losses of consciousness caused by a disruption of blood flow to the brain.

[2] Blood sugar levels are measured in millimoles of glucose per litre of blood – mmol/l.

[3] The table has been created from the chart that recorded Mr A's blood glucose levels.

> "I used to check [Mr A] in the morning when I read the report and checked … the [blood glucose measurement]."

20 September 2003
Ms C stated that she had informed staff that she would be unavailable over the weekend of 20 and 21 September 2003 for personal reasons, but she is unable to recall who she spoke to. Ms E and Ms F (who were the senior caregivers on duty the evening of 20 September and the morning of 21 September, respectively) said that Ms C did not tell them that she was not to be contacted. Mrs D stated that the normal procedure in the event of Ms C being unavailable owing to leave or sickness was that staff would have been told to contact Mrs D rather than Ms C. Mrs D stated that she was "definitely" not told by Ms C that she was unavailable on the weekend of 20 and 21 September.

On the evening of 20 September, Mr A was observed by Ms E to be experiencing "some sort of fit … Lashing out with his hands and feet." She stated, "[Mr A] has a past history of transient ischaemic attacks [TIAs] but this seizure was different. It was definitely not a TIA. I rang [Ms C] ... and told her all of this." Ms E contacted Ms C at 7.45pm and stated that she was "really concerned about [Mr A] because he has no past history of fitting".

Ms C advised me that when Ms E called her, she requested that a blood glucose level be taken and ordered the use of cot-sides to maintain Mr A's safety. Ms E's recollection is different; she informed me that Ms C did not request that the blood glucose level be taken, but that Ms E, as a diabetic herself, had taken it on her own initiative. The blood glucose level was recorded as 2.5mmol/l at 8pm. Ms E obtained and fitted the cot-sides and gave Mr A some sweetened Milo (a chocolate milk drink), again on her own initiative, intending to raise his blood glucose level. Ms C does not recall being informed of the blood glucose level, and stated that she did not ask to be told what it was. Ms E did not perform a further blood glucose test that evening, nor was one performed overnight by any other staff member.

Mr A's condition was described in the nursing record for that night as "very, very heavy", and the staff "[t]ried to give him Milo, but [it] kept dribbling out of his mouth".

Mr A's temperature was measured by the night staff as 34.1°C. There is no indication what time during the shift this temperature was taken. The normal range for body temperature is from 36° to 37°C.[4, 5]

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[4] Nursing Practice in Healthcare (Hinchcliffe, Norman, Schober, 1991) states:

> "Breakdown in homeostasis takes place when body core temperature falls to about 35 degrees Celsius or lower. … At temperatures between 35 and 32.2 the normal response is vasoconstriction and shivering."

[5] The Lippincott Manual of Medical and Surgical Nursing (Brunnar and Suddarth, 1985) states that one of the signs of low blood glucose levels is pallor and a chilling sensation. It also states:

21 September 2003
Ms F was the senior caregiver on the morning of 21 September. When Mr A was handed over to Ms F, he was described by her as being "not too well", and she checked him first after arriving on duty. She stated that "he was snoring, which was unusual for him as he would normally [have] been awake and smiling". Ms F administered Mr A's insulin injection at 8am, after she had recorded his blood glucose level as 3.2mmol/l.

Ms C stated that the reading of 3.2mmol/l at 8am was "normal" for Mr A.

Ms F made a statement to the New Zealand Police on 26 September 2003, which was provided to me. In it, Ms F says that she first called Ms C after she had done the drug round for the rest of the patients following Mr A's insulin injection. Both Ms F and Ms C have estimated this call to have been about 8.30am. Ms F stated:

> "I went back to [Mr A] and took his blood pressure, which was 160 over 110; he started to look a bit pale so I gave [Ms C] a ring for instructions. I then carried out the instructions given which were to give [Mr A] some sugar."

Ms F advised me as follows:

> "[Ms C] asked me to check to see if [Mr A] was responsive by touching his eyelash to see whether he responded in any way, whether it would twitch. That's when I thought he was semi-conscious. … [Ms C] said to ring back if I wasn't happy."

Ms F believed that Mr A was able to swallow. She gave him one and a half cups of Milo, as he was unable to eat his breakfast.

Having given the Milo and taken a further blood glucose level, which recorded 1.1mmol/l, Ms F called Ms C a second time. Ms C recommended that blood glucose levels be measured every quarter hour. According to the clinical record, the blood glucose at 9.50am was 1.1mmol/l and quarter-hourly observations started at that point.

Ms F telephoned Ms C a third time as Mr A's blood glucose level was still low, and at that stage Ms C told Ms F to call an ambulance. The clinical record does not indicate what the blood glucose reading was prior to this telephone call. According to the emergency service records, the call from Ms F for the ambulance was made at 10:46am.

Ms F stated to the Police:

> "Some patients experience [low blood glucose levels] so rapidly that the symptoms progress to convulsions almost without warning. Severe and prolonged [low blood glucose levels] may cause brain damage and sometimes death."

> "After I rung the ambulance [Ms C] had rung back and told me what to say to the Ambulance staff when they arrived. I was still on the phone when the ambulance arrived."

To my Office, Ms F stated:

> "[Ms C] rang me and said take his vital signs and to ask whether the ambulance was there."

However, Ms C disputes that she made this call:

> "I doubt [I called back], why? I don't know if I did or I didn't."

In a statement to the Police on 29 September 2003, Ms C stated:

> "After the ambulance had attended, [Ms F] rang me to say he had been transferred to hospital in [a town]."

However, in her letter to my Office dated 11 April 2004, Ms C stated:

> "I never heard further until I phoned later that morning."

Mr A was assessed by the ambulance staff as having a Glasgow Coma Score (GCS) of three (which is the lowest possible measurement, 15 being the measurement for fully conscious) and a blood glucose level of 1.7mmol/l. He was admitted to the local public hospital before being transferred by helicopter to the Intensive Care Unit at a city hospital later that day.

Mr A was transferred to the Aged Care Facility in a nearby town on 23 September and died on 24 September without having regained consciousness.

Other matters

Ms E, Ms F and Mrs D stated that they had not received any training from Ms C, nor had they been observed administering insulin or taking blood glucose measurements. Mrs D had been taught by the previous manager, (who had left prior to April 2001), how to give injections and take blood glucose levels. Ms F and Ms E had started work after Ms C commenced at the rest home. Ms E was a diabetic herself, and knew from personal experience how to take blood glucose measurements. Ms F had received training from another caregiver.

Ms C stated that she had trained the staff to do blood glucose tests and that she updated their training. Training records have been provided to the Commissioner for Ms E, signed by Ms C in February 2003, relating to a number of areas, including the administration of medications. The measurement of blood glucose levels has been signed by Ms C, and has "ACE Programme" noted next to the entry.

In September 2003, a number of the caregiver staff, including Ms F and Ms E, were enrolled in the ACE (Aged Care Education) training programme. This is run by Health Ed Trust and provides 12 modules for training caregiver staff who work in rest homes. Health Ed Trust informed me that no specific content in the ACE programme refers to the management of a patient with diabetes, or the monitoring of blood glucose levels. Ms C was the 'in-house' assessor at the rest home, marking work done by those involved in the programme.

Ms C stated that she never did any drug administration for patients at the rest home, it being the caregiver's role.

Ms C stated that the topic of diabetes management was discussed at the regular staff meetings. The rest home has provided my Office with minutes of staff meetings held between September 2002 and September 2003. There are minutes of four meetings (4 September, 26 September, 19 March, 10 September), an agenda for a meeting (6 August) and details of a training session (2 April). There is no mention of diabetes, the administration of insulin or the measurement of blood glucose levels in these documents.

Ms C stated that there was a policy in the rest home for giving insulin. However, the rest home was unable to provide a policy that was current in September 2003.

Staff at the rest home used an Advantage II blood glucose meter. This equipment requires regular calibration in order to ensure continued accuracy, and this information is provided with the meter's accompanying documentation. The rest home was unable to provide any record of calibrations of the blood glucose meter. Mr and Mrs D confirmed that in September 2003 it was Ms C's responsibility to train and update caregivers in the use of equipment that measured blood glucose levels.

Ms C stated that Mr and Mrs D, as licensees, had an unrealistic expectation of her ability to provide clinical guidance out of hours to the staff at the rest home. However, Mr and Mrs D stated that Ms C had never reported to them that there had been any difficulty about her being on call. Ms C lived five minutes away from the rest home by car.

Mrs D stated that there had been some concerns raised about Ms C, in particular that "she [didn't] move from the front desk, she tended to sit there and shout". Mr D was also concerned that Ms C did not always do a daily check of the residents and that "she tended to sit at the front [desk] and delegated a lot of things that a lot of other [registered nurses] would … do themselves". Mr D stated that he and Ms C had had "numerous meetings" to deal with the concerns raised.

Ms F stated that the only general guidance she had received at the rest home about when not to give insulin was "[w]hen you wouldn't get any response from the resident, if the patient is unconscious". She was unaware of any policies available to provide guidance on when insulin should not be given.

Mrs D said that to her knowledge there had not been any change in processes, guidelines or procedures, or any training in diabetes management from 21 September 2003 to the end of March 2004, when Ms C left the rest home.

Independent advice to Commissioner

The following expert advice was obtained from Ms Jan Featherston, Registered Nurse:

"**Background**

[Mr A] was a 69 year old man who suffered from Parkinson's disease, hypertension, postural hypotension and was an insulin dependent diabetic.

He was admitted to [the rest home] on 29th October 1998. At the time of his admission he required assistance with activities of living. The medical notes demonstrate that he was seen approximately every 2-4 months. His condition reflects a frail gentleman who required care. He was seen for the usual medical ailments you would relate to his documented medical condition, and several times for the falls he had.

The nursing documentation shows that staff recorded [Mr A's] BMs [blood glucose levels] twice a day. The documentation includes BM records from May 03 till September 03. Insulin records are also available for that time. Blood pressure and pulse chart are also included, as are TIA charts. [The rest home] nursing evaluation and progress notes range in dates from 1/8/03 till 22/9/03. Throughout this time the progress notes indicate that [Mr A's] BMs ranged from 2.5mmol/l (6/9/03) through to 14.2mmol/l (8/9/03). He had what was reported as several TIAs. He was up for his meals and appeared to be swallowing well.

On the 20/9/03 afternoon shift the progress notes indicate that [Mr A] had a fit at 7.45pm and he lashed out with his hands and feet. The Registered Nurse was contacted and advised to put up cot sides and check his BM. The progress notes indicate that the BM at 8pm was 2.5. It does not appear that the caregiver contacted the Registered Nurse again that night.

The night staff reported that [Mr A] was not co-operative in the early morning BP [blood pressure] is listed as 120/80, Temp 34.1. At this point he was unable to drink his Milo.

The caregiver on the [morning] shift recorded his BM at 3.2 at 8am, 20 units of Insulin was given at 8am. BP160/110 at 9.30am, and BM of 1.1 was recorded at 9.50. F in her interview with HDC on 23 August said that when the BM was 1.1 she rang the Registered Nurse [Ms C] who asked her to take the BM every 15 min. The

last reading was 2. The caregiver then rang the RN who asked her to ring the ambulance. Subsequently [Mr A] was admitted the hospital.

1. Based on her understanding of [Mr A's] condition, should [Ms C] have arranged for a professional assessment (doctor or ambulance) of [Mr A] following the call from [Ms E] if she was unable to attend personally?

There is conflicting evidence here. [Ms C] interpreted [Mr A's] fit as another TIA which he had had several times before. [Ms E] observed and described this as a much bigger seizure from what [Mr A] has previously had.

[Ms C] instructed cot sides to be put in place – correct action – but she did not ask for any sort of assessment or feedback. She should have in my opinion given a process for the care staff to follow, in that if [Mr A] did not improve or if any base line recording varied then a doctor should have been contacted if she was not available.

2. Based on her understanding of [Mr A's] condition, should [Ms C] have requested to be informed of the blood glucose level taken by [Ms E] at 8pm?

As I have stated if [Ms C] was not available to be on call then she should have left instructions and a process for the staff to follow and to implement if [Mr A's] BM was below a certain level.

3. Should [Ms C] have made herself aware of the blood glucose levels taken earlier on the 20th September?

A review of the notes shows that [Mr A's] BMs had been decreasing over a 5-6 day period. The recordings from the 16th show that the AM (8am) BMs ranged from 6.4-2.3; this is a low reading and below what would be desired. The night recordings also had dropped from around an average of 10-7 to 4.34 which is very low for an evening recording.

In my opinion [Ms C] should have been aware of this and when the caregiver notified her of [Mr A's] fit she should have questioned the BMs.

4. Were further observations indicated during the night?

This is difficult as many patients will have a fit and recover well. Knowing the patient history it would have been appropriate to check level of consciousness over night as well as BMs. General recordings should have also been taken. But the question must be asked are the caregivers able to accurately take the recordings?

Concern must have been raised over the very low temperature of 34.1 which would indicate severe loss of body temperature. Action should have been put in place to address this.

5. Did [Ms C] give adequate and appropriate advice in the circumstances that she recalled?

If [Ms C] interpreted [Mr A] as having a TIA, then in my opinion this would be adequate advice.

6. Did [Ms C] give adequate and appropriate advice in the circumstances described in the clinical record and recalled by [Ms E]?

If the circumstances described by the caregiver were accurate then in my opinion [Ms C] did not give adequate advice. I think it would have been more appropriate to … give a list of processes to follow and to inform the care staff that if [Mr A] had a change or worsening of his condition then medical staff should have been called to carry out a physical assessment.

Question 7-14: Events of the morning of 21st September 2003

As stated I have raised concerns over what appears to be the decreasing measurements of the BM readings. The normal action for readings is that they are lower in the mornings than what they are in the afternoon. The three readings the day of the 20th range from 2.7 to 2.3. Although the staff may take the recording correctly the machine may be faulty.

It was the correct advice to check the LOC [level of consciousness] of [Mr A]. In my opinion the manner in which this was done was incorrect. Staff should have followed a recognised process for this. There should have been a policy and procedure available for the care staff to use.

The 'Glasgow Coma Scale' is a recognised method to check someone's LOC. This tool involves three main areas, eye opening, verbal response or speech and movement or motor activity. This tool is commonly used and can be found in any 1st aid [book].

The order to give 'sugar' is correct if the BM is low but if the patient is semi conscious then you are at real risk of aspiration by giving any fluids. The LOC must be checked before the fluid is given.

[Ms C] should have asked or rather should have known what the BMs had been as I understand she had been at work on the Friday.

Judging by [Ms F's] statement she assumed that [Mr A] was conscious, if she explained this to the RN then the advice to check the BMs again would have been appropriate.

Once [Ms F] phoned back and advised the RN what the BM was (1.1) then it was appropriate to call the ambulance. It was in my opinion not appropriate to ask the caregiver to check it every 15 minutes. An ambulance should have been called at that stage.

The time delay may have affected the outcome for [Mr A]. It would have been more appropriate to take the BMs every 15 minutes after giving the insulin at 8am. As soon as the measurement started going down or in fact did not go up then independent medical advice should have been given."

Ms Featherston was also asked:

15. Would the caregiver staff be able to accurately assess and treat [Mr A's] hypoglycaemic attack from the available care plan?
16. Under what circumstances is it appropriate for caregiver staff to administer insulin?
17. What guidance should be available if caregiver staff administer insulin?
18. What training and updating is required for caregiver staff to record blood sugar levels?
19. Is it appropriate to observe quarter hourly blood sugars in a rest home environment?
20. What is the Manager's role in relation to staff training?
21. Should registered or enrolled nurse cover be provided in cases of [Ms C's] absence?

Ms Featherston provided the following comments:

"**Generally**

[Question 15:]
No, the caregivers would not have been able to assess and treat if they had followed the care plan. The care plan was generic in nature.

It lists the problems as Diet and Fluids related to Diabetes

The objective – To have [Mr A] stable with Diabetes

The interventions are related to tasks and cares.

The evaluations note that [Mr A] requires regular assistance with his feeding as he is prone to swallowing problems.

There are no potential problems identified in relation to Hypoglycaemia or Hyperglycaemia. If these were not written in the care plan then it would have been appropriate to have a reference as to where to locate these.

What would have been important is to [emphasise the speed at which] hypoglycaemia happens and what causes it, what sign and symptoms to look out for and what action to take if it occurs.

[Questions 16 – 18:]
Care staff do administer insulin in rest homes as many rest homes do not have registered staff available 24 hours a day. The regulations are very minimal on this and in fact some of the smaller rest homes may only need RNs 8 hours a week. There have been improvements in the administration of insulin in that the pen syringe is able to be programmed to give a certain amount of insulin, rather than the old way of care staff having to draw it up themselves.

I am of the understanding that there is no law or requirement that says care staff can not give insulin.

In saying that care staff should have some training in the administration of injections and especially insulin it is up to the facility to provide that training in one of two ways. In-house, in that the senior staff train the staff. This is fairly subjective in that there is no accountability as to what staff get trained. The second is for the care staff to attend and gain a nationally recognised certificate in care giving. The two that are available are the ACE programme or the better option is the National Certificate in Care of the Older Adult. There may be some limitations to the content but care staff are taught to observe and report.

Care staff should be able to take blood sugar levels. This can happen in two ways: either the old way which is a pin prick and a measurement on a lab stick or the most commonly used method of doing BMs is the glucometer, a device where the patient's finger is pricked and a drop of blood is placed on the lab stick and the machine measures the blood sugar level. These machines should be recalibrated every 6 months to ensure they are accurate.

The other option is a … blood test called HBA1C which gives an average glucose reading over the last three months.

[Question 19:]
It would be appropriate to take a blood sugar reading every 15 minutes but only in an emergency situation and only while waiting for the ambulance or medical intervention.

[Question 20:]
The Manager and Licensees both have a responsibility for staff education and on going training. There are requirements under certification in relation to what staff need.

[Question 21:]
Not all facilities are able to provide RN cover for on call and out of hours. In general the larger rest homes have RN coverage and many larger facilities have a hospital attached where there is a RN on duty [at] all times in the hospital. Some of the small rural facilities do not have coverage. Enrolled Nurses are regulated to work under the direction of a Registered Nurse.

This issue is brought up many times … who gives advice when there is no qualified staff available. The care staff usually phone the owner of the facility or the medical officer. The issues of higher dependency and more acutely sick patients is huge. The patients we now see in Rest Homes would have been assessed as hospital level several years ago. [Mr A's] notes indicate that this may well be the case with him. His diabetes was not that stable, his Parkinson's had deteriorated to the point that he had difficulty swallowing.

[Ms C's] contract is similar to ones found commonly in Rest Homes. Many contracts are generic in nature.

I did not view in the documentation provided a performance review and there is no indication as to when that was done. The owners of the facility should have evaluated [Ms C's] work performance.

The evidence should have been presented to the person undertaking the evaluation such as training records for staff, education programmers that had been designed for staff and a list of staff who attended.

Section C [of Ms C's job description] relates to 'Safe Drug administration'.

Many job descriptions will have this listed but it has always been interpreted as explaining that if a patient is on an antibiotic then care staff are asked to withhold laxatives, as antibiotics can cause loose bowel motions. Such things as if a patient starts a sedative to watch that they are not sleepy. It is not possible for caregivers to know the therapeutic levels, side effects and desired effects from all drugs.

What care staff need, is to understand and report any issues to the Registered Nurse that seem outside the norm for that patient.

Education must also include the '5 Rights', the right drug, [dose], route, patient and right time.

As stated before there are programmes that staff can do.

Most facilities would pay for staff to attend this type of course as it is very important for care staff to be aware of giving medications to patients.

It is my opinion that [Ms C] did not provide an appropriate standard of care in relation to the assessment of [Mr A] in the days leading up to the hypo event. Processes should have been put in place before this event to guide staff through this. In my opinion … if BMs are below 4 then care staff should be able to contact a health professional to seek guidance.

Other Comments

It is common practice that small stand alone rest homes with only one registered nurse have to implement procedures to deal with this type of event. These organisations also place huge responsibility on one RN who is expected to be on call 24 hours a day without any supervision or professional support."

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.

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 the 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."*

Competencies for the registered nurse scope of practice (Nursing Council of New Zealand, Feb 2002) include:

"3.1 [The nurse] makes nursing judgements based on current nursing knowledge, research and reflective practice. …
4.5 [The nurse] uses professional judgement, including assessment skills, to assess the client's health status and to administer prescribed medication and/or to consult with the prescribing practitioner and/or to refer client to other health professionals. …
4.8 [The nurse] administers and monitors the effect of prescribed interventions, treatments and medications within a framework of current nursing knowledge and knowledge of pharmacology, physiology, pathophysiology, pharmodynamics and pharmacokinetics. …
4.10. [The nurse] evaluates the effectiveness of the client's response to prescribed interventions, treatments and medications and monitors prescribing, takes remedial action and/or refers accordingly.

4.11. [The nurse] directs, monitors and evaluates the nursing care provided by nurse assistants/enrolled nurses.

4.12. [The nurse] combines effective assessment and professional judgement in determining the needs of the client and the preparation and ability of the health service assistant or family/carers to perform the delegated activities in relation to assistance with care."

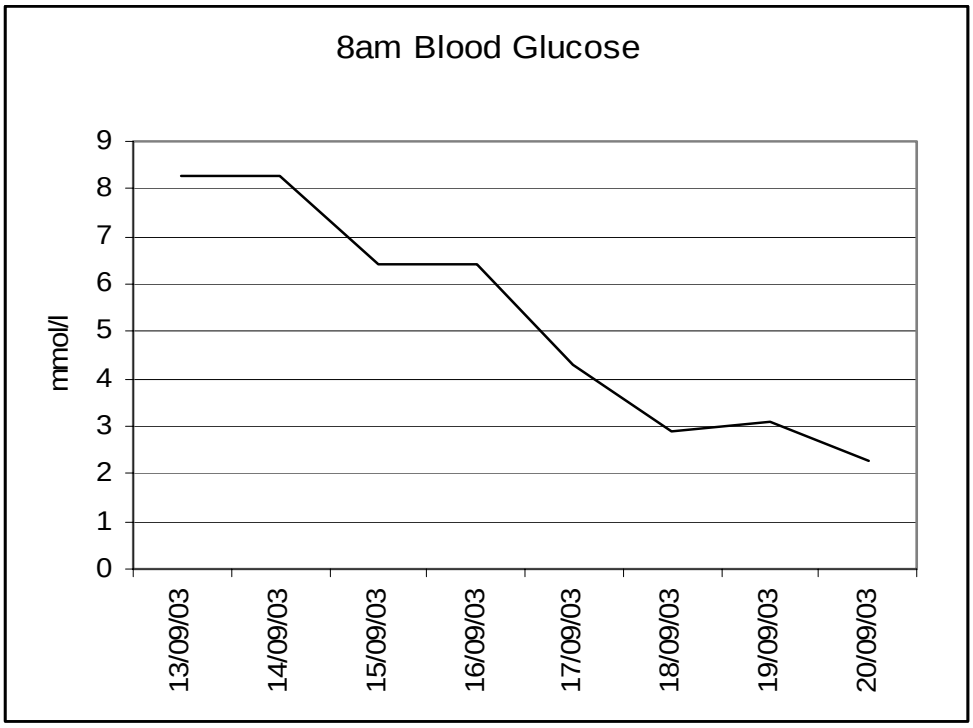
Opinion: Breach – Ms C

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mr A had the right to have services provided by Ms C with reasonable care and skill, and that complied with professional standards.

Failure to monitor blood glucose measurements

As the only registered nurse at the rest home, Ms C was responsible for planning and monitoring the care that residents received. This included the monitoring of Mr A's blood glucose measurements to ensure that his diabetes was being correctly managed.

My advisor, Ms Featherston, stated that Ms C should have been aware of the decreasing blood glucose levels over the week preceding Sunday 21 September 2003. From 13 to 20 September, Mr A's 8am blood glucose level had consistently fallen (see graph below, "8am Blood Glucose").

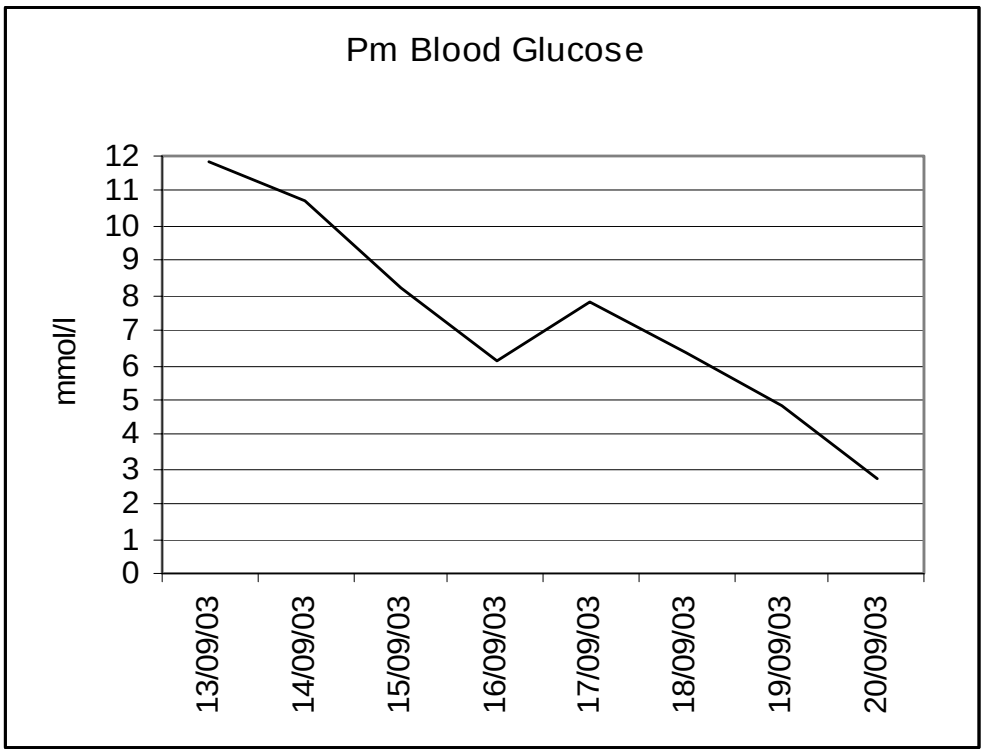


Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name

However, Ms C apparently believed that the measurement of 3.2mmol/l at 8am on 21 September was "normal" for Mr A. In fact, analysis of the results of Mr A's twice-daily tests (see Appendix II) shows that from 20 August to 20 September, the average blood glucose level for Mr A at 8am was 5.6mmol/l.

Ms C clarified her position by saying that the 8am reading of 3.2mmol/l was normal for Mr A if the analysis of the blood glucose measurements covered a longer period. However, I consider that Ms C's analysis was incorrect. Over a five-month period (1 May to 20 September 2003, see Appendices 1 and 2), the average reading for Mr A at 8am was again 5.6mmol/l.

Mr A's blood glucose measurement in the afternoon/evening also fell during the period 13 to 20 September (see graph below, "Pm Blood Glucose"). The average afternoon/evening measurement during the period 1 May to 19 September 2003 was 8.2mmol/l.



Ms C stated that she checked Mr A's blood glucose level on a daily basis when she looked at the nursing documentation. Yet had Ms C performed this check as she stated, she should have seen the fall in blood glucose measurements from 13 September. In my opinion, a registered nurse in these circumstances should have seen the trend of Mr A's blood glucose levels and reacted accordingly. That Ms C did not react meant either that she had a fundamental lack of understanding of diabetes, or that she had not looked at the documentation. Ms C informed me that, as a diabetic herself, she has a personal as well as a professional knowledge of diabetes, and so I believe that it is more probable that she failed to monitor Mr A's blood glucose levels from 13 to 20 September. It follows that Ms C's statement, that she checked Mr A's blood glucose levels on a daily basis, is not credible.

Ms Featherston advised that, as the registered nurse, Ms C should have been aware of Mr A's falling blood glucose levels over the period from 13 to 20 September, and that a review of Mr A's diabetes management should have occurred. I accept this advice. By failing to ensure that Mr A's diabetes was monitored effectively, Ms C did not provide services with reasonable care and skill and therefore breached Right 4(1) of the Code. By failing to evaluate the effectiveness of Mr A's response to prescribed interventions and treatments, and to take remedial action and/or refer accordingly, Ms C breached Right 4(2) of the Code.

Events of 20 and 21 September

On Saturday 20 and Sunday 21 September, Ms C's responsibility was to provide professional clinical advice to the caregivers on duty at the rest home. I consider Ms C's statement that she was not available because of personal reasons to be irrelevant; by freely providing advice to Ms E and Ms F when they telephoned her, Ms C accepted the responsibility for the guidance she gave and assumed a duty of care to Mr A.

20 September

The clinical record completed by Ms E on the evening of 20 September matches her recollection, in that the fit suffered by Mr A was a new and more serious event than a usual transient ischaemic attack. I accept her statement that she informed Ms C of this. I also accept my advisor's view that Ms C should have given Ms E more precise instructions to follow at this point. I believe that Ms C provided inadequate advice to Ms E. In my opinion Ms C did not provide services with reasonable care and skill and breached Right 4(1) of the Code. By failing to direct, monitor and evaluate the nursing care provided by caregivers, Ms C breached Right 4(2) of the Code.

By failing to ensure that Mr A was monitored more effectively on the evening of 20 September, Ms C missed the opportunity to prevent the occurrences of the following day.

21 September

As a result of Ms F's first call to Ms C, Ms C requested that Mr A's consciousness level be checked by brushing a finger over his eyelashes. Ms Featherston stated that this is incorrect guidance for a registered nurse to give a caregiver. She also stated that 15-minute blood glucose levels should have been commenced after the first call from Ms F to Ms C. For Ms C to give Ms F guidance to call her back in the event "she wasn't happy" was inadequate and inappropriate.

After the second telephone call, when Ms F reported that the blood glucose level was 1.1mmol/l, Ms C should have instructed that an ambulance be called immediately. However, it was at this time that her sole order to Ms F was to check blood glucose levels every 15 minutes. While this advice would have been appropriate and necessary one and a half hours earlier, it was inadequate by this time. It is remarkable that such a low blood glucose level did not prompt Ms C to call an ambulance. This did not happen until after the third call from Ms F to Ms C, a further 45 minutes later.

At 10:50am, the ambulance crew assessed Mr A's level of consciousness using the Glasgow Coma Scale (GCS) and it was measured at 3, which is the lowest possible measurement. As

Ms F has stated that Mr A's conscious level did not alter throughout the morning, it is likely that Mr A's GCS was 3 from 7am.

I accept Ms Featherston's advice. Because she failed to instruct Ms F to perform 15-minute blood glucose levels immediately after receipt of the first call, recommend an appropriate consciousness level check, call an ambulance after the second call from Ms F, and did not give precise guidance to Ms F on a consciousness level check and when she should call back, Ms C failed to provide services with reasonable care and skill and therefore breached Right 4(1) of the Code. By failing to direct, monitor and evaluate the nursing care provided by caregivers, Ms C breached Right 4(2) of the Code.

Clinical observations
As the registered nurse at the rest home, Ms C was responsible for monitoring the clinical observations taken by the caregivers and providing appropriate guidance on actions to be taken. She had to take positive steps to acquire the results of observations, not simply rely on untrained staff to recognise atypical observations and contact her if they weren't "happy".

Mr A's temperature, taken by the night staff over the night of 20 September, was 34.1°C. Ms C was not informed of this clinical observation, nor did she ask about this or any of Mr A's observations when contacted by Ms F on the morning of 21 September. My advisor stated:

> "Concern must have been raised over the very low temp. 34.1 would indicate severe loss of body temp. Action should have been put in place to address this."

In my opinion, Ms C should have asked for all the clinical observations (including blood glucose measurements) to be reported to her, including the observations performed on 20 September, when she was first contacted by Ms F on 21 September. Ms C should also have made herself aware of the blood glucose level taken at 7.45pm on 20 September (2.5mmol/l). A reading of 2.5mmol/l is significantly low and would have prompted action by a responsible and competent registered nurse in similar circumstances. All three blood glucose levels taken on 20 September were recorded as less than 3mmol/l, showing that Mr A was hypoglycaemic from 7am on 20 September. Ms C should have obtained these results when contacted by Ms E, and acted accordingly. By failing to act, Ms C did not provide services with reasonable care and skill and breached Right 4(1) of the Code. By failing to direct, monitor and evaluate the nursing care provided by caregivers, Ms C also breached Right 4(2) of the Code.

Other comments

Staff training
In my opinion the caregiver staff had been inadequately trained in the administration of insulin injections and the measurement of blood glucose levels.

Ms C stated that the management of diabetes was discussed at the staff meetings. However, within the staff meeting minutes made available to me, there is no reference to diabetes.

Even if there were staff meetings at which diabetes had been discussed, and I have not been provided with the minutes, it remains my opinion that this would be an inappropriate forum for teaching the practical tasks of drug administration and blood glucose level measurements. Ms C should have taken positive steps to ensure that caregiver staff had the appropriate level of skills in these areas.

It was Ms C's role to ensure that staff were appropriately trained to perform their role. Ms C stated that she was never involved in drug administration, this being a caregiver's role at the rest home. However, this did not absolve her from the responsibility to ensure that drug administration was performed in a safe manner. In my opinion, Ms C did not take adequate measures to train staff.

Care plans and guidelines
It was Ms C's responsibility to ensure that Mr A's care plan reflected his needs, and that guidelines were available for staff to allow them to care for residents in a safe manner. Ms Featherston stated that "the caregivers would not have been able to assess and treat if they had followed the care plan".

I agree with my expert, and it is my opinion that Mr A's care plan was inadequate to allow caregiver staff to manage Mr A safely, should he have an abnormal blood glucose level.

Ms Featherston was also critical that there were neither policy nor guidelines for the caregivers to follow when checking the consciousness level of a patient. Ms C's contract is clear that this is her responsibility.

The rest home was unable to provide records from September 2003 of the regular calibration of the Advantage II blood glucose meter. I am guided by my advisor, who stated that this calibration should be done on a six-monthly basis. Again, it is my opinion that Ms C should have ensured that this routine check occurred.

I endorse my advisor's comment that "processes should have been put in place before [the events of 20 and 21 September] to guide staff".

Summary

Ms C has attempted to excuse her actions on 20 and 21 September 2003 by saying that there had been a family emergency that prevented her from attending the rest home. However, this point is irrelevant, as she freely advised Ms E and Ms F on 20 and 21 September. The point is equally irrelevant to my opinion that she failed to monitor Mr A's decreasing blood glucose levels in the preceding week, she failed to train staff, and she failed to provide an accurate care plan and appropriate guidelines. I am concerned that Ms C has made no acknowledgement of her errors.

I am also concerned that Ms C has made statements to my Office and to the Police that lack credibility: that 3.2mmol/l was a "normal" blood glucose reading for Mr A; that Mr A was "restless" when he was, in my opinion, having a fit; that she informed staff that she was not available on 20 and 21 September; that she trained staff in administering insulin and

measuring blood glucose levels; that diabetes was discussed at staff meetings; that a policy for insulin administration was available; that she checked Mr A's blood glucose levels on a daily basis; and that she does not recall a telephone call she made to Ms F on 21 September 2003.

Opinion: Breach – The Rest Home

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the code. 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 breaching the Code.

Mr and Mrs D were experienced rest home owners in September 2003 and Mrs D was closely involved in the provision of care through being a caregiver at the rest home. She was involved in the administration of medications, including insulin, and the monitoring of clinical observations, which included blood glucose measurements. As a licensee, she was aware of the requirements in Ms C's contract to train and maintain the competence of staff at the rest home. Mrs D stated that she never received any update to her clinical practice in respect of the administration of insulin or the practice of measuring blood glucose levels. She should also have been aware that there were no guidelines available to staff on the administration of insulin or the measurement of blood glucose levels. She should have been aware that the care plans were insufficient to provide clinical guidance to maintain Mr A's safety should he suffer either high or low blood glucose levels. Mrs D was in a unique position as a caregiver to observe these aspects of Ms C's performance as Manager.

In my opinion, the licensees should have been alerted to Ms C's deficiencies, and acted on them. By failing to take steps to ensure that Ms C performed her role as Manager, they are vicariously liable for Ms C's breaches of the Code.

Other matters
A critical event occurred at the rest home on 20 and 21 September 2003, which resulted in the death of a 68-year-old man. Mrs D stated that there were no changes made to guidelines, or training from that date until Ms C left the rest home in March 2004. In my opinion the licensees, Mr and Mrs D, bear some responsibility for ensuring that the events that occurred on that weekend did not recur. As licensees they should have formally reviewed the event in detail, including the actions of Ms C, Ms E and Ms F. It is of concern to me that a review did not occur.

I have been informed that the rest home has made significant changes since April 2004, with the employment of a Matron/Manager to replace Ms C. Regular training is in place for staff, with policies and guidelines being available for the management of diabetes. The equipment used to measure blood glucose levels is regularly calibrated.

Action taken

Mr and Mrs D have provided an apology to Ms B, representing Mr A's family, for their breach of the Code.

Recommendation

I recommend the following action:

- Ms C apologise in writing to Ms B, representing Mr A's family, for her breaches of the Code. This apology should be made in writing and signed by Ms C, and is to be sent to the Commissioner for forwarding to Mr A's daughter.

Follow-up actions

- This matter will be referred to the Director of Proceedings in accordance with section 45(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of my final report will be sent to the Nursing Council of New Zealand with a recommendation that the Council undertake a competency review of Ms C's practice.

- A copy of my final report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings issued proceedings before the Health Practitioners Disciplinary Tribunal and, at a hearing on 10 October 2005, a charge of professional misconduct was upheld. Ms C was ordered to practise only under the supervision of a registered nurse approved by the Nursing Council of New Zealand, and was ordered to contribute $10,000 towards the costs of the hearing and prosecution.

Appendix 1

Blood glucose levels 1 May to 21 September 2003

	am	pm
1/05/2003	5.8	8.8
2/05/2003	5.1	3.3
3/05/2003	4.7	7.8
4/05/2003	4.2	2.4
5/05/2003	7	6.9
6/05/2003	4.2	7.7
7/05/2003	5.6	11.4
8/05/2003		6.5
9/05/2003	2.1	7.2
10/05/2003	5.1	10.2
11/05/2003	5.5	8.3
12/05/2003	6.8	8
13/05/2003	6.3	10.6
14/05/2003	6.3	13.9
15/05/2003	6.1	19.2
16/05/2003	9.9	5.7
17/05/2003	4.3	6.2
18/05/2003	4.9	7.3
19/05/2003	6.4	9.3
20/05/2003	8.2	13.3
21/05/2003	7.9	6.1
22/05/2003	9.5	10.2
23/05/2003	5.7	8.4
24/05/2003	4	6.5
25/05/2003	6.1	9
26/05/2003	4.4	4.6
27/05/2003	7.2	9.8
28/05/2003	4.4	10.7
29/05/2003	5.6	10.3
30/05/2003	5.1	2.6
31/05/2003	4.7	6.2

	am	pm
1/06/2003	6.5	9
2/06/2003	7.2	7.3
3/06/2003	8.9	7.4
4/06/2003	7.5	6.3
6/06/2003	5.1	3.2
7/06/2003	4.8	10.7
8/06/2003	5.4	5.7
10/06/2003	5.6	7.7
11/06/2003	5.9	7.7
12/06/2003	5.8	6.1
13/06/2003	6.7	10.6
14/06/2003	6.5	7.9
15/06/2003	5.6	6.1
16/06/2003	5.9	7.3
17/06/2003	3.2	9.4
18/06/2003	4.2	4.9
19/06/2003	5.4	16.9
20/06/2003	6.9	11
21/06/2003	5.2	3.6
22/06/2003	4.2	10.9
23/06/2003	7.1	6.8
24/06/2003	6.4	5.1
25/06/2003	4.2	5.4
26/06/2003	5.9	8.5
27/06/2003	4.4	8.4
28/06/2003	4.8	5.1
29/06/2003	3.6	9.2
30/06/2003	4.9	8.8

	am	pm
2/07/2003	7.2	9.4
3/07/2003	6.8	5.2
4/07/2003	6.9	3.9
5/07/2003	4.9	9.2
6/07/2003	8.2	10.6
7/07/2003	6.8	7.3
8/07/2003	4.9	5.6
9/07/2003	4.9	10.6
10/07/2003	4.8	9.8
11/07/2003	4.9	9.4
12/07/2003	4.9	10.5
13/07/2003	7	9.3
14/07/2003	6.6	10.8
15/07/2003	6.7	10.7
16/07/2003	4.7	14
17/07/2003	4.6	7.6
18/07/2003	4.2	7.4
19/07/2003	6.4	3.7
20/07/2003	4	3.7
26/07/2003	6.5	6.4
27/07/2003	5.4	4.8
28/07/2003	4.7	8.2
29/07/2003	4.6	7.6
30/07/2003	4.8	7.3
31/07/2003	5.7	11.2

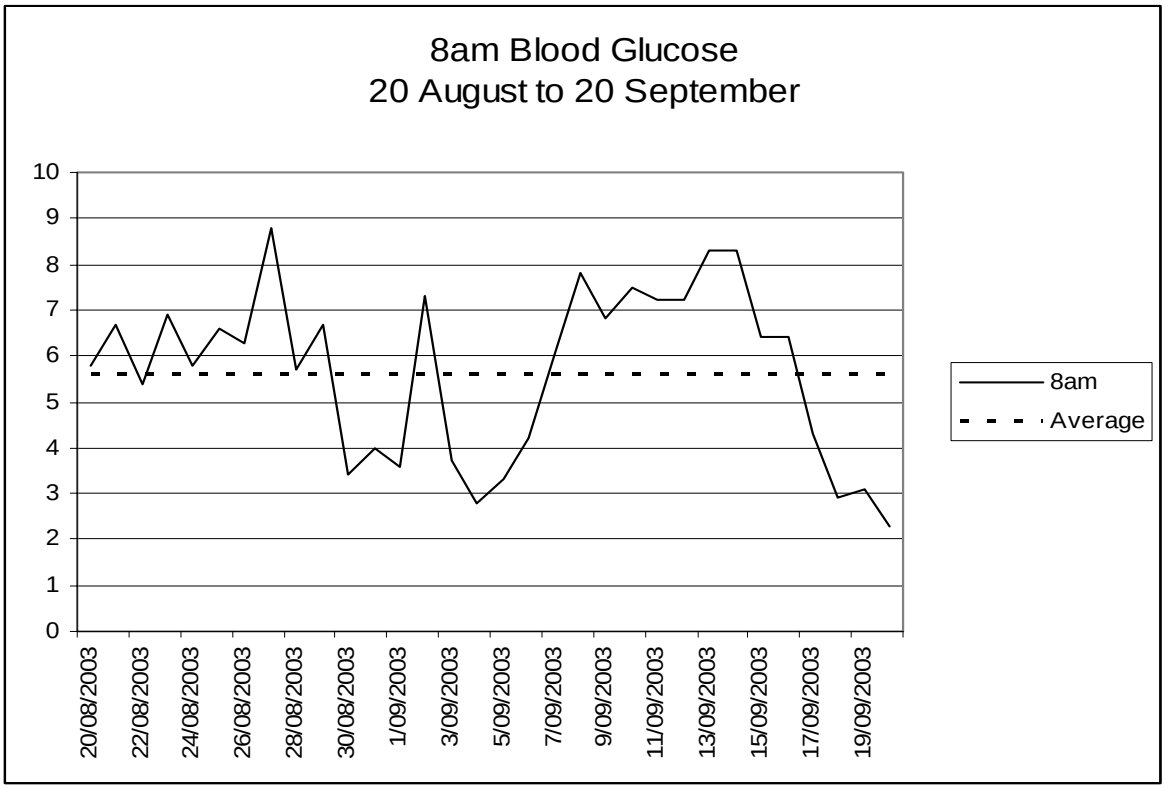
Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

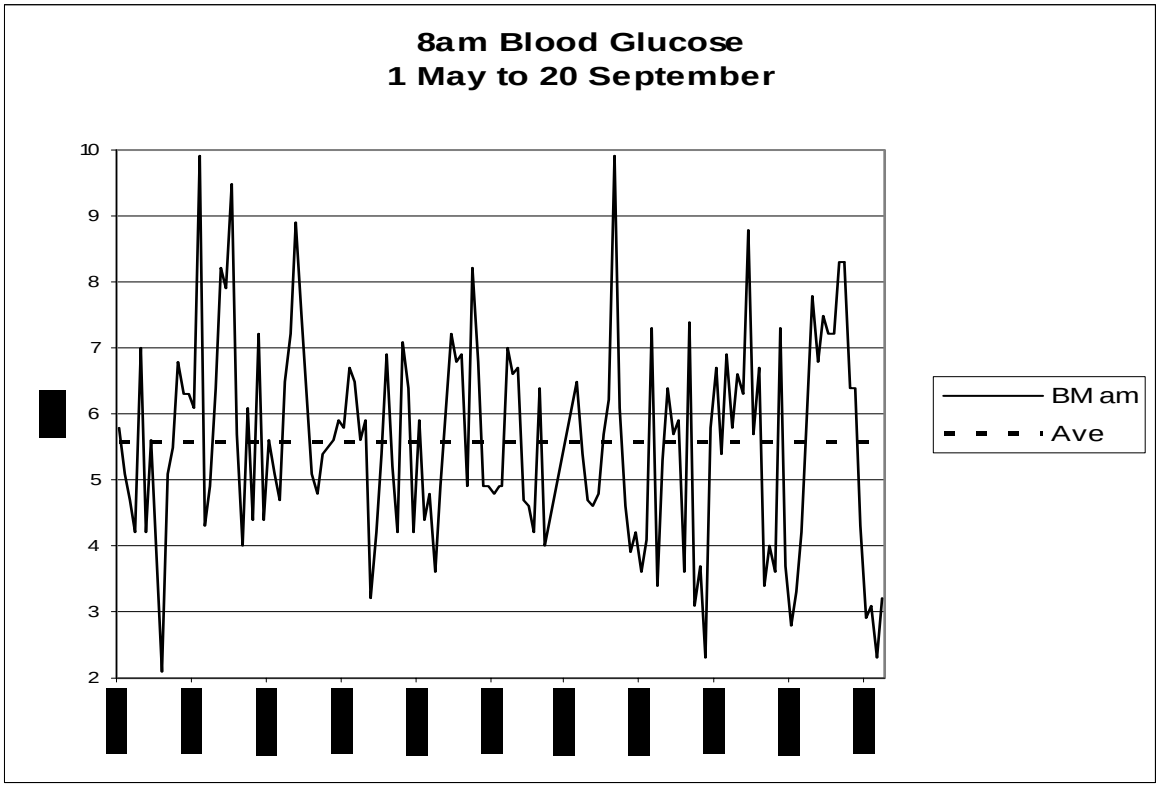
Appendix 1 (cont'd)

	am	pm
1/08/2003	6.2	12.2
2/08/2003	9.9	5.1
3/08/2003	6.1	5.8
4/08/2003	4.6	8.9
5/08/2003	3.9	8.9
6/08/2003	4.2	9.2
7/08/2003	3.6	12.3
8/08/2003	4.1	8.5
9/08/2003	7.3	5.6
10/08/2003	3.4	7.5
11/08/2003	5.3	10.7
12/08/2003	6.4	9.3
13/08/2003	5.7	10.6
14/08/2003	5.9	3.8
15/08/2003	3.6	10.5
16/08/2003	7.4	7
17/08/2003	3.1	5.6
18/08/2003	3.7	5.4
19/08/2003	2.3	8.6
20/08/2003	5.8	5.6
21/08/2003	6.7	3.9
22/08/2003	5.4	4.6
23/08/2003	6.9	6.5
24/08/2003	5.8	6.1
25/08/2003	6.6	12
26/08/2003	6.3	10.9
27/08/2003	8.8	9.6
28/08/2003	5.7	11.2
29/08/2003	6.7	6.3
30/08/2003	3.4	5
31/08/2003	4	6.4

	am	pm
1/09/2003	3.6	10.8
2/09/2003	7.3	8
3/09/2003	3.7	9.2
4/09/2003	2.8	4.3
5/09/2003	3.3	10.6
6/09/2003	4.2	8.7
7/09/2003	6.1	9.8
8/09/2003	7.8	14.2
9/09/2003	6.8	9.8
10/09/2003	7.5	10.9
11/09/2003	7.2	7
12/09/2003	7.2	11
13/09/2003	8.3	11.8
14/09/2003	8.3	10.7
15/09/2003	6.4	8.2
16/09/2003	6.4	6.1
17/09/2003	4.3	7.8
18/09/2003	2.9	6.4
19/09/2003	3.1	4.8
20/09/2003	2.3	2.7
21/09/2003	3.2	

Appendix 2





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