Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 21HDC02320)

Contents

Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner.

2. This Office received a complaint from Ms B about the care provided to her late mother, Mrs A (69 years old at time of events) while she was a resident at Kauri Lodge between 1 Month2[1] 2021 and 15 Month4 2021 (inclusive).

3. The following issues were identified for investigation:

- *Whether Kauri Lodge provided [Mrs A] with an appropriate standard of care from 1 [Month2] 2021 to 15 [Month4] 2021 (inclusive).*
- *Whether [Dr C] provided [Mrs A] with an appropriate standard of care from 1 [Month2] 2021 to 15 [Month4] 2021 (inclusive).*

[1] Relevant months are referred to as Month1–Month4 to protect privacy.

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

Background

4. In 2018, Mrs A was admitted into rest-home level care at Kauri Lodge.

5. Mrs A's co-morbidities included paroxysmal atrial fibrillation,[2] depression, ischaemic heart disease,[3] ischaemic cardiomyopathy,[4] angina pectoris,[5] type 2 diabetes,[6] congestive cardiac failure,[7] recurrent urinary tract infections[8] and chronic renal failure.[9]

6. Mrs A's daughter, Ms B, was one of her next of kin.

Advance and long-term care plans

7. Mrs A had an advance care plan. She noted that she wanted to be told all the details about her condition and treatment and to have a say in every decision about her health care. She noted that if she was dying, she wanted to have medications to help settle her during this process and wanted her family around her. She wanted to pass away at Kauri Lodge, in her room.

8. According to Mrs A's interRAI[10] undertaken prior to her admission, her overall health had improved since her previous assessments, and continence, mood changes, and cardiorespiratory function were identified as areas for continued support and monitoring.

9. Mrs A had long-term care plans that had been prepared prior to her admission. These care plans documented that she mobilised independently with a walking frame and was 'independent' with her personal cares. In terms of toileting, her care plan documented that she '[remained] independent with toileting [and was] [i]nfrequently incontinent of urine'. Mrs A was independent with eating and drinking and enjoyed meals with her friends in the dining room, 'having laughs and conversations'. It was documented that she spoke clearly and was 'articulate'. It was noted that Mrs A '[kept] her brain functioning and active by using her laptop frequently and participating in craft work and other [diversional therapist][11] activities'. Mrs A's long-term care plans were due to be updated.

Mrs A's presentation Month1 to Month4 2021

Month1 2021

Summary of Month1 2021 presentation

10. In Month1 2021, progress notes indicate that Mrs A was independent with her personal cares and independent using her walking frame. The progress notes document that she would walk to the resident dining room to eat her meals, and that she had a good appetite.

[2] An irregular, rapid heart rhythm.
[3] Arteries are narrowed and cause heart problems.
[4] The heart is damaged and unable to pump blood properly.
[5] A type of chest pain.
[6] The body is not using insulin properly, leading to high levels of blood sugar.
[7] A chronic condition where the heart does not pump blood as well as it should.
[8] Infections that occur in any part of the urinary system (the kidneys, bladder, or urethra).
[9] The kidneys stop working.
[10] An interRAI is a suite of clinical assessments used to build a picture of a person's health and wellbeing needs.
[11] A diversional therapist creates leisure programmes for residents in care homes.

Progress notes during Month1 report that Mrs A was 'happy', 'content', 'settled', and '[e]njoyed a phone call' from her daughter. Mrs A went on leave with her family twice during Month1.

Key events in Month1 2021

11. On 29 Month1 2021, Mrs A was admitted to a public hospital for an operation to treat kidney stones and to place a kidney stent.[12]

Month2 2021

Summary of Month2 2021 presentation

12. Between 3 and 28 Month2 2021, progress notes indicate that Mrs A remained independent with her personal cares and was 'refusing any help'. Mrs A continued to mobilise independently using her frame. She went to the dining room for her meals and ate her meals independently. Notes indicate that Mrs A was 'well enough' to participate in exercises with the physiotherapist assistant and helped the diversional therapist to set up bowls for the other residents. Progress notes document that Mrs A '[a]ppeared happy' on her computer in her room and 'settled'. A staff member noted that Mrs A was an 'independent lady'. Mrs A went on leave with her family twice during Month2. However, as documented below, towards the end of the month she began to feel unwell.

Key events in Month2 2021

13. On 3 Month2 2021, Mrs A was discharged back to Kauri Lodge following her kidney operation, with instructions from the hospital doctors to take pain relief and antibiotics, see her GP regarding her breathing and inhaler, and attend a follow-up clinic in two weeks' time. There is no evidence that a short-term care plan was developed for Mrs A on her return from hospital, nor evidence that her GP was notified.

14. Progress notes on 8 Month2 2021 indicate that Mrs A approached a registered nurse as she was having trouble breathing. Her vital observations were recorded, and she was given her asthma inhalers. Mrs A told the nurse that after her surgery she had noticed that her asthma had worsened.

15. Progress notes on 19 Month2 2021 indicate that Mrs A went to the public hospital for the removal of her kidney stent. There is no evidence that a short-term care plan was developed for Mrs A on her return from the hospital.

16. On 28 Month2 2021, it is documented that Mrs A 'didn't feel well' though she could not 'specifically say what's wrong'. A registered nurse tested Mrs A's urine and recorded her observations. Later in the evening, Mrs A told the healthcare assistant that she was not feeling well and refused a shower.

17. It is documented in the morning of 30 Month2 2021 that Mrs A felt short of breath. Her observations were taken, and she was given her inhalers. In the afternoon, it was

[12] A thin tube inserted into the ureter to help drain urine from the kidney.

documented that Mrs A was again 'not feeling well'. Her observations were taken, and she was given her usual medications.

18. On 31 Month2 2021, it is documented that Mrs A was 'not feeling well' and declined a shower.

Month3 2021

Summary of Month3 2021 presentation

19. In Month3 2021, the progress notes indicate that Mrs A mostly stayed in her room as she was 'very sleepy' and had a 'poor appetite'. Notes document that Mrs A now had more limited use of her limbs, particularly on her right side, she required full assistance with her hygiene cares, and she was now incontinent of urine. It is documented that Mrs A was now '[non-]weight bearing' and required hoist transfers. She was also progressively getting more confused, had more difficulty speaking, and had a low mood. Mrs A did not go on leave with her family in Month3.

Key events in Month3 2021

20. On 6 Month3 2021, a cleaner found Mrs A on the floor. Mrs A said that she slid down the side of the bed and could not get herself back off the floor. She was checked for pain and range of movement and hoisted to bed. Neurological observations[13] were completed, and her family was notified.

21. On 7 Month3 2021, progress notes document that Mrs A appeared confused and was incontinent of urine overnight. Vital observations were recorded in the progress notes.

22. On 8 Month3 2021, progress notes document that Mrs A remained in bed all evening and had a poor appetite. It was noted that 'when [Mrs A] was trying to use her right arm to feed or drink it appeared to be weak [and] while talking she seemed to be getting confused or tried to explain something but wasn't making sense'.

23. On 10 Month3 2021, Mrs A was found by a carer on the floor in her bedroom. Mrs A stated that she had lost her balance while trying to get up from the bed. She was hoisted to her bed and checked for bruising, and neurological observations were recorded. Mrs A's family was notified on the same day.

24. On 16 Month3 2021, Dr C and a nurse practitioner reviewed Mrs A, as a nursing referral documented that she was 'feeling very low and confused [and] unable to complete sentences', had asked for someone to feed her, had rejected cares, and '[could not] be bothered getting out of bed'. Although the referral noted that Mrs A was unable to complete sentences and did not want to get out of bed, Dr C did not perform a neurological assessment, check for postural hypotension, or perform other assessments such as lung and heart auscultation. Instead, Dr C's plan was for staff to monitor Mrs A's behaviour and restart her fluoxetine,[14] as she had responded well to it in the past.

[13] Neurological observations provide a snapshot of a person's level of consciousness.
[14] Fluoxetine is a type of antidepressant.

25. In response to the provisional opinion, Dr C stated that he was in an 'observational role' and that it was a nurse practitioner who conducted this review, and together they concluded that 'the symptoms were consistent with [Mrs A's] chronic depressive disease, and therefore a delirium screen was not undertaken' or an assessment for 'possible hypotension' due to Mrs A's 'expressed reluctance to move'.

26. On 18 Month3 2021, the nurse practitioner reviewed Mrs A and asked for a BATOMI[15] assessment to be performed on Mrs A to determine her mental state.

27. On 22 Month3 2021, Ms B contacted Kauri Lodge and informed staff that her family believed that Mrs A 'may have had a stroke'. She told HDC that a nurse replied, '[N]o, she has depression.' There is no record of this conversation in Mrs A's progress notes.

28. On 23 Month3 2021, a registered nurse sent a referral to physiotherapy.[16] The referral noted: '[Mrs A] [s]ometimes needs x 2 to transfer ? Depression. Not trying to mobilize herself at times [sic].' The physiotherapist conducted an assessment and documented that [Mrs A] was 'extremely weak in her [right] hand/arm [and right] leg/foot [and that she was] no longer safe to walk' and now required hoist transfer and two carers to assist. The physiotherapist noted that [Mrs A] was unable to speak easily. In response to a query whether [Mrs A's] change in mobility was due to depression, the physiotherapist documented that when [Mrs A] arrived at Kauri Lodge in 2018 she had clinical depression, but was still able to talk, and 'physically able to move all her limbs, stand, walk [and] sit independently'. The physiotherapist added: '[Mrs A] cannot do these now … something has changed.' The physiotherapist felt that Mrs A had a motor neuron[17] issue and that she required a GP follow-up and further investigations such as a CT head[18] scan. The physiotherapist's review was to be sent to the GP by the registered nurse. However, while there is evidence that a referral was prepared by the registered nurse, there is no evidence confirming that it was sent to the GP.

29. On 24 Month3 2021, notes indicate that the registered nurse spoke to the clinical services manager regarding moving Mrs A to the hospital-level wing. It is documented that Mrs A agreed (however, Mrs A was not moved to the hospital-level wing until 6 Month4 2021).

30. Ms B stated that on 24 Month3 2021 she arrived at the lodge having travelled from overseas. She spoke to a nurse on duty, who told her that Mrs A had been assessed by the physiotherapist and that the report would be sent to the GP for follow-up. She said that the nurse also mentioned that scans might occur. The nurse did not elaborate further, and it appeared to Ms B that the nurse did not realise that she was one of Mrs A's documented

[15] An examination that gives a snapshot of the person's emotions, thoughts, and behaviour at the time of observation.
[16] Physiotherapy treatment is used to restore, maintain, and make the most of a person's mobility, function, and wellbeing.
[17] Motor neurons are cells in the brain and spinal cord that allow us to move, speak, swallow and breathe.
[18] CT head is a special type of X-ray that takes images of the brain.

next of kin. This communication with Mrs A's family was not documented in Mrs A's progress notes.

31. Ms B also said that when she visited, '[her mother] was not able to say more than yes or no to questions', and she was 'mostly refusing food [and] struggling to feed herself'.

32. Ms B told HDC that on 25 Month3 2021, she and her father spoke to Kauri Lodge. They said they believed that Mrs A had 'suffered a stroke' as they had noticed that Mrs A was 'no longer able to use her right hand'. Ms B stated that the response was that Mrs A was 'suffering from depression' and had just been started back on antidepressants, and that Mrs A '[was] not displaying all of the symptoms associated with a stroke'. This communication between clinical services and Mrs A's family was not documented in Mrs A's progress notes.

33. Ms B told HDC that on 30 Month3 2021, the day they were leaving town, the family spoke to Kauri Lodge. They expressed their concerns regarding Mrs A and said that they 'did not believe her symptoms could only be attributed to depression'. Ms B stated that Kauri Lodge said that they had 'noticed the sudden downturn' in Mrs A's health and 'questioned if it was depression alone'. This conversation between Kauri Lodge and the family was not documented in Mrs A's progress notes.

34. In response to the provisional opinion, Dr C stated that Mrs A's family saw Mrs A on 30 Month3, and then 'went away on holiday in [New Zealand] thereafter. They were seemingly unconcerned and could see she was in a place she preferred to be and with a team they were comfortable with.' Dr C said that in hindsight, however, he should have ensured that contact had been made with Mrs A's family when Mrs A started to 'seriously deteriorate'. Dr C stated:

> 'I apologise for this oversight on behalf of the nursing staff, the nurse practitioner and myself for not making contact with the family after [the] 30 [Month3] 2021 review to confirm their suspicions regarding the possibility of [Mrs A] suffering a stroke.'

35. On 30 Month3 2021, the nurse practitioner and Dr C both assessed Mrs A and noted that she had right-sided weakness and could not move her right leg or hand. It was documented that Mrs A struggled to communicate and that although she was aware of what was being said, she found it 'difficult to respond appropriately'. It was also noted that Ms B had said that her mother was not depressed. The plan for Mrs A included a nursing assessment regarding cares, and a review of blood tests. It was documented that Dr C and the nurse practitioner thought that Mrs A had had a stroke and therefore the BATOMI assessment was no longer needed. Dr C told HDC that although he considered calling an ambulance, he chose to manage Mrs A conservatively instead, as her 'weakness appeared quite stable' and she was already on medication to prevent any thrombosis.[19]

36. In response to the provisional opinion, Dr C stated that when they reviewed Mrs A on this date, the nurses informed him that the right-sided weakness had been present 'for a week' but he had not been made aware of this earlier. He noted that '[t]his would have taken [Mrs

[19] Blood clots.

A] outside of the therapeutic window for radiological intervention clot extraction, for which she was unlikely to be fit enough to undergo', so he had elected for conservative treatment and rehabilitation. He said that if Mrs A had been referred to a public hospital, 'she would have [had] to suffer over two and a half hours of travel over rough roads to be in a strange hospital away from familiar surroundings'.

Month4 2021

Summary of Month4 2021 presentation

37. Mrs A continued to deteriorate and remained '[fully] dependent' for all her cares and required assistance with eating and drinking. She was moved to the hospital wing on 6 Month4 2021. Sadly, on 15 Month4 2021 Mrs A passed away.

Key events in Month4 2021

38. On 7 Month4 2021 Dr C documented that Mrs A's right leg movement was improving but she still did not have movement in her right hand and arm. Dr C made a referral for a CT head scan for Mrs A to 'determine if bleed or infarct causing [right] leg hemiparesis[20] and [right] arm hemiplegia[21]'. The referral noted that Mrs A was taking low-dose aspirin[22] and Pradaxa.[23]

39. On 8 Month4 2021 the CT referral was declined, noting: '[Mrs A] does not meet the criteria for [a] non urgent CT Head as there are neurological symptoms, please phone and discuss with relevant specialist.' It is not documented whether Dr C spoke to a neurology specialist.[24]

40. On 12 Month4 2021 a referral for a review of Mrs A was made to Dr C. The referral noted:

> '[Mrs A] has deteriorated. Not talking, unable to understand instructions. Unable to move right arm. Sleepy at times. Not swallowing at times. Has deteriorated the last few days … Please can [Dr C] review for further treatment and advice.'

41. Dr C told HDC that he undertook a virtual consultation on 12 Month4 2021 as flooding was keeping him isolated 60km away. He noted that Mrs A was deteriorating. He said that neither he nor the nurse in attendance recorded any notes because of 'problems with the computer system and the reliability of it recording consultations'.

42. In response to the provisional opinion, Dr C told HDC that '[i]t is important to note that [their town] is a very rural community in a remote area with particularly poor internet access, subject to the vagaries of atmospheric conditions' and therefore, at times, medical notes were lost due to the poor nature of the IT network. Dr C stated: 'I would have made notes

[20] Weakness or inability to move one side of the body.
[21] Paralysis that affects one side of the body.
[22] Medication used to treat mild to moderate pain and lower the risk of a blood clot or a stroke.
[23] Medication used to treat and prevent blood clots and strokes.
[24] A specialist in disorders and diseases of the nervous system.

for 12th [Month4] 2021 in the same way I did for the other reviews, but the records must have been lost in the constant crashing and rebooting of the IT system.'

43. Dr C reviewed Mrs A on 13 Month4 2021 as she had increasing wheezing and difficulty using a spacer[25] with her inhalers. He prescribed Mrs A a nebuliser[26] to use with her asthma medications.

44. In response to the provisional opinion, Dr C told HDC:

> '[HDC's in-house advisor, GP Dr Maplesden] assumes that because I do not write non-contributory findings towards the diagnosis in my notes, that I did not do the examination fully. This is incorrect. I write only positive findings, and things which guide my diagnostic decision making.'

45. Mrs A's progress notes document that she was reviewed by Dr C on 14 Month4 2021, but there is no evidence of consultation notes made by Dr C.

46. In response to the provisional opinion, Dr C told HDC that at times the IT system would 'crash', and this could affect whether notes were saved or lost. He said that IT outages were often 'a daily occurrence' in this rural area.

47. On 15 Month4 2021 Dr C documented: '[Mrs A has] lapsed into light unconsciousness … with coarse creps[27] in chest posteriorly. Probable chest infection …' At 5.00pm Mrs A was given an intramuscular antibiotic, ceftriaxone, as per Dr C's request, as her breathing was laboured. Sadly, Mrs A passed away around 5.15pm.

Further information

Kauri Lodge's response

48. Kauri Lodge acknowledged the passing of Mrs A and noted that it appreciates the stress Mrs A's 'rapid deterioration and death has caused her family and certainly hope this investigation helps them through the ongoing grief and loss of their beloved mother'. Kauri Lodge stated: 'Although the diagnostic review [to diagnose a stroke] took longer than was desirable [Mrs A] did receive appropriate bedside care throughout this ordeal.'

Dr C's response

49. Dr C told HDC that in 2021 he was the sole practitioner at the rural health clinic, during a time when 'Covid was rampant' and consultations were often in the car park. He was also the on-call doctor at night and during weekends as the nearest on-call doctor was 60km away. Dr C noted that usually he was the only doctor in the clinic, and treatment was further impacted by the poor IT infrastructure due to the rural nature of the area, and by COVID-19 lockdown restrictions. He said that often the computer server would go down, which meant the loss of patient notes and the inability to send electronic referrals. He noted that the

[25] A device that makes using an inhaler easier and more effective.
[26] A device used to turn liquid medicine into a mist that can be easily inhaled.
[27] Crepitations — an abnormal sound heard in the lungs.

clinic contacted technicians regularly for assistance with IT to 'reduce the disruptions they were causing'.

50. Dr C said that in the review of Mrs A on 30 Month3 2021, it was found that she had right-sided weakness. He stated that although he considered calling an ambulance for interventional radiology,[28] he chose to manage Mrs A conservatively as her 'weakness appeared quite stable' and she was already on medication to prevent any thrombosis. He noted that it was a '60km rough ambulance trip to [a larger hospital] and a possible helicopter trip to [a tertiary hospital] [and Mrs A] would also be at risk of developing Covid infection'. Dr C recalled that on that day, the weather conditions were too poor for helicopter transport from the town.

51. Dr C told HDC that sometimes he would 'quickly drop into Kauri Lodge to check on [Mrs A] … perhaps not writing a patient note as the situation with [Mrs A] was unchanged or gradually improving and the computer was not working properly'.

52. Dr C offered his sincere condolences to Mrs A's family.

Community clinic response

53. The community clinic told HDC that they were 'facing a national shortage of General Practitioners', and it was worse in remote and rural areas where Kauri Lodge and the general practice is based. COVID-19 also affected this. He said that the clinic had very limited access to appropriate IT infrastructure, which made the network very slow, and at times it would crash. He noted that access to the clinic is further limited by natural disasters such as floods. He said that there are dedicated doctor rounds for Kauri Lodge patients at least once a week, and emergency slots for acutely unwell patients. He noted that often Dr C saw patients out of hours.

Policies

Clinical Documentation and Report Writing Policy — Kauri Lodge (issued 2019)

54. The purpose of the Clinical Documentation and Report Writing Policy is '[t]o ensure all documents relating to service provision are completed accurately, in a timely manner that meets legislative and contractual [requirements].' The policy states that '[d]ocumentation provides proof of appropriate care and service provision … [and clinical documents are considered] legal documents'.

55. This policy provides detailed guidance on documentation and report writing. Specific provisions of the policy are incorporated into the opinion section where relevant.

Statements from staff

56. A staff member stated:

> 'Before [Mrs A] was moved to the hospital wing on 6 [Month4] 2021 she did not appear well and independent like she normally would be [and] wanted to stay in bed. When asked if she wanted to go to the dining room for her meals, she refused …

[28] Procedures used to diagnose and treat disease.

> [Mrs A had] weakness on her right side and could not hold her fork properly to feed herself [and] appeared to be confused [and] tried to answer a question but did not know how to.'

57. Another staff member noted that Mrs A was an independent individual 'who actively participated in meals and activities with other residents', but over time they noted that Mrs A's speech 'gradually declined, sometimes struggling to form coherent sentences', and she became 'completely dependent on staff for personal care, transfers, and even basic meals and fluids'. These changes in her behaviour were 'stark and evident' as they deviated from her usual vibrant and engaged self.

Responses to provisional opinion

Ms B

58. Ms B was given the opportunity to respond to the 'information gathered' section of the provisional opinion. She had no further comment.

Kauri Lodge

59. Kauri Lodge was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

60. Kauri Lodge told HDC: '[There is] overwhelming evidence [Kauri Lodge] appeared to be in breach. Action was required in this instance, if not a GP assessment in person, another option needed to be taken …'

61. Kauri Lodge stated: '[T]he Board accepts that in this situation [Kauri Lodge] fell short … and we are genuinely sorry for failing to assist [Mrs A] in a timely manner.'

Dr C

62. Dr C was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. His comments have been incorporated into this report where relevant.

63. Dr C told HDC:

> 'I believe that I (and the nursing staff) offered an appropriate level of care to [Mrs A] at all times, and that any lost documentation of notes would not have affected the sad outcome of [Mrs A's] passing. It is also significant that [Mrs A's] deterioration happened at the time of Covid and I was at all times mindful of this risk with unnecessary hospital transfers.
>
> …
>
> It is important to note that in her Advance Care Plan … [Mrs A] implies that she preferred to die at Kauri Lodge rather than a hospital, and preferred treatment aimed at symptom control rather than life extension if she became very unwell.
>
> …

I offer again my sincere condolences to the family.'

Opinion: Kauri Lodge — breach

64. First, I acknowledge the distress that these events have caused Mrs A's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered regarding the concerns raised. As noted above, in determining whether the care provided by Kauri Lodge was appropriate, I also considered in-house clinical advice from RN Jane Ferreira (Appendix A).

Escalation to GP and nursing assessments

65. Mrs A was resident at Kauri Lodge from 2018. The interRAI assessment undertaken prior to her admission showed that her overall health had improved since her previous assessment, and it identified continence, mood changes, and cardiorespiratory function as areas for continued support and monitoring. The long-term care plan noted that she was independent with toileting and was '[i]nfrequently' incontinent of urine. Her care plan noted that she could mobilise independently with her frame and regularly went to the dining room to eat with her friends, '[enjoying] laughs and conversations'. Mrs A kept her mind active by using her laptop and participating in activities. Her long-term care plan noted that she spoke clearly and was 'articulate'.

66. Mrs A's progress notes from Month1 to Month3 2021 show that she continued to remain independent in all areas of her life and had been on leave with her family four times during this period.

67. However, during Month3 and Month4 2021, the progress notes document Mrs A's deterioration, including becoming incontinent, unable to wash or feed herself, unable to express herself clearly verbally, unable to use her computer or socialise, and requiring a hoist transfer.

68. RN Ferreira advised that throughout this period, there was insufficient escalation and follow-up regarding Mrs A's deterioration.

69. For example, on 3 Month2, upon Mrs A's return from hospital, there is no evidence of a discussion of a wider nursing assessment, such as vital signs or pain assessment. There is also no evidence of escalation to a GP at this time. On 6 Month3, Mrs A had a fall, but there is no record of GP or nurse practitioner involvement. On 8 Month3 2021, it is documented that Mrs A was trying to use her right arm but it 'appeared to be weak', and her speech was affected as she tried to talk 'but wasn't making sense'. RN Ferreira advised: 'Given the ongoing signs of deterioration with new reports of limb weakness it would be recommended that nurses seek urgent medical guidance.'

70. It is documented that on 23 Month3 2021 Mrs A was 'extremely weak in her [right] hand/arm [and right] leg/foot' and now required a hoist transfer and the assistance of two carers. A nurse completed a referral to the physiotherapist for a review of Mrs A's mobility. The physiotherapist's report noted some concerns and said that the report was to be shared

with the GP the next day (I note that Dr C disputes receiving this report). Mrs A was not seen by Dr C until 30 Month3 2021. RN Ferreira was critical of this delay and advised: 'Given the expressed concerns it is unclear why the RN team did not follow up with the GP, NP or medical practice in line with professional responsibilities.' I agree and consider that regardless of whether the report was in fact seen by Dr C, the responsibility remained on the nursing team to follow up with Dr C and ensure that Mrs A's care was escalated appropriately.

71. A further failure to involve Dr C appropriately occurred following his 30 Month3 review. RN Ferreira advised that accepted practice would be for a family meeting to have been arranged with the GP/NP and nursing team to discuss Mrs A's health status and ongoing plan of care, and there is no evidence that this occurred.

72. Mrs A had been a resident of Kauri Lodge since 2018 and was well known to the staff. In Month1 2021 Mrs A was stable, and her independent health status was reinforced by her long-term care plans completed prior to her admission. The progress notes from Month1 to 28 Month2 2021 reinforce that Mrs A was independent with her hygiene cares, mobility, eating, socialising, and maintaining her continence. In my opinion, Mrs A started to deteriorate from 28 Month2 2021, when she alerted the staff that she felt unwell. During Month3 2021, there were obvious signs of Mrs A's deterioration, as she was becoming incontinent, was unable to walk independently, was unable to undertake her own cares, and needed assistance with meals. This was in contrast to her independent status only a month previously. However, despite this obvious deterioration, there were multiple failures by Kauri Lodge staff to escalate Mrs A's care appropriately and follow up on the care being provided. Accordingly, I am critical of Kauri Lodge staff, who failed to escalate Mrs A's care and conduct the necessary nursing assessments, both before and after she began to deteriorate.

Documentation of care and effective use of care plans

73. RN Ferreira advised that Mrs A's progress notes document her continued health decline, but there are 'apparent delays in … review of essential care documentation in response to her changing needs'. RN Ferreira considers that at times the documentation fell below the expected standard.

74. Sufficient guidance and tools were available to enable effective documentation of Mrs A's care. RN Ferreira noted that the Clinical Documentation and Report Writing Policy 'provides clear guidance regarding documentation standards and related role responsibilities'. Specifically, I note that the policy states that documentation provides 'proof of appropriate care and service provision … [and clinical documents are considered] legal documents'. The policy also states that care plans must be tailored to the needs of the resident and be 'updated by a registered nurse every six months, or more frequently if there are changes to the resident's needs'.

75. RN Ferreira noted that the Robinson's Resident Acuity Assessment form[29] could be completed 'when significant changes in health occur and on return from acute hospital setting' but said that its use is based on the nurse's clinical decision.

76. However, the evidence demonstrates examples of failures to document adequately, utilise short-term care plans, record progress, and document the actions taken.

77. RN Ferreira noted that in response to Mrs A's 'significant physical changes' during Month3 and Month4 2021, generally it appears that no appropriate short-term care plans were developed or the current care plans updated. For example, I note that no short-term care plans were developed upon Mrs A's return from hospital on 3 and 19 Month2. I also note that it was not until 4 Month4 2021 that Mrs A's long-term care plan was updated despite documented changes to her presentation from 28 Month2 2021. RN Ferreira stated that specific short-term care plans were not used to guide Mrs A's care effectively, but instead the care was documented in Mrs A's progress notes. RN Ferreira said that this 'indicates a deviation in documentation rather than care standards'.

78. RN Ferreira identified further examples of a lack of documentation of care. For example, following Mrs A's fall of 10 Month3, there is no evidence of changes made to the nursing care plan, and it is unclear whether the nursing team considered moving Mrs A to the hospital-level community for closer nursing oversight and care.

79. RN Ferreira advised:

> 'I acknowledge that workforce issues and competing RN priorities may have impacted upon documentation standards at the time, however [Mrs A] was demonstrating clear signs of change to her health and wellbeing therefore her related care requirements would still be considered a clinical priority.'

80. I accept this advice. To provide Mrs A with appropriate and coordinated nursing care, first she had to be assessed appropriately to determine any changes to her baseline, and a care plan developed to guide nursing care. I am concerned that assessments such as vital signs and neurological observations were not documented on an appropriate observation form but instead were noted in Mrs A's progress notes. It is easier to track deviations in recordings if they are recorded on one form. Generally, but also considering the deterioration in Mrs A's health, nurses should have made efforts to capture the relevant information in care plans in order to guide staff to provide coordinated care to Mrs A in response to her changing needs. RN Ferreira advised that the progress notes show that staff were encouraging Mrs A to engage in her normal daily routines and note the extra support she needed to meet her needs, but 'it is unclear if additional strategies such as the use of assessment and monitoring tools were considered by the nursing team to assist them to identify contributing factors to the observed changes in Mrs A's mood and level of functioning'.

[29] An assessment to determine whether significant changes in health have occurred and the impact on the person.

81. Although I am critical that these care plans were not documented appropriately, I acknowledge that Kauri Lodge is in a remote and rural area, where there was limited access to an appropriate IT infrastructure, with a slow and at times unreliable network, which would have affected the ability of staff to save documentation consistently. However, as the IT issues were well known, Kauri Lodge had a responsibility to initiate a contingency plan, such as using paper-based documentation as a backup.

Documentation of communication with Mrs A's family

82. Ms B told HDC that she spoke to Kauri Lodge staff on 22, 24, 25, and 30 Month3 2021 regarding her concerns about her mother. However, these communications were not entered into Mrs A's progress notes. According to the Clinical Documentation and Report Writing Policy, all family communication 'will be recorded in the Family Contact Sheet in the front of the Resident folder', and all family contact and family input into assessments and care plans 'must also be evidenced in writing'. There is no evidence that a family contact sheet was in place for Mrs A.

83. Mrs A's family travelled from overseas because of their concerns about Mrs A, and when they visited her at Kauri Lodge they expressed these concerns to different staff members. Family play a major role in supporting loved ones, and their opinions and concerns need to be heard and considered. I am critical that these important family conversations were not recorded in Mrs A's progress notes or on a contact sheet.

Conclusion

84. In summary, I find that Kauri Lodge did not provide Mrs A with an appropriate standard of care between 1 Month2 2021 and 15 Month4 2021 (inclusive) for the following reasons:

a) There were delays in escalating Mrs A's care to Dr C and conducting the necessary nursing assessments, despite it being documented that she was deteriorating from late Month2 2021.

b) Despite Mrs A's deterioration throughout Month3 and Month4 2021, short-term care plans were not developed and documented adequately, and her long-term care plan was not updated until 4 Month4 2021.

c) There is insufficient documentation of family contact and communications.

85. Accordingly, I consider that Kauri Lodge did not provide Mrs A with an appropriate standard of care and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[30]

[30] Right 4(1) stipulates that '[e]very consumer has the right to have services provided with reasonable care and skill'.

Opinion: Dr C — adverse comment

86. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Dr C was appropriate, I also considered in-house clinical advice from Dr Maplesden (Appendix B).

Dr C's review of Mrs A on 16 Month3 2021

87. On 16 Month3 2021 Dr C reviewed Mrs A as nursing staff had reported that she felt 'very low and confused [and] unable to complete sentences', was rejecting personal cares, and had asked for assistance with meals. Dr C told HDC that in the past Mrs A had responded well to fluoxetine, so he decided to restart it.

88. Nothing in the documentation received from Kauri Lodge or Dr C suggests that Mrs A's history of right arm weakness was conveyed to Dr C on this date. Accordingly, I cannot conclude that this information was known to Dr C. Dr Maplesden advised:

> 'If the documented history accurately reflects the information provided to [Dr C] by [Kauri Lodge] staff, and noting [Mrs A's] complex medical history which meant there was a broad differential diagnosis regarding the cause of her general deterioration, I am mildly critical there was no recorded heart and lung auscultation or assessment for postural blood pressure drop (given relative hypotension) or basic neurological assessment (given reference to possible speech issue). I believe consideration to undertaking a delirium screen was required (particularly relevant blood tests) and am mildly to moderately critical this was apparently not considered.'

89. Dr Maplesden noted:

> 'I acknowledge some of the symptoms presented may have been consistent with a depressive illness although I am not convinced other equally likely causes for the symptoms were adequately exclude[d] at this time, particularly noting prominence of decreased mobility as a symptom.'

90. Dr Maplesden acknowledged that Dr C was in an observational role, and noted: 'I remain of the view that best practice would be to have performed a delirium screen but accept that the nurse practitioner was apparently very familiar with [Mrs A's] presentations.'

91. I accept Dr Maplesden's advice that given Mrs A's complex medical history, further tests and assessments should have been performed in order to exclude or include any other possible reasons for Mrs A's deterioration. However, I also acknowledge Dr C's submission that in this situation, the nurse practitioner conducted the review, and Dr C was only observing, and that the nurse practitioner considered Mrs A's symptoms more consistent with her depressive disease, which is why a delirium screen was not done.

Dr C's review of Mrs A on 30 Month3 2021

92. Dr C assessed Mrs A on 30 Month3 2021 and noted that she had right-sided weakness in her hand, arm, and leg and found it difficult to express herself verbally. Although Dr C considered calling an ambulance, he chose to manage Mrs A conservatively, as '[her] weakness

appeared quite stable' and she was on medication to prevent thrombosis. Mrs A's family was not consulted after this review.

93. Dr Maplesden advised that 'for a patient with new focal neurological symptoms of uncertain duration … it was important to try and establish the likely duration of symptoms which influences subsequent management decisions'. Dr Maplesden noted that an assessment for any swallowing difficulties would have been important in Mrs A's case and, in addition, the blood tests and clinical review that were listed as part of the management plan on this day appear not to have been completed.

94. Dr Maplesden advised:

> 'I accept the assessment of [Mrs A] on 30 Month3 2021 may have been adequate, but I believe it has been inadequately documented … and I remain mildly critical of the overall standard of clinical documentation.'

95. I accept this advice. In determining how to manage what appear to be stroke symptoms, it should be established when the symptoms began, as management of a stroke changes depending on whether it is diagnosed early (in which case interventions may be an option), or later when damage may have occurred (in which case treatment options such as medication may need to be considered). I acknowledge Dr C's submission that he chose conservative management because Mrs A's 'weakness appeared quite stable' and she was already on medication to prevent thrombosis. I also acknowledge that given the rural location of the care home, it may have been very uncomfortable for Mrs A to endure ambulance travel over two and a half hours to reach the hospital.

96. Dr Maplesden noted that following the assessment of Mrs A, it would have been accepted practice for Dr C to discuss 'the most likely diagnosis with the patient/whānau and the recommended management options'. Dr Maplesden considers that the documented management plan written by Dr C was 'inadequate' and meant that Mrs A's family was 'left with the impression nothing was being done to address [Mrs A's] deterioration'.

97. Dr Maplesden stated:

> '[Mrs A's] next of kin required notification of her likely stroke diagnosis on [30 Month3] 2021 … But [I] accept that the management decisions made by [the nurse practitioner] and [Dr C] were consistent with [Mrs A's] [advance care plan].'

98. I accept this advice and am concerned that Mrs A's family was not consulted following this review, particularly as they had visited from overseas in Month3 and had expressed their concerns about her. I agree that the family may have been left with the impression that nothing had been done for Mrs A, which would have been distressing for them. I acknowledge Dr C's response that on reflection he should have ensured that contact was made with the family. Dr C apologised for this oversight.

Dr C's review of Mrs A on 12 Month4 2021

99. On 12 Month4 2021, a request was made for Dr C to review Mrs A as she had 'deteriorated. Not talking, unable to understand instructions. Unable to move [her] right arm … Not swallowing at times.' Dr C stated that he conducted a virtual consultation because flooding had isolated him and he was unable to visit the care home. Dr C told HDC that he and the nurse did not record notes because of problems with the computer system. I accept that the consultation occurred and that notes were not recorded because of computer problems.

100. However, as advised by Dr Maplesden:

> 'If formal clinical advice was provided as part of a teleconsultation on [12 Month4] 2021, I would have [expected] this to have been recorded in [Kauri Lodge] and [the community clinic] notes (even if retrospectively).'

101. Dr Maplesden said that if a consultation note was completed but lost due to technical issues, he would not be critical of Dr C.

102. I accept this advice and am concerned that this consultation was not documented by the GP or the nurse, given that Mrs A was a very vulnerable resident with complex medical issues and was deteriorating. However, I also acknowledge Dr C's submission that due to the poor IT infrastructure, notes could be lost if the system crashed. It is likely that there would have been no indication that one's specific notes had been lost in the IT crash.

Dr C's review of Mrs A on 13 Month4 2021

103. On 13 Month4 2021 a referral was sent to Dr C to review Mrs A as she was having difficulty using her inhalers. Dr C prescribed a nebuliser for her asthma medications and said that Mrs A should use oxygen overnight if short of breath.

104. Dr Maplesden considers that Mrs A's symptoms may have been an exacerbation of her congestive heart failure or COPD,[31] and that further assessments such as 'auscultation of lung bases (posterior), heart sounds and assessment for fluid overload (ankle oedema, JVP[32])' was warranted.

105. Dr Maplesden advised:

> 'I accept that [Dr C] may have undertaken a more comprehensive assessment than represented by the clinical notes. However, I believe it is accepted practice to document relevant positive and negative clinical findings …'

106. Dr Maplesden was mildly critical of the standard of Dr C's clinical documentation.

[31] Lung disease that causes breathing problems.
[32] Jugular venous pulse, used to determine central venous pressure.

107. I accept Dr Maplesden's advice. Given Mrs A's complex medical history, further assessments to explore the root cause of her breathlessness would have helped to determine whether her treatment plan was appropriate.

Dr C's review of Mrs A on 14 Month4 2021

108. The progress notes document that Mrs A was reviewed by Dr C on 14 Month4 2021. However, Dr Maplesden noted that 'there was no consultation note recorded for the review undertaken on [14 Month4]'. Dr Maplesden said that Dr C '[implied] it is likely he completed a consultation note but this was lost due to the technical issues previously described'. Dr Maplesden advised that if a note was completed and then lost due to technical issues, he would not be critical of Dr C.

109. I am concerned that no consultation note was recorded, but I acknowledge Dr C's submission that again, due to the poor IT infrastructure, notes could be lost when the system crashed.

Conclusion

110. In summary, I am critical that Dr C did not perform further tests and assessments during the consultations of 16 and 30 Month3 2021.

111. Mrs A's family was not consulted following the medical review on 30 Month3 2021, although they were in New Zealand in Month3 and had expressed their concerns about Mrs A. When Mrs A complained of being short of breath, further assessments were not considered during the 13 Month4 2021 consultation to rule out other causes (such as congestive heart failure or exacerbation of COPD).

112. In addition, I am concerned that on two occasions[33] there are no recorded notes. However, I acknowledge that Kauri Lodge is situated in a remote rural area and had poor access to the internet and experienced constant IT crashes, which contributed to notes being lost. Accordingly, I do not find that Dr C breached the Code.

Changes made

113. Kauri Lodge told HDC that the integration of GP notes into its system is much improved, and Kauri Lodge staff prompt medical staff to ensure that this occurs. Kauri Lodge said that a meeting with staff occurs at least once a year to review performance and to identify any gaps in staff training. In addition, every second month, staff are encouraged to attend a 50-minute in-service training session provided by a staff member who has specific skills or knowledge relating to aged care.

114. Dr C told HDC that he has tried to improve his record-keeping practices by ensuring that he writes about every patient at the end of his medical rounds. He noted that in 2021 he was the sole practitioner and had repeatedly encouraged his clinic managers to enlist more

[33] See paragraphs 39 and 41.

medical staff. However, it was difficult to attract GPs and nurse practitioners to the rural location.

Recommendations

115. I recommend that Kauri Lodge:

a) Provide a written apology to Mrs A's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b) Provide training for staff on identifying deteriorating residents, how to escalate this, and how to identify when a change in care level is required. Please provide evidence of this training to HDC within three months of the date of this report.

c) Undertake an audit of the files of 10 residents to identify whether communication with family is documented in both the progress notes and corresponding family contact form. The summary of findings with corrective actions to be implemented (if appropriate) is to be provided to HDC within three months of the date of this report.

d) Develop a process to meet documentation and reporting requirements in circumstances where internet access is limited or power outages occur and provide this to HDC within three months of the date of this report.

116. I recommend that Dr C:

a) Provide a written apology to Mrs A's family for the issues identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to the family.

b) Participate in a documentation course/refresher and provide a written report on the learnings from the course and the changes to practice instigated (or considered if not currently practising) as a result of this case, within six months of the date of this report.

c) Familiarise himself with the Te Aka Whakapiri resources for end-of-life care and report back to HDC on his learning, within three months of the date of this report.

Follow-up actions

117. A copy of this report with details identifying the parties removed, except Kauri Lodge and the advisors on this case, will be sent to the Medical Council of New Zealand, HealthCERT, and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from RN Ferreira:

'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Kauri Lodge Care Home. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

1. **Documents reviewed.**

- Letter of complaint received …
- Provider responses received ….
- Clinical records including nursing assessments, care plans, progress notes, monitoring forms, incident reports, medication records, medical health information, allied health involvement, communication records.
- Organisational policies including COVID-19 vaccination, falls prevention and management, medication management, restraint management, clinical management, documentation standards, admissions, transfer and discharge processes, assessment tools, care planning and communication responsibilities.
- Education records.

2. **Complaint**

[Ms B] has expressed concern regarding the care provided to her mother by the care home between [1 Month2] to [15 Month4] 2021. Her concerns relate to COVID-19 vaccination processes, stroke management, recognition of decline and related care responsibilities.

3. **Review of clinical records**

For each question, I am asked to advise on what is the standard of care and/or accepted practice. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

- Whether the actions of the staff at Kauri Lodge in managing [Mrs A] as she was deteriorating from [mid-Month2] to [15 Month4] 2021, were appropriate and timely?
- If the GP's decision to treat [Mrs A] conservatively was appropriate?
- Whether the diagnosis of depression was appropriate?

- If the action of the GP to occasionally "drop into" Kauri, but not document his assessments or visits, was appropriate?
- If information received shows whether or not the GP was notified about the physio's concern that Mrs A had a significant neurological issue following her assessment?
- If the wider issues of the clinic (such as the remoteness of the clinic, lack of staffing, poor IT infrastructure) impacted negatively on the actions of the staff and to what degree?
- Whether there were any short-term care plans made (if deterioration was identified)?
- How was her presentation on admission different to how she started presenting from [mid-Month2] 2021?
- Please feel free to advise on any other issues you identify in your review.

Background

Mrs A was admitted to the care home in 2018 at rest home level care. Her medical history included multiple, complex medical conditions; Ischaemic heart disease (IHD), chronic obstructive pulmonary disease (COPD), congestive cardiac failure, chronic kidney disease, type 2 diabetes, gout, hyperlipidaemia, recurrent urinary infections, and depression. File information indicates that until [Month2] 2021 [Mrs A] was independently mobile with a walking frame and required minimal assistance from carers to meet daily living requirements. She was socially engaged in the care home, enjoyed a range of activities and was well supported by her whānau/family.

Concerns have been raised regarding [Mrs A's] health decline and related care between [Month2] and [Month4] 2021. The care record indicates that [Mrs A] received COVID-19 vaccinations on 14 [Month2] 2021, and 4 [Month3] 2021 with no observed or reported side effects at the time. File information indicates that [Mrs A's] presentation changed during this time, with signs of increased fatigue, reduced oral intake, and low mood with reluctance to engage in her daily routines. Progress notes 8 [Month3] 2021 describe signs of right-sided arm and leg weakness (hemiparesis), reporting that [Mrs A] required increased carer assistance to mobilise and meet personal care needs. [Mrs A] was seen by her General Practitioner (GP) and a community Nurse Practitioner (NP) on 16 [Month3] 2021, in response to registered nurse (RN) concerns. Prescribed medications were reviewed and antidepressant therapy recommenced. On 24 [Month3] 2021 [Mrs A] was assessed by a Physiotherapist who recommended urgent referral for a CT scan to review neurological function. On 30 [Month3] 2021 [Mrs A] was seen by the GP and NP with clinical notes suggesting a stroke event. On 7 [Month4] 2021 a radiology referral was sent for a CT scan to determine if a bleed or infarct was causing the right-sided weakness. Records show that [Mrs A's] health continued to decline and she passed away on 15 [Month4] 2021. I extend my sincere condolences to [Mrs A's] whānau/family at this time.

1) Whether the actions of the staff at Kauri Lodge in managing Mrs A as she was deteriorating from mid-Month2 to 15 Month4 2021, were appropriate and timely?

Provider communication stated that [Mrs A] had lived at the care home since 2018 and was well known to the care home team. The InterRAI assessment undertaken prior to her admission indicated her overall health status had improved since her last routine assessment. The assessment tool identified areas for further monitoring and support which included cardiorespiratory conditions, urinary continence and mood changes. A holistic long-term nursing care plan was in place which outlined goals for care with supportive interventions and ongoing evaluation in line with accepted nursing practice. Progress notes 8 [Month1] 2021 to [mid-Month2] 2021 report that [Mrs A] was generally independent with activities of daily living, noting that she would ask for assistance if required.

File information shows that [Mrs A] had returned to the care home on 3 [Month2] 2021 following a short hospital stay for a surgical procedure. The discharge summary outlined ongoing care requirements, which included a course of antibiotics with instructions to see her GP in one week to review breathing and inhaler use. The document states to seek medical attention if symptoms worsen or new concerns develop. The RN progress note entry outlines [Mrs A's] return to the care home, noting no dressing insitu on the surgical site, and that [Mrs A] needed to be seen by the GP the next day. There is no discussion of wider nursing assessment at this time, such as recording of vital signs or pain assessment, or commencement of a short-term care plan to guide nursing or medical requirements. It is unclear if [Mrs A] was seen by the GP on 4 [Month2] 2021. Nursing progress notes provide no discussion of GP involvement until 12 [Month2] 2021 which was for a different health issue, as sighted in medical records.

The Clinical Documentation and Report Writing policy provides clear guidance regarding documentation standards and related role responsibilities. The policy advises that clinical risk assessments are completed for residents returning from hospital admission, or when health needs changed, to ensure appropriate plans of care were in place. The Robinson's Resident Acuity Assessment form states "*complete when significant changes in health occur and on return from acute hospital setting".* However, the policy also states that use of the assessment tool is optional and based on an RN's clinical decision. Given [Mrs A's] complex health history, COVID-19 pandemic timeline and recent surgical intervention, accepted practice would be to complete vital sign, pain, and skin integrity assessments, review clinical care and safety needs, and commence a relevant short-term care plan to guide medication and care requirements in line with policy guidance.

Progress notes 28 [Month2] 2021 onwards report changes in [Mrs A's] usual presentation, abilities and daily routines, with reports of her feeling unwell and short of breath. It appears RNs were responsive with discussion of vital sign recordings, administration of prescribed medications and increasing the frequency of resident checks. Entries 31 [Month2] to 5 [Month3] 2021 describe a reluctance to leave her bedroom or attend to personal care requirements, extended periods of bedrest,

increased periods of sleep, reduced appetite and meal refusal, and comments such as "*appears in low mood this shift".*

[Mrs A's] medical history included depression and medication records show that she was prescribed regular antidepressant medications. Progress note entries indicate that the care team were encouraging [Mrs A] to engage in her daily routines however entries indicate that she was requiring increasing levels of support to meet her needs. It is unclear if additional strategies such as the use of assessment and monitoring tools were considered by the nursing team to assist them to identify contributing factors to the observed changes in [Mrs A's] mood and level of functioning, and prompt clinical decision making.

On 6 [Month3] 2021 [Mrs A] was found on the floor following an unwitnessed fall event. She was assessed by an RN with post-fall actions commenced as outlined in organisational policy. Further shift entries indicate carer concern with reports of lethargy, minimal food and fluid intake, and assistance needed with personal cares. On 7 [Month3] 2021 an RN described [Mrs A] as confused with reports of incontinence, noting that vital signs were recorded but it is unclear whether there was any deviation from baseline data. She was seen by the clinical manager (CM) who reported low mood, commenting that [Mrs A] *required assistance to sit up to take medications and drink*. Progress note entries across the day continue to report observations of weakness, fatigue, continence concerns and low mood, noting to send a primary request for GP review the next day. A short-term care plan was commenced for low mood with instructions to monitor oral intake and assist with care and mobility needs, however there is no record of GP/NP involvement at this time, or evidence of RN follow up.

On 8 [Month3] 2021 carers report that [Mrs A] was experiencing right arm weakness during meals, with observed confusion and communication changes. It is unclear from the RN entry if neurological and vital sign assessment occurred, or if health concerns other than low mood were considered by the RN team at the time. Given the ongoing signs of deterioration with new reports of limb weakness it would be recommended that nurses seek urgent medical guidance. Shift entries 8 and 9 [Month3] 2021 continue to report concerns with appetite, fatigue, continence and a reluctance to leave her bedroom. On 10 [Month3] [Mrs A] was found on the floor of her bedroom following an unwitnessed fall event. Nursing notes indicate that neurological observations and limb movement were of normal range and reflect communication with whānau/family. It is unclear whether her falls risk was reviewed at this time, with no evidence of changes made to the nursing care plan. It is unclear whether the RN team considered moving [Mrs A] to the hospital level community for closer nursing oversight and care. Entries 11 to 15 [Month3] 2021 continue to describe mobility difficulties noting a requirement for wheelchair transfers, fear of falling, in bed, not eating, difficulty self-medicating with inhalers noting … *needs to have further assessment …*

Medical records indicate that [Mrs A] was first seen by the GP and NP on 16 [Month3] 2021 in response to RN concerns with medications reviewed, however there is no reflection of this within nursing records. There appears to be a six-day delay in

contemporaneous reporting due to an internet outage with the next entry in progress notes on 21 [Month3] 2021. The provider has discussed ongoing concerns with internet access at that time but it is unclear what process was in place to meet documentation and reporting requirements in the circumstances. There is no evidence sighted of a paper-based care record or evidence of policy guidance regarding clinical and operational responsibilities during a power or internet outage which presents an improvement opportunity.

On 23 [Month3] 2021 [Mrs A] was assessed by an RN in response to carer reports that she appeared weak with difficulty weight-bearing, requiring two carers to transfer, including sling hoist transfers. The RN assessed for signs of stroke noting that speech was not slurred and face appeared symmetrical, commenting on medication changes for management of depression, and a physiotherapy referral. The physiotherapy assessment 24 [Month3] 2021 stated … *since she ([Mrs A]) came out of hospital recently, she has steadily deteriorated ...* Assessment notes are comprehensive and raise concern regarding neurological functioning, with a recommendation for urgent referral for further assessment. Progress notes indicate that the physiotherapist's report was shared with the GP by an RN the next day, however medical notes indicate that [Mrs A] was not seen until 30 [Month3] 2021. Given the expressed concerns it is unclear why the RN team did not follow up with the GP, NP or medical practice in line with professional responsibilities.

Nursing progress notes continue to discuss [Mrs A's] observed health decline however there are apparent delays in nursing assessments and review of essential care documentation in response to her changing needs, with the nursing care plan not updated until 4 [Month4] 2021. It appears that following communication with whānau/family, [Mrs A] was transferred to a larger room in the hospital community on 6 [Month4] 2021 for further care. It is unclear whether communication with the funder and needs assessors occurred given the significant change in health status, in line with organisational policies and contractual requirements.

While progress note entries indicate that regular communication occurred with whānau/family there is no evidence that a family meeting was arranged with the GP/NP and RN team to discuss [Mrs A's] health status and ongoing plan of care, which would be considered accepted practice in the circumstances. [Mrs A] had a detailed advance care plan that discussed her wishes for her last days of life and end-of-life care, which the RN advocated for on 13 [Month4] 2021. Given [Mrs A's] complex health history and the identified health decline, it is unclear why related care planning had not been commenced. There appears to be some blurring within the multi-disciplinary team process regarding communication with [Mrs A], her whānau/family and related care responsibilities at this time, however there are no meeting minutes, communication records or related information included in the evidence bundle to inform further comment.

As outlined in the Health Quality and Safety Commission's (HQSC) Frailty Care Guides and related health education resources, a stroke is considered a medical emergency

requiring urgent assessment and care (HQSC, 2019; HQSC, 2023). Nurses have a responsibility to recognise signs of change and ensure appropriate and timely actions. The provider has explained that GP services were stretched during this period, however it is unclear if the nursing team considered alternative options such as telehealth or paramedic consultation if/when the GP or NP was unable to attend, in line with guidance in submitted clinical policies and health resources.

On review of the evidence to respond to this question, there appear to be concerns with recognition of resident decline, timely escalation to GP/NP services with lack of follow-up and advocacy by the nursing team. Submitted policies and organisational information indicates that systems and processes were in place to guide nursing actions, however while progress notes describe care occurring, there are deviations in nursing responsibilities to communication, care and documentation standards. I note that lack of access to integrated healthcare records possibly contributed to the delayed oversight and coordination of [Mrs A's] care. Based on my review I consider there are moderate to serious deviations in standards of practice which would be viewed similarly by my peers.

Departure from accepted practice: Moderate to serious.

2) If the GP's decision to treat Mrs A conservatively was appropriate?

I am unable to provide comment as this question is outside my scope of practice and recommend seeking medical advice.

3) Whether the diagnosis of depression was appropriate?

I am unable to provide comment as this question is outside my scope of practice and recommend seeking medical advice.

4) If the action of the GP to occasionally "drop into" Kauri, but not document his assessments or visits, was appropriate?

The reviewed evidence shows that the organisation had policies in place to guide clinical documentation responsibilities that references Health and Disability sector standards, and the Age-Related Residential Care (ARRC) agreement (D8) regarding record-keeping responsibilities for visiting health practitioners. A local document outlines service requirements and contractual responsibilities, which states that *The Memorandum of understanding between providers regarding ARRC services states that (8) "if a GP or NP has cause to visit a resident, WHST must ensure that the GP enters findings and any treatment given to or ordered for the resident, into the relevant clinical records maintained on-site at the time of attendance".*

Nurses have a responsibility to provide planned care. If concerns were identified regarding documentation standards it would be considered accepted practice for the RN to escalate this risk to the care home leaders who are responsible to ensure that clinical and operational standards are maintained. However, based on the lack of

submitted nursing evidence I am unable to provide further comment and recommend seeking medical advice regarding professional practice standards.

5) If information received shows whether or not the GP was notified about the physio's concern that Mrs A had a significant neurological issue following her assessment?

An RN progress note entry 24 [Month3] 2021 states that [Mrs A] had been assessed by the physiotherapist … *have copied PTs documented information and will follow this up with GP* … An entry 25 [Month3] 2021 states … *GP given a copy of the physiotherapist notes from yesterday, awaiting any further instruction or advice …* There is no further evidence of communication with the GP, guidance received or attempts to follow up with the GP reported in progress notes. The Physiotherapist notes are comprehensive and raise clinical concerns, however records show that [Mrs A] was only seen by health professionals six days later on 30 [Month3] 2021. I consider nursing actions to be below the standard of accepted practice in the circumstances and this would be viewed similarly by my peers.

Departure from accepted practice: Moderate to serious

6) If the wider issues of the clinic (such as the remoteness of the clinic, lack of staffing, poor IT infrastructure) impacted negatively on the actions of the staff and to what degree?

I am unable to provide comment as this question is outside my scope of practice and recommend seeking advice from a community healthcare provider.

7) Whether there were any short-term care plans made (if deterioration was identified)?

The organisation's MoU states that the ARRC RN is responsible for initiating short-term or specific care plans or amending current care plans, entering progress notes, and referring staff to the care plan or special orders.

File evidence shows that short-term care plans were in use at the care home at the time, with a plan commenced 7 [Month3] 2021 to manage [Mrs A's] identified low mood. It does not appear that the short-term care plan was evaluated or a revised plan commenced to address [Mrs A's] significant physical changes, increasing levels of dependency and signs of health decline in keeping with accepted nursing processes. I acknowledge that workforce issues and competing RN priorities may have impacted upon documentation standards at the time, however [Mrs A] was demonstrating clear signs of change to her health and wellbeing therefore her related care requirements would still be considered a clinical priority.

On review of the submitted evidence, it appears that specific short-term care plans were not used at the time to guide [Mrs A's] care but progress notes describe care occurring with evidence of RN involvement which indicates a deviation in documentation rather than care standards. As an improvement opportunity I

recommend additional training about timely nursing assessment, recognition of risk, and responsibilities to short-term and last days of life care planning which would be viewed similarly by my peers.

Departure from accepted practice: Mild to moderate.

- **How was [Mrs A's] presentation on admission different to how she started presenting from mid-[Month2] 2021?**

File information indicates that [Mrs A] was living with multiple and complex long-term health conditions that required oversight from a range of healthcare professionals. Physiotherapy assessment notes 24 [Month3] 2021 indicate that [Mrs A] presented with signs of health and well-being changes following her return from hospital in [Month2] 2021. The report provides a comparison to [Mrs A's] presentation on admission (2018), however there are insufficient care home records across this extended timeframe to inform further comment to respond to this question.

5) Clinical advice

I note that the events occurred during the COVID-19 pandemic period 2020–2022 and would like to acknowledge the challenges and distress caused to residents, whānau/family, care teams and health service providers during this time.

Based on this review I recommend the care home team complete additional education on communication with and about older people and their whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the family in the resident's clinical record, and the use of communication tools to better inform clinical assessments, actions, and safe, evidence-based decision-making.

To support this approach, I recommend that the care home team complete the HDC online modules for further learning.

https://www.hdc.org.nz/education/online-learning/

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

References

Health and Disability Commissioner. (2022). Online Learning. https://www.hdc.org.nz/education/online-learning/

Health Quality and Safety Commission. (2019, 2023). Frailty Care Guides. http://www.hqsc.govt.nz/'

Appendix B: In-house clinical advice to Commissioner

The following in-house advice was obtained from Dr David Maplesden:

'CLINICAL ADVICE — MEDICAL

26 February 2024; **Addendum 22 January 2025 (bold)**

1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner holding a current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from [Ms B], daughter of the late [Mrs A], about the care provided to her mother by staff of [the community clinic]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the following information:

- Complaint from [Ms B]
- Response and clinical records Kauri Lodge
- Response and clinical records [community clinic]
- Response from TWO … including a comprehensive complaint review (CR)
- Response from [community clinic] GP [Dr C]
- **Addendum 22 January 2025: A response from [Dr C] to my preliminary advice was reviewed on 22 January 2025 with my comments based on this response recorded as addenda (bold) in the body of this report**

3. [Mrs A] was a resident of Kauri Lodge where she died on 15 [Month4] 2021. [Ms B] expresses concerns about her late mother's management over this period, in particular that signs of a stroke were not recognised or managed appropriately, and that there was no appropriate escalation in her care as her general condition deteriorated from [mid-Month2] 2021. An aspect of the complaint relates to administration of the Covid-19 vaccine and this has been addressed separately in my file steer dated 9 [Month2] 2023 and will not be revisited in this advice.

4. [Mrs A] had been a resident of KL since 2018. She had a complex medical history including chronic renal failure (CRF), non-insulin dependent diabetes, ischaemic heart disease with cardiomyopathy and congestive heart failure, paroxysmal atrial fibrillation (PAF), implantable cardioverter defibrillator, chronic obstructive pulmonary disease (COPD), gout, depression, morbid obesity, intestinal polyposis, and renal calculi. Regular medications included aspirin and rivaroxaban (of some relevance with respect to stroke management). On file is an Advance Care Plan (ACP) completed [prior to admission]. While not explicit, it implies [Mrs A] preferred to die in KL rather than in hospital, and preferred treatment aimed at symptom control rather than life extension if she became

very unwell. On 29 [Month1] 2021 [Mrs A] had undergone removal of kidney stones (lithotripsy and JJ stent insertion) complicated by a period of post-operative hypotension and desaturation requiring monitoring in ICU. Chest X-ray result dated 1 [Month2] 2021 showed *no pleural effusion, no obvious pulmonary consolidation or significant pulmonary oedema.* [Dr C] reviewed [Mrs A] on 12 [Month2] 2021 in relation to an infected sore on her right hand (antibiotics prescribed). Notes include *nil problems with chest now.* This appears to refer to [Mrs A] having reported some transient breathing issues following her lithotripsy. The JJ stent was removed at [the public hospital] on 19 [Month2] 2021 with no apparent complications noted in the discharge summary and no reference to complaint by [Mrs A] of any particular health issues on that occasion.

5. [Dr C] notes he did not review [Mrs A] again until 16 [Month3] 2021 in conjunction with the nurse practitioner (NP). There was apparently some subtle gradual decline in [Mrs A's] overall condition noted by care staff up to early [Month3] 2021 with more obvious decrease in mobility and increased assistance required for ADLs from around 6 [Month3] 2021. This includes observation by a health care assistant (HCA) on 8 [Month3] 2021: *Noticed when [Mrs A] attempted to use her right arm to feed or drink — it was weak.* It is not clear if this specific symptom was mentioned to [Dr C] on 16 [Month3] 2022. Notes (recorded by the nurse practitioner) include:

concerns that client is feeling very low and confused

— unable to complete sentences,

— can't be bothered getting out of bed

— not getting herself dressed

— not socialising with others

— not accepting of cares

— request for someone to feed her

Noted allergies

Bp 90/60 \P 76 \02 97 \RR 20

Plan

1 Monitor behaviour

2 Restart on Fluoxetine

[Dr C] notes in his response: *She had responded well in the past to fluoxetine and so I decided to restart this anti-depressant.* An MSU was taken on 17 [Month3] 2021 (no infection) and the nurse practitioner reviewed [Mrs A] on 18 [Month3] 2021 (appears to be routine medication review). Notes include *needs GP review when able* (reason for this not recorded) … *1. Review mood and emotions — please facilitate BATOMI*

assessment 2. Last bloods done prior to admission. 3. Restarted Fluoxetine. There is no reference to ordering of further investigations at this time.

6. Comment: If [Mrs A] had exhibited possible focal neurological symptoms (R arm weakness) I would expect the GP or NP to have been notified of this symptom at the time of observation. It is not clear the history of R arm weakness was conveyed to [Dr C] on 16 [Month3] 2021 (not recorded in the GP notes). If the symptom was reported, I would be moderately critical it was not documented and moderately critical there was no focussed neurological examination undertaken as part of the assessment of [Mrs A] on this date. If the documented history accurately reflects the information provided to [Dr C] by KL staff, and noting [Mrs A's] complex medical history which meant there was a broad differential diagnosis regarding the cause of her general deterioration, I am mildly critical there was no recorded heart and lung auscultation or assessment for postural blood pressure drop (given relative hypotension) or basic neurological assessment (given reference to possible speech issue). I believe consideration to undertaking a delirium screen was required (particularly relevant blood tests) and am mildly to moderately critical this was apparently not considered. However, I acknowledge some of the symptoms presented may have been consistent with a depressive illness although I am not convinced other equally likely causes for the symptoms were adequately excluded at this time, particularly noting prominence of decreased mobility as a symptom.

Addendum 1

[Dr C] notes the consultation on 16 [Month3] 2021 was undertaken by [the nurse practitioner] and he was present as an observer as part of the [nurse practitioner's] professional development. He recalls the [nurse practitioner] auscultating [Mrs A's] heart and lungs and performing a basic neurological assessment with no abnormalities reported. There is no reference to information provided by nursing staff regarding prior observation of right arm weakness. [Mrs A's] presentation was very similar to previous episodes of depression she had suffered, and [Dr C] supported [the nurse practitioner's] diagnosis with neither party believing there was, at this stage, any need to perform further tests including a delirium screen. Postural drop in blood pressure was not assessed because of [Mrs B's] morbid obesity and reluctance to mobilise. I remain of the view that best practice would be to have performed a delirium screen but accept that [the nurse practitioner] was apparently very familiar with [Mrs A's] presentations and recognised the current pattern as one with which she was familiar. It appears an adequate assessment was undertaken (again with the assumption there was no attention drawn to the prior observation of right arm weakness) but [the nurse practitioner] should be reminded of the importance of documenting all relevant positive and negative assessment findings.

7. On 24 [Month3] 2021 [Dr C] recorded *needs prn salbutamol inhaler.* A blood test request form was generated at this time, but it does not appear the test was completed until sometime later (results on file dated 7 [Month4] 2021 — see below). On 24 [Month3] 2021 [Mrs A] was assessed by a physiotherapist following referral by KL

staff given the deterioration in [Mrs A's] mobility. The physiotherapist undertook a comprehensive neurological assessment noting *she is extremely weak in her R hand/arm & R leg/foot. She also has weakness in her L arm/hand & L leg/foot but not as severe …* absence of clonus and positive Babinski reflex was noted in both feet with the physiotherapist concluding: *This indicates an upper motor neurone issue. Showed [registered nurse] … will refer to GP again. Need further investigation ie CT scan head/other?* The KL RN notes dated 24 [Month3] 2021 include *Have copied PTs documented information and will follow this up with GP.* [Dr C] states in his response that he *made no record of seeing* [the physiotherapist note] *and may not have seen it.* Based on the KL care notes it appears GP review was arranged on 28 [Month3] 2021 for [Mrs A] to be seen the following day. The complaint review refers to a copy of the physio report being provided to [the community clinic] on 25 [Month3] 2021.

8. [Dr C] and the nurse practitioner reviewed [Mrs A] on 30 [Month3] 2021 (notes recorded by the nurse practitioner). R sided weakness of unknown duration is noted but *L leg moving well.* Difficulty with verbal communication is noted but nature of this is unclear (? dysphasia or dysarthria). Other than the observation *unable to move R leg or R hand — has a claw of her hand ?how long she has been like this* there is no record of a more detailed neurological assessment and there is no reference to the physio assessment. Management plan is recorded as: *1. Request for nursing assessment regarding ADLs cares and BATOMI emotional wellbeing 2. Will review client [in the morning] 3. Review bloods in the morning.* The only blood results on file from around this time are dated 7 [Month4] 2021 (no particular changes from baseline). On 7 [Month4] 2021 [Dr C] has recorded reviewing [Mrs A]. Clinical notes read: *[Mrs. A] improving somewhat with R leg movement, feeling brighter in herself, eating and drinking better. Still no R hand and arm movement. Needs scan, cough with small expiratory wheeze on R side.* A referral was made for brain CT scan with indication recorded as *determine if bleed or infarct causing R leg hemiparesis and R arm hemiplegia.* Blood sample was evidently taken on this date.

9. [Dr C] notes in his initial response, with respect to his management of [Mrs A] on 30 [Month3] 2021: *On 30 [Month3] 2021 [Mrs A] was reviewed by another [nurse practitioner] and myself & found to have right sided weakness. We were unsure of the exact time this had started, but from nursing notes it was greater than the six hour window for greatest benefit. For an ambulance to arrive at Kauri Lodge in an urgent call is usually at least 40 minutes, and to travel to [a public hospital] where the decision is made for thrombectomy, a further 2.5 hours and then transport to [a tertiary hospital]. On the day the weather conditions were too poor for helicopter transport from the town with low cloud. [Mrs A] was already on Pradaxa for prevention of thrombosis and her weakness appeared quite stable. I chose to manage her conservatively, and although stopping Pradaxa at this point would seem a good action, I was aware of her end stage cardiomyopathy and paroxysmal atrial fibrillation which promoted thrombosis. From this point, I observed [Mrs A] everyday or every second day and noticed her gradual improvement in function. On [7 Month4], I requested a CT scan to get a definitive look at the cerebral pathology*. [Dr C] elaborates in his response on his working conditions at

the time of the events in question including heavy workload (double and triple booked patients), chronic IT issues impacting on timely recording of consultations, and the impact of Covid requiring use of PPE when consulting. He would casually review [Mrs A] when the opportunity arose … every day or two after the consultation of 30 [Month3] 2021 but did not always document this contact (for the reasons described above) if [Mrs A] was stable or improving.

10. Comments:

(i) Following the physio review on 24 [Month3] 2021 I believe some urgency was required in organising a GP review. I am unable to confirm the steps taken by KL staff in this regard, but I do not believe review arranged for five days later (30 [Month3] 2021) was consistent with accepted practice under the circumstances. However, given the unknown duration of the right sided symptoms at the time of review on 24 [Month3] 2021, and [Mrs A's] comorbidities and use of anticoagulants, I believe it is highly unlikely she would have been considered a candidate for thrombolytic therapy or clot retrieval had she been referred to hospital acutely on that date and ischaemic stroke confirmed. Nevertheless, the possibility of a haemorrhagic rather than ischaemic stroke remained (particularly given [Mrs A's] medications), hence there was some urgency required for clinical review.

(ii) I believe the assessment of [Mrs A] on 30 [Month3] 2021, as documented, was mildly to moderately deficient for a patient with new focal neurological symptoms of uncertain duration. In particular, I believe it was important to try and establish the likely duration of symptoms which influences subsequent management decisions, and for reasons that are unclear it does not appear [Dr C] was aware of the results of the physiotherapy assessment undertaken five days previously. Assessment for any swallowing issues is also important. There is no diagnosis or differential diagnoses recorded. Recommended management of a patient with suspected stroke is contained in the Northland Community Health Pathways[34] which note use of anticoagulants is a potential red flag. In hindsight, it seems likely that by 30 [Month3] 2021 (and certainly by 7 [Month4] 2021) [Mrs A's] symptoms had been present for over one week with recommendations in that scenario as follows:

- *Acute admission is not required.*
- *Discuss with the on-call stroke physician via the hospital switchboard … if there is any swallowing impairment after the stroke.*
- *Request either urgent non-acute neurology assessment or urgent non-acute older person's health* [OPH] *assessment. The urgent outpatient assessment will cover the need for imaging, rehabilitation needs and secondary prevention.*
- *Do not initiate aspirin or anticoagulants.*
- *Continue all long-term medications including aspirin and anticoagulants.*

[34] Northland Community Health pathways. *Stroke.* https://northland.communityhealthpathways.org/ Accessed 26 February 2024

(iii) I believe accepted practice following the assessment of a patient such as [Mrs A] would be to discuss the most likely diagnosis with the patient/whānau and the recommended management options — in this case urgent (non-acute) neurology or OPH assessment, and for the management plan to reflect the patient's informed preference. If [Mrs A] declined referral for further assessment and preferred symptom management only (which could be perceived as being consistent with her ACP) it would be reasonable to take a more conservative approach to management, but such a decision required appropriate patient/whānau consultation which does not appear to have been the case on 30 [Month3] 2021. The documented management plan was inadequate and meant whānau were left with the impression nothing was being done to address [Mrs A's] deterioration. Blood tests and clinical review the next day were listed as part of the management plan on 30 [Month3] 2021 but do not appear to have been completed. These are mild to moderate criticisms.

(iv) [Dr C] states he reviewed [Mrs A] informally and briefly on occasions between 30 [Month3] and 7 [Month4] 2021 and she showed some improvement over this time. Expected practice is to document any clinical assessment of a patient and [Dr C] has noted several factors influencing his ability to undertake such documentation over the period in question. I believe it was appropriate to refer [Mrs A] for a brain CT on 7 [Month4] 2021 (provided she consented to the investigation) although why this decision was not made on 30 [Month3] 2021 is unclear, and it would have been most appropriate to arrange the investigation (either directly or via neurology/OPH referral as discussed) as soon as the stroke diagnosis was considered. If [Dr C] considered the possibility of a haemorrhagic stroke as a possible diagnosis (as indicated in the CT referral letter and in his response) I believe it is accepted practice to discuss continued use of anticoagulants with a neurologist although in hindsight, given the likely duration of [Mrs A's] symptoms by the time of her review by [Dr C] and her complex cardiac issues increasing her risk of thromboembolic disease, advice may have been to continue the medications.

(v) Addendum 2

[Dr C] confirms the consultation of 30 [Month3] 2021 was undertaken by the nurse practitioner and he was an observer. Nursing staff informed them of the result of the physiotherapy assessment but this information had not been conveyed to them previously. [Dr C] states: *… a more detailed neurological assessment was undoubtedly undertaken at the time by the nurse practitioner and myself and because there was no significant additional findings, we elected for conservative treatment, rehabilitation and mobilisation … On 30th [Month3] when I saw [Mrs A] and learnt of the 6–7 days neurological deficits, her condition had not deteriorated. This was much more likely to be an ischaemic clot than a cerebral bleed.* [Dr C] notes his request for CT was subsequently declined by the public hospital. He notes also that [Mrs A's] family had visited her since the onset of her right sided weakness but were currently holidaying out of the area. This may have influenced his decision not to call them following the assessment of 30 [Month3] 2021, and he reiterates there had been some improvement in [Mrs A's] overall condition at review on 7 [Month4] 2021. I accept

the assessment of [Mrs A] on 30 [Month3] 2021 may have been adequate, but I believe it has been inadequately documented (see previous criticism in Addendum (1)) and I remain mildly critical of the overall standard of clinical documentation. I remain of the view that [Mrs A's] next of kin required notification of her likely stroke diagnosis on 30 [Month3] 2021 (although this notification could have come via nursing staff) but accept that the management decisions made by [the nurse practitioner] and [Dr C] were consistent with [Mrs A's] ACP. I agree with [Dr C] that the stability of [Mrs A's] symptoms since first observation made a significant intracerebral bleed a less likely diagnosis than ischaemic stroke and I do not believe there was an indication for acute hospital admission on 30 [Month3] 2021 given the time that had elapsed since onset of [Mrs A's] symptoms, her apparent stability and absence of current swallowing difficulties.

11. Care notes indicate [Mrs A's] condition was stable for the next few days although she had ongoing respiratory symptoms and there is reference on 8 [Month4] 2021 to: *she is coughing and needs to be reviewed by GP tomorrow. RR 16, SPO2 96%, T 36.6* [vital signs not particularly concerning]. It does not appear GP review was actually requested at this time. RN notes dated 12 [Month4] 2021 note an impression [Mrs A] has deteriorated over the preceding weekend with a primary care team advice request for review completed the same day requesting further treatment and advice. Notes include: *Not talking, unable to understand instructions, unable to move right arm, sleepy at times, not swallowing at times … P 89, BP 110/74, T 36.1, O2 95%.* The request was faxed to [Dr C] who was consulting in another town as flooding made the town inaccessible. A virtual consultation was possibly completed later on 12 [Month4] 2021 (per GP response) but there is no record of this in [the community clinic] or KL notes other than the comment (KL notes): *No updates from [clinic] till 1800hrs … needs to be reviewed by GP tomorrow.* If formal clinical advice was provided as part of a teleconsultation on 12 [Month4] 2021, I would expect this to have been recorded in the KL and [community clinic] notes (even if retrospectively). The absence of any such note may mean the consultation did not occur, or a moderate deficiency in clinical documentation if the consultation was undertaken.

Addendum 3

[Dr C] feels it is likely a teleconsult was undertaken on 12 [Month4] 2021 *but unfortunately there appear to be no clinical notes — which is not unusual for the poor state of the IT provision at [the community] clinic, at that time. I expect clinical advice was indeed provided as part of the consultation but the record of this appears to have been lost through the IT inadequacies at the time, exacerbated by meteorological conditions in winter.* If a consultation note was completed but lost due to technical issues, I withdraw the adverse comment noted above. I assume work has been done to try and address the technical issues discussed in the response.

12. [Dr C] states in his response: *On 13th [Month4] I saw* [Mrs A] *for wheezing, instituted treatment for what I likely decided was an exacerbation of COPD.* His notes dated 13 [Month4] 2021 read: *[Mrs A] wheezing more this afternoon with difficulty using spacer.*

Nebulizer to salbutamol and Atrovent 5mg/500mcg started, q6hrly overnight if needed. Low flow PRN oxygen was also prescribed. Vital signs recorded in nursing notes at 1530hrs (prior to GP visit) were BP 100/67, P 85, T 36.7, O2 sats 88%, RR 25. The RN also recorded anterior lung auscultation findings of inspiratory and expiratory wheeze. Taking into account the findings documented by the RN, I am mildly critical of [Dr C's] assessment of [Mrs A] on 13 [Month4] 2021. I believe the possibility of exacerbation of CHF as a cause of the symptoms required consideration with auscultation of lung bases (posterior), heart sounds and assessment for fluid overload (ankle oedema, JVP). This may be a deficiency in clinical documentation or assessment. Exacerbation of COPD may also have been a very reasonable diagnosis and the management prescribed was appropriate for this condition, with care notes suggesting there was some initial response to therapy.

Addendum 4

[Dr C] responds: *I would have examined for the possibility of exacerbation of her chronic congestive heart failure by auscultation of her chest and examination of her ankles for oedema with no new findings, but decided COPD was the predominant causative pathology that day …* [Dr Maplesden] *assumes that because I do not write non-contributory findings towards the diagnosis in my notes, that I did not do the examination fully. This is incorrect. I write only the positive findings, and things which guide my diagnostic decision making.* I accept that [Dr C] may have undertaken a more comprehensive assessment than represented by the clinical notes. However, I believe it is accepted practice to document relevant positive and negative clinical findings. The Medical Council of New Zealand publication "Coles Medical Practice in New Zealand"[35] notes: *A common error found in clinical notes is failure to record important negative findings. This particularly applies to vital signs. A record showing that there was no fever, a normal pulse, blood pressure and respiratory rate and a normal oxygen saturation is very useful information if the patient subsequently deteriorates and the doctor is criticised for not taking a more proactive stance at the time of the consultation. A useful rule of thumb about how much information to include is to think about another doctor reading the notes. Is there sufficient information to allow another doctor to arrive at the same or similar conclusion and could justify the management plan? Could this doctor reasonably exclude other important diagnoses on the basis of the clinical information?* One criterion presented in the RNZCGP clinical notes audit[36] is: *Sufficient positive and negative history and examination findings are present to justify management decisions.* I therefore remain mildly critical of the standard of [Dr C's] clinical documentation.

[35] Lillis S. The purpose of medical records and notes. In: Morris KA, editor. Cole's medical practice in New Zealand, 14th ed. Wellington: Medical Council of New Zealand; 2021. https://www.mcnz.org.nz/assets/standards/08588745c0/Coles-Medical-Practice-in-New-Zealand.pdf Accessed 22 January 2025

[36] https://www.rnzcgp.org.nz/gpdocs/New-website/Quality/Draftv1RecordReviewAUGUST2018.pdf Accessed 22 January 2025

13. KL notes dated 14 [Month4] 2021 refer to a further review of [Mrs A] by [Dr C] including review of her ACP. There is a comment: *GP will call family to give NPK update on patient's health.* I am unable to confirm the contact was completed or what was discussed and there is no reference in the GP notes to a consultation on 14 [Month4] 2021. Care notes dated 15 [Month4] 2021 note a gradual decline in [Mrs A's] reactivity but there is no refence to any patient distress. Notes include: *[Mrs A] needs comfortable cares and don't need morphine as per her advanced care plan*. *At around 1600hrs [Mrs A] looks cyanosed and observations done = SpO2 56% on RA, PP 45, HR 70, BP 73/55. Oxygen 2 litres by nasal prongs started immediately. Informed GP.* [Dr C] reviewed [Mrs A] around 1620hrs noting *[Mrs A] has lapsed into light unconsciousness with a pulse of 70 O2 sats of 92& rapid resp rate. OE weak pulse with coarse creps in chest posteriorly. Probable chest infection, for 1gm IM Amoxil* (Ceftriaxone administered as Amoxil amp had expired). [Mrs A] continued to deteriorate although there is no reference to symptoms of distress, and she died around 1715hrs on 15 [Month4] 2021. Cause of death was recorded as respiratory failure due to congestive cardiac failure with co-morbidities of ischaemic heart disease, diabetes and chronic renal failure.

14. Comment: I am moderately critical there was no consultation note recorded for the review undertaken on 14 [Month4] 2021 given this was formal review of a very unwell patient. In the absence of any recorded examination findings, it is difficult to comment specifically on medical management although a comfort cares approach seems reasonable considering [Mrs A's] ACP, best decided in consultation with whānau. It is possible [Dr C] discussed [Mrs A's] condition with whānau on this date (intention noted per KL notes) but I am unable to confirm this. At review on 15 [Month4] 2021, it is apparent [Mrs A] was entering the terminal phase of her illness. Best practice would be to inform whānau of the situation (may be delegated to KL staff — unsure if whānau were notified in a timely manner) and to consider anticipatory prescribing for end-of-life symptom management. It does not appear there was any such prescribing undertaken (and perhaps this might have taken precedence over IM antibiotic prescribing under the circumstances). However, I acknowledge there is no reference to [Mrs A] experiencing unaddressed pain or distress in her final hours. Nevertheless, I recommend [Dr C] familiarise himself with the Te Aka Whakapiri resources[37] for end-of-life care if he does not already use these.

Addendum 5

[Dr C] confirms he reviewed [Mrs A] on 14 [Month4] 2021 and *her condition appeared poor but stable.* He does not recall a plan for him to contact [Mrs A's] family to update them on her condition but notes *In hindsight, I should have ensured contact has been made with her holidaying relatives when [Mrs A] started to seriously deteriorate which in this case sadly turned out to be close to her passing.* He implies it is likely he completed a consultation note but this was lost due to the technical issues previously described. If a note was completed the previous adverse comment in this regard will

[37] https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life Accessed 26 February 2024

not apply. It is implied [Dr C] may have assumed nursing staff were keeping [Mrs A's] family informed regarding her condition and communication between providers might have been improved in this regard.

15. There is reference in the responses from [Dr C] and [the community clinic] to factors which may have negatively impacted on [Mrs A's] care including: geographical isolation and climate issues; restricted access to technology such as mobile phone coverage and reliable internet connections which impacted on efficiency of the PMS; medical workforce constraints … resulting in high workload and access issues; the effects of the Covid pandemic on the functioning or primary care (shift to greater use of telehealth, requirement for PPE and impact this had on patient interactions). I believe these factors certainly require consideration when assessing [Mrs A's] management and I note the remedial actions referred to in the various provider response and the complaint report which may go some way towards addressing specific issues (particularly integration of clinic notes). However, clinical workforce issues remain prominent and will continue to do so in the foreseeable future.'