A Rest Home

A Report by the

Health and Disability Commissioner

(Case 01HDC00072)

Parties involved

Ms A	General Manager, Alzheimer's Foundation
Ms B	Complainant / Consumer's daughter
Mrs C	Consumer
Ms G	Provider / Principal Nurse Manager
Mr I	Provider / Licensee of the Rest Home

Expert advice was obtained from Dr Tessa Turnbull, an independent general practitioner with experience in caring for elderly rest home patients.

Complaint

On 3 January 2001 the Commissioner received a complaint from Ms A, General Manager, Alzheimer's Foundation, on behalf of Ms B about the treatment her mother, Mrs C, received at the rest home. The complaint is that:

- *Between 10 August 2000 and 24 November 2000 Mrs C did not have a medical assessment despite her deteriorating condition.*
- *During the same period Mrs C developed congestive heart failure, which went undetected until Ms B, on her return to New Zealand, took her mother to a general practitioner on 24 November 2000. Mrs C's condition did not improve and she was admitted to a public hospital in a critical condition on 25 November 2000.*

An investigation was commenced on 15 May 2001.

Information reviewed

- Medical records from Dr D, general practitioner.
- Nursing and medical records from the rest home.
- MOH Licensing and audit report for the rest home.
- Interview with Ms E, nurse at the rest home.
- Medical and admission records from the public hospital.
- Expert advice from Dr Tessa Turnbull, an independent general practitioner.
- Response from Ms B to provisional opinion.

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Information gathered during investigation

Background and admission to the rest home

Prior to her admission to the rest home, 86-year-old Mrs C usually lived with her daughter, Ms B, in their suburban home. Mrs C was a regular day care client at the rest home in nearby suburb, attending twice a week from April 2000. In July 2000, Ms B enquired about the possibility of her mother being admitted as a short-term stay / respite care client at the rest home for a period anticipated to be six to eight weeks when Ms B was going to be overseas. The arrangements were finalised in early August 2000 and Mrs C was admitted to the rest home on 15 August 2000. However, Ms B's plans changed and Mrs C eventually stayed fourteen and a half weeks at the rest home, until 24 November 2000.

On Mrs C's admission to the rest home, Ms B was supplied with, and signed, a four-page document containing admission information. This admission document noted that Mrs C's general practitioner was Dr D. On page two of the admission document under the heading "Agreement to conditions of admission" is the following explanation:

> "Residents have the choice of being attended by the medical practitioner of the house, or may retain their own GP. In the case of emergency, the GP must however, be prepared to visit the Home. Medical records must be maintained in the rest home."

Ms E, the registered nurse who admitted Mrs C to the rest home, advised that she could not remember Mrs C's admission in detail because it was some time ago and she had left the rest home a year ago. She was, however, able to advise her usual practice. Under normal circumstances, if a resident were admitted to the rest home for long term care, he or she would be routinely assessed every three months. However, if the option of a patient's own doctor was chosen, then the family would arrange any required routine assessments. Ms E also said that she would have explained to Ms B that Mrs C's doctor would have to be able to make house calls and be available on a 24-hour basis. She further advised that, in view of the explanation about options for medical care, the question how often a respite care patient (such as Mrs C) would be reviewed did not usually arise. Following the admission procedure, the rest home understood that if Mrs C required a doctor during her stay, staff were to contact her general practitioner, Dr D. This occurred on 4 September 2000, as explained below.

Other information in the admission document provides advice about valuables, personal effects and clothing, notice periods, guarantee of payment of fees, and special instructions on death. The document also contains a declaration section and checklist for Residents' Rights and Complaints Procedure, Cost Structure, Medical Records and the Resuscitation Policy.

The initial assessment made by the admitting registered nurse records Mrs C's mobility as "Walking stick and assistance, improving (walker)". Mrs C was also assessed as needing assistance with toileting and personal hygiene. She was classified as having level three support needs. Her admission weight was 54kg and she was to be "encouraged to eat & drink & do things".

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Ms B advised that she had not received an explanation from Ms E and had understood that Dr F, the doctor engaged by the rest home to attend to patients on a regular basis, would see her mother during her stay at the rest home. Ms B further understood that she gave the rest home the name of Mrs C's general practitioner so that Dr F could contact Dr D if necessary. Ms B said that Dr D's practice was too far away from the rest home to see her mother regularly and that it would have been difficult for her to arrange appointments from the United States.

Dr D had treated Mrs C for many years. In the four months prior to Mrs C's admission to the rest home, Dr D had seen Mrs C at her practice on five occasions. The comments from the clinical record entries for June and July 2000 describe Mrs C as "eating better, more energy, well". Mrs C's weight varied between 51kgs and 53.5kgs, her weight when she was seen on 11 August 2000 just prior to her admission to the rest home. Dr D advised that "at that time [Mrs C] was walking unassisted and apart from the confusion due to multi-infarct dementia she was medically well".

Dr D advised me that although she knew Mrs C was going to the rest home while Ms B was away, she understood that Mrs C would be cared for at the rest home by their visiting doctor, as she had been at another rest home where she was a resident the previous winter. Dr D also advised that if she had known Mrs C remained under her care during her stay at the rest home she would have visited her at least twice in the period from 15 August to 24 November 2000.

The rest home

The rest home is a 42-bed, stage two rest home that has been in operation for over 10 years. The rest home contains 40 beds for permanent residents and two beds for respite care residents, and has a high occupancy rate. A day care unit is run as part of the rest home and caters for up to 25 people per day. The majority of rest home residents are admitted through the day care unit in a similar way to Mrs C's admission. The rest home has been ISO 9002 accredited since 1998. As part of this accreditation, the rest home undergoes regular surveillance audits.

The rest home confirmed that it contracts a general practitioner, Dr F, to visit on a weekly basis. Dr F sees patients as required, and routinely sees level three support needs patients once every three months. However, it is the practice at the rest home for respite care patients, who are usually short term stay patients, to retain their own general practitioner, although patients have the opportunity to request otherwise on the admission document. Where residents retain their own general practitioner, nursing staff refer them to their own doctor for medical care rather than to Dr F.

After the morning, afternoon/evening, and night shifts the rest home documents treatment given and observations made by nursing staff and caregivers. A Nursing Care Plan is completed for all residents outlining specific care requirements for each patient under the headings: personal care; toileting; eating and drinking; communication, sleeping patterns; and mobility. The Nursing Care Plan includes a second page for notation of any specific problems that arise. A Nursing Care Plan for Mrs C was completed on admission and was updated on 11 September 2000.

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The rest home advised me that it employs a nurse whose sole responsibility is staff training, and that all "caregiving staff have or are undertaking the A.C.E. training programme. This is a 12 module training programme devised and run by Residential Care New Zealand; its content is approved by NZQA. After undertaking this year long course several of our staff have now undertaken the follow-up module on Dementia Care."

GP consultation

On 4 September 2000 the rest home staff faxed Dr D advising the result of a mid stream urine (MSU) test conducted by nursing staff on 31 August 2000. The MSU indicated that Mrs C had an E. coli urinary tract infection. Dr D prescribed a course of Noroxin, which successfully resolved the infection. Dr D also advised the rest home staff that a skin scraping taken from Mrs C on 11 August 2000 had not grown any fungus.

Dr D advised me that, apart from the treatment for the urinary tract infection, her only other contact in relation to Mrs C during her stay at the rest home was a request in October 2000 from Ms B. This was a request to complete a medical questionnaire about Mrs C's fitness to undertake a cruise.

Mrs C's care in the rest home

Ms G, Principal Nurse Manager for the rest home, advised:

> "[Mrs C] settled well into the day to day routine of living at the rest home. She enjoyed Daycare diversional therapy and attended most days. [Mrs C] also enjoyed the bus rides. Our mini bus picks up and returns our Daycare clients everyday. [Mrs C] used to enjoy going out for a ride most afternoons.
>
> [Mrs C] however did miss her daughter and was very anxious to return home."

Ms G also advised that Mrs C regularly attended concerts, afternoon picnics and outings to an older persons club, but with an active lifestyle she "would tire quite easily which is common in a lady of her age". Ms G advised me that these activities were "not strenuous affairs" and involved no exertion "apart from climbing small steps on to the bus". Mrs C was given two cartons of dietary supplement daily to assist in maintaining her weight. Ms G further advised:

> "[Mrs C's] health was monitored and discussed ... twice daily. Her urine was sent several times to the laboratory to monitor for any chance of a repeat infection. Our staff are trained to report any signs of change. [Mrs C] at no stage had swollen puffy legs, shortness of breath, significant changes in pulse rate, change of body weight or any other classic symptoms associated with heart failure. Heart failure often occurs with our residents due to their age and general state of health. The staff are highly experienced at observing for the symptoms and report on a daily basis."

Nursing records indicate that on 20 and 22 October 2000 respectively Mrs C was "very sleepy and breathless" and "did not drink and eat much". There were no further concerns noted until 19 November 2000 when Mrs C was recorded as being "sleepy and confused" and on 20 November as "not walking well".

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Two friends of Mrs C advised that a few weeks before her discharge from the rest home she had no "energy or strength" and was "paler than usual, rather breathless, listless, [and had] no energy". Mrs C's son also advised that when he visited his mother on 21 November 2000 she had "gone downhill dramatically".

On 21 November 2000 Ms B returned to New Zealand. In the complaint letter written on her behalf, Ms B is reported as not initially recognising her mother because she was so frail. Ms B advised me that when she first saw her mother again, she was short of breath, had swollen feet, could not complete a sentence, kept falling asleep and needed assistance to walk with her stick. It was Ms B's impression that her mother was dehydrated and had lost weight from lack of food.

On 22 November 2000, Ms B visited her mother but did not take her home because she felt her mother was unwell and she herself had a virus. Ms G informed Ms B that her mother's room was needed by 24 November 2000, as it had been booked for another resident. The rest home had initially been advised that Ms B would return to New Zealand in September 2000 but this was extended by Ms B to 16 October 2000 and then to 21 November 2000.

On 23 November 2000 Mrs C "refused a shower and ate very little dinner". On the morning of 24 November 2000 a nursing entry records that Mrs C "showered and full cares given. Weight = 54 kg. Looking forward to going home, very happy. Appears well and in good health." Later that day, Mrs C attended a concert (according to Ms G, at the request of Ms B), before being discharged at approximately 2.30pm into Ms B's care. Ms B's solicitor advised that Ms B "arrived at the rest home at 11am to collect her mother, to be informed by staff that her mother would be going to a concert with other persons in the Rest Home van. She was requested to collect her mother after the concert at 2.30pm."

Subsequent events

At 3.30pm on 24 November 2000, following Mrs C's discharge from the rest home, Ms B took her mother to see Dr D. At this visit Dr D noticed that Mrs C was:

> "[v]ery frail and pale. Not walking well. SOB. [Short of breath] OE [On examination] Pitting oedema to 2/3 up calves. AF [atrial fibrillation or flutter] not rapid. Chest – inspiration [crepitations] both bases. CHF [congestive heart failure]."

Dr D advised me that the ankle oedema (swelling) should have been "very obvious" to the nurses who were bathing and dressing Mrs C at the rest home.

Dr D prescribed Navidrex, a diuretic, when she saw Mrs C on 24 November. The admission letter for the public hospital indicates that Mrs C did not receive her Navidrex until 1.00pm the following day, 25 November. Ms B explained that Dr D had advised her to give the Navidrex to her mother the following morning but Mrs C did not wake until later. On the afternoon of 25 November Ms B contacted Dr D and reported that her mother was "distressed and very confused". Dr D telephoned ambulance transport and the public hospital and arranged Mrs C's admission.

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The ambulance patient report stated:

> "Chief complaint: SOB. Patient began episode of SOB at approximately 1500 hrs [3.00pm] 25/11/00. O/A patient conscious, alert, pale colour, skin warm and dry. Patient has basal creps to both lungs by auscultation. Monitor AF. Pt c/o no pain. Temp 35.4C. Pt obtained good relief from O2/GTN/Frusemide."

Mrs C was admitted to an acute medical ward at the public hospital. The admission notes from the public hospital indicate an initial diagnosis of possible urinary tract infection and congestive heart failure with "[m]ild shortness of breath, JVP raised to about 3cms, bilateral basal crepitations and oedema of legs".

During Mrs C's stay in the public hospital, the clinical and nursing notes record that Mrs C was "tired" and "lethargic" but was also "comfortable", "looking better" and "doing well". On 30 November, a house surgeon was asked to see Mrs C and noted that she had a slow heart rate and decreased consciousness. Mrs C went in and out of consciousness but eventually rallied. On 13 December 2000 she was transferred to a rehabilitation ward. On 8 January 2001, Mrs C was discharged from the public hospital.

Mrs C died on 25 November 2001.

Independent advice to Commissioner

Dr Tessa Turnbull, an independent general practitioner with experience in caring for elderly rest home patients, provided the following expert advice:

> "'To advise the Commissioner whether [Mrs C] received services from [the rest home] consistent with her needs.'
> Question:
> Did any deterioration in [Mrs C's] health from her discharge from [the rest home] on 24/11/00 to her admission to [the public hospital] the following day, reflect upon the standard of care [Mrs C] received while at [the rest home]?
>
> In addition:
> - Did [Mrs C] have pre-existing heart failure or any other condition that could have caused her health status to deteriorate rapidly enough to significantly compromise her within a few hours?
> - Is [Mrs C's] ability to participate in activities on 22 and 24 November 2000 consistent with heart failure?
> - Was [Mrs C], as read from the [the public hospital] notes, in a 'critical' condition at the time of her admission to [the public hospital]? If not, did she later become critical? If so, when was that?
> - If [Mrs C's] condition became critical sometime after her admission to [the public hospital], was any deterioration in her condition attributable to any aspect of care she either did, or did not, receive from the rest home?

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- Any other relevant matter?

Background:

[The rest home] is a stage two rest home with an interest in dementia and an extremely high occupancy rate i.e. 98–100%. The daycare unit runs in conjunction with the rest home. The rest home has achieved ISO9002 accreditation twice, most recently in May 2001. Staff are well orientated and have, or are undertaking, the ACE training programme run by Residential Care NZ. The handover procedures from one shift to another seem well co-ordinated and there is regular medical cover.

[Mrs C] was a regular daycare client at the rest home Retirement Home attending twice a week from April 2000. She lived in her own home and was supported by her daughter [Ms B] in otherwise independent living.

[Mrs C] was admitted to the rest home on 15/8/2000 for a period of respite care thought to be about five weeks while her daughter was visiting [overseas]. [Dr D] reviewed her medically on 11/8/00 and felt her general health was stable.

[Mrs C] appeared to settle in well and joined in communal activities although she was anxious to return home and to see her daughter again. [Ms B] delayed her return to NZ on a couple of occasions, returning on 21/11/00 and took her mother home on 24/11/00.

The nursing progress notes from the rest home are brief with an annotation most days. Extra events such as falls (13/9, 27/9) are recorded. The handover notes are brief and contain a small annotation on all clients at the hand over times. They also record care and extra events i.e. falls not recorded in the progress notes and the urinary infection treated by [Dr D] on 4/9/00.

On 20/10/00, the night notes record 'no appetite at tea. Very sleepy and breathless' and again 22/10 'appeared very sleepy and tired. Did not drink and eat much.' Annotations 23/10 and 24/10 and following indicate no concern except periods of poor appetite, tiredness and sleepiness. The notes of 19/11 record: 'sleepiness and confusion', on 20/11: 'not walking well', on 21/11: 'visited by daughter who has some concerns regarding her mother's lethargy', 22/11: 'appears fine, out to CMA club', 23/11: 'Refused shower. Ate very little dinner.'

[Mrs C's] medical history:

At the time of her admission to the rest home, [Mrs C] was a frail, elderly lady who lived at home with extra support from her daughter and twice-weekly day care. She suffered from:

- Multi-infarct dementia meaning her memory was poor and she got confused and this had happened in a stepwise fashion over some years.
- Atrial fibrillation meaning an irregular heart rate and labile hypertension, or a swinging blood pressure.

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- Other medical problems were diverticulosis, osteoporosis, osteoarthritis with previous left hip replacement, poor vision due to macular degeneration and retinal vein occlusion.

There is no suggestion of a history of previous heart failure or medication to control this condition. Her medications were rocaltrol, digoxin, cartia, nicotinic acid, folic acid and fortisip.

[Ms B] was concerned at her mother's state of health on her discharge from the rest home Retirement Home and made an appointment for her to see [Dr D] on her way home.

[Dr D's] notes of 24/11/00 report [Mrs C] to be 'very frail and pale. Not walking well, short of breath, with pitting oedema to mid calves and crepitations at both bases.' She prescribed Navidrex one daily, and asked to review her the following day. [Dr D's] admission letter to [the public hospital] indicated that she was unable to walk without two assistants and was considerably more confused than when she had reviewed her three months previously.

The mild diuretic prescribed the previous day i.e. Navidrex was not given to [Mrs C] until the 25/11 and [Ms B] contacted [Dr D] that afternoon and reported her mother's condition to be worsening. Admission to [the public hospital] was arranged by telephone and ambulance transport.

The ambulance records state: 'shortness of breath of two hours duration' prior to the ambulance dispatch at about 5.00pm. They administered 40mg intravenous frusemide at 5.36pm.

The admission notes from [the public hospital] indicate an initial diagnosis of congestive heart failure with 'mild shortness of breath, a JVP raised to about 3cm, bilateral basal crepitations and oedema of legs'.

The [public hospital] notes contain a progressive record of medical, nursing, physiotherapy, social worker and other health workers input. The medical notes of 28/11 indicate some general improvement in [Mrs C's] condition but also detail possible dehydration, anxiety and hyperventilation. On 30/11 there was deterioration in [Mrs C's] condition with fluctuating unconsciousness, and variable respiration. It would seem that from all the pointers in the notes that the situation at this time was critical. Her condition stabilised somewhat in the next few days but [Mrs C] became ill again on 5/12/00 with a febrile episode and antibiotics were given on 6/12. A hypertensive episode was recorded on 8/12.

[Mrs C] was transferred to [the public hospital] rehabilitation ward on 13/12 and was discharged home to the care of her daughter on 8/1/01 where she remains in a fragile state of poor health.

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Questions:

- ***Did [Mrs C] have pre-existing heart failure or any other condition that could have caused her health status to deteriorate rapidly enough to significantly compromise her within a few hours?***

GPs see heart failure in four different forms, which is really a spectrum of the illness:

1. Controlled heart failure where there has been heart failure but the condition is controlled by medication.
2. Acute heart failure. This is a medical emergency, which often gets GPs out of bed at night for acute management and referral to hospital in many cases.
3. Chronic heart failure. This is where the heart fails somewhat gradually i.e. over some days and causes a build up of fluid in the lungs, legs and other tissues.
4. Acute on chronic heart failure is where there is an acute episode on top of a chronic situation.

[Mrs C] did not have heart failure when she went into the rest home but she had a number of significant risk factors for this i.e. hypertension and atrial fibrillation as well as being elderly and frail. In hindsight, she may have been on the brink of developing heart failure at times during her admission but the symptoms were attributed to her generally frail state.

I believe she must have developed chronic heart failure in the day/s prior to her discharge from the rest home. It was certainly present when she visited [Dr D] on 24/11/00.

[Dr D's] notes of 24/11/00 report [Mrs C] to be 'very frail and pale. Not walking well, short of breath, with pitting oedema to mid calves and crepitations at both bases.' She prescribed Navidrex 1 daily and asked to review her the following day. [Dr D's] admission letter to [the public hospital] indicated that she was unable to walk without two assistants and was considerably more confused than when she had reviewed her three months previously.

[Dr D] comments that she was struck by the fact that [Mrs C] had deteriorated generally in the three preceding months. There were other factors that would have contributed to this including the emotional ones of [Mrs C] missing her daughter and her own home and the continuing uncertainty about when her daughter would return. It is interesting to note that [Dr D] prescribed a very mild diuretic and indeed this was not given to [Mrs C] until the following day. It seems that although [Ms B] and [Dr D] were concerned about [Mrs C] this was not sufficient to prompt an admission that day.

On 25/11/00, it seems clear that [Mrs C] developed acute on chronic heart failure with more acute breathlessness in the two hours prior to the ambulance arriving. The ambulance crew certainly treated her with the traditional treatment for this i.e. intravenous frusemide. On admission and in the next few days, she was treated for

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continued heart failure and remained frail and unwell. On discharge she was in controlled heart failure.

- ***Is [Mrs C's] ability to participate in activities on 22 and 24 November 2000 consistent with heart failure?***

Not with incipient or developing heart failure. The nursing notes do record odd episodes of breathlessness, confusion, lethargy and poor appetite which may be associated with heart failure and she may have 'tottered on the brink' of this at times during her admission. It is hard to gauge to what extent [Mrs C] 'participated' in these activities or was a 'quiet attender' as the nursing notes do not record this.

- ***Was [Mrs C], as read from the [the public hospital] notes in a 'critical' condition at the time of her admission to [the public hospital]?***

[Mrs C] was clearly unwell but the medical and nursing notes do not indicate 'critical' on admission. She had had some emergency treatment for acute heart failure en route by the ambulance crew.

The admission notes from [the public hospital] indicate an initial diagnosis of congestive heart failure with 'mild shortness of breath, a JVP raised to about 3cm, bilateral basal crepitations and oedema of legs.'

If not, did she later become critical? If so, when was that?

I think the date [Mrs C] could best be described as becoming critical from a medical point of view was 30/11/00. The house surgeon was called because of falling oxygen saturations, peripheral cyanosis, bradycardia and decreased consciousness. The notes do record, however, her daughter saying, 'her condition is not too much different than over the past few days'. There were two more episodes of concern on 5/12 and 8/12 when acute medical events occurred.

'Critical' is a very subjective term and it is possible to see a continuum of failing health from 24/11/00 with fluctuating episodes of greater concern from that date. The decision to resuscitate or not was discussed with [Ms B] and signed 'not for resuscitation' on 4/12. This again was an arbitrary decision as antibiotics were given on 6/12 presumably to make [Mrs C] more comfortable.

If [Mrs C's] condition became critical sometime after her admission to [the public hospital], was any deterioration in her condition attributable to any aspect of care she either did, or did not, receive from the rest home?

I do not think so. [The rest home] seems well run with good systems. [Mrs C's] health did deteriorate after she entered care but there may have been many factors for this including anxiety about being separated from her principal caregiver and support person i.e. [Ms B]. She also had a urinary infection, which they picked up and managed very adequately. It seems an unfortunate coincidence that [Mrs C] developed the first definite signs of CHF in the day/s just prior to her discharge.

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- ***Did any deterioration in [Mrs C's] health from her discharge from [the rest home] on 24/11/00 to her admission to [the public hospital] the following day, reflect upon the standard of care [Mrs C] received while at [the rest home].***

I really do not think so although I have no doubt the staff missed the onset of heart failure in the day/s prior to her discharge.

- ***Any other relevant matter?***

Health in the frail elderly is easily disturbed and no case illustrates this more. [Mrs C's] health has continued to go down hill after her return home after leaving the rehabilitation ward at [the public hospital] i.e. she has had a further admission for dehydration and kidney failure in early February 2001."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

RIGHT 5
Right to Effective Communication

1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

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Opinion: No breach

Right 5(1)

Explanation about medical care
Mrs C, who was elderly, was admitted to the rest home on 15 August 2000 to be cared for while her daughter, Ms B, was overseas.

Ms B filled in the admission form and attended to all the arrangements on behalf of her mother. She filled in the name of Dr D as Mrs C's general practitioner and signed the admission document which states that there is a "choice of being attended by the medical practitioner of the house, or [retaining] his or her own GP".

Ms B understood that her mother was to be cared for, and thus regularly reviewed as appropriate for a level three support needs patient, by the doctor contracted to the rest home, as this had been the understanding with another rest home where her mother had stayed the previous winter. Ms B understood that the name of her mother's general practitioner was obtained only so that Dr F could contact Dr D if necessary.

Ms E, the nurse who admitted Mrs C, stated that it was her usual practice to advise patients and their family of the choice of medical care provision. She also stated that it was usual to explain that if the patient's own doctor was retained he or she would have to be available for house calls on a 24-hour basis. Ms E further stated that because this explanation was given, the question who would medically review the patient did not normally arise. Ms B later advised that she did not receive such an explanation. However, Ms B signed the admission document with the statement about the choice of medical practitioner. I am satisfied that some explanation was given.

The understanding of the rest home was that Mrs C's general practitioner, Dr D, was responsible for her medical care. Consistent with this understanding, in September 2000 when a urinary tract infection was detected, Dr D was contacted by the rest home staff, and prescribed medication that successfully treated the condition.

Clearly there were different understandings about who was to provide Mrs C with medical care. I acknowledge Ms B's explanation that her understanding arose from her previous experience with another rest home and that she understood she was asked for Dr D's name only as a source of information for Dr F if required. Nevertheless, I accept that the rest home took reasonable steps to outline the options for medical care in the admission document. In addition, the explanation by the admitting nurse of the 24-hour on-call requirement if medical care by the patient's general practitioner was elected, provided an opportunity to clarify the arrangements. These arrangements operated successfully in September 2000 when Mrs C's condition was relayed to Dr D, who prescribed treatment.

In my opinion, therefore, the rest home took reasonable steps to effectively communicate arrangements about medical care with Ms B and did not breach Right 5(1) of the Code.

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Opinion: No breach

Right 4(3)

The crux of Ms B's complaint is that the rest home did not adequately monitor Mrs C's condition and did not seek medical assistance when she developed symptoms of congestive heart failure.

On admission to the rest home, Mrs C was assessed by Ms E, the admitting registered nurse, as requiring level three support. This assessment was documented on the initial assessment form. Mrs C's mobility was described as "being able to walk with a stick and assistance but improving with a walker". She was also described as needing help with toileting and personal hygiene.

Dr D, Mrs C's usual general practitioner, described her prior to her admission as "eating better, [having] more energy, well". Dr D later advised that Mrs C was at that time walking unassisted and, apart from confusion due to multi-infarct dementia, she was medically well.

However, Ms B complained that her mother's state of health prior to her discharge on 24 November 2000 should have alerted the staff of the rest home to contact Dr D or to arrange for the rest home doctor, Dr F, to see Mrs C.

Deteriorating condition

The nursing record for October 2000 indicates that on 20 and 22 October Mrs C was noted respectively as "very sleepy and breathless" and "did not drink and eat much". Ms G explained that because Mrs C led a very active life "she would tire quite easily which is common in a lady of her age". However, there was no further concern recorded in the nursing record in the following period until 19 November 2000 when Mrs C was noted to be "sleepy and confused" and on 20 November as "not walking well". The next day, 21 November, Mrs C was visited by her daughter, who found her mother "lethargic". On 23 November, the day before Mrs C was discharged, she "refused a shower and ate very little dinner". Ms G advised that on 24 November, the day Mrs C was discharged, she attended a concert. A nursing entry for that morning recorded, "Appears well and in good health." However, on the afternoon of 24 November, Dr D reported Mrs C to be "very frail and pale. Not walking well, short of breath, with pitting oedema to mid-calves and crepitations at both bases."

The following day, Mrs C had an acute episode and was admitted by ambulance to the public hospital where she was diagnosed as suffering from congestive heart failure.

My general practitioner advisor commented:

> "[Mrs C] did not have heart failure when she went into the rest home but she had a number of significant risk factors for this i.e. hypertension and atrial fibrillation as well as being elderly and frail. In hindsight, she may have been on the brink of developing heart failure during her admission but the symptoms were attributed to her generally frail state. I believe she must have developed chronic heart failure in

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> the day/s prior to her discharge from the rest home. It was certainly present when she visited [Dr D] on 24/11/00. … [Dr D] comments that she was struck by the fact that [Mrs C] had deteriorated generally in the preceding months. There were other factors that would have contributed to this including the emotional ones of [Mrs C] missing her daughter and her own home and the continuing uncertainty about when her daughter would return. It is interesting to note that [Dr D] prescribed a very mild diuretic and indeed this was not given to [Mrs C] until the following day. It seems that although [Ms B] and [Dr D] were concerned about [Mrs C] this was not sufficient to prompt an admission that day.
>
> On 25/11/00, it seems clear that [Mrs C] developed acute on chronic heart failure with more acute breathlessness in the two hours prior to the ambulance arriving. …"

My advisor noted that "[i]t seems an unfortunate coincidence that [Mrs C] developed the first definite signs of CHF [congestive heart failure] in the day/s just prior to her discharge".

In response to the question whether Mrs C's admission to the public hospital reflected upon the standard of care she received at the rest home, my advisor stated:

> "I really do not think so, although I have no doubt the staff missed the onset of heart failure in the day/s prior to her discharge."

In response to the question whether Mrs C's ability to participate in activities on 22 and 24 November 2000 was consistent with heart failure, my advisor commented:

> "Not with incipient or developing heart failure … [but] she may have 'tottered on the brink' of this at times."

In response to the question whether Mrs C was in a critical condition on admission to the public hospital, my advisor stated:

> "[Mrs C] was clearly unwell but the medical and nursing notes do not indicate 'critical' on admission. … I think the date [Mrs C] could best be described as becoming critical from a medical point of view was 30/11/00. … There were two more episodes of concern on 5/12 and 8/12 when acute medical events occurred."

I accept my advisor's view that Mrs C developed chronic heart failure shortly prior to her discharge on 24 November 2000, and that this condition developed gradually. The nursing records between 19 and 24 November, in the last days of Mrs C's stay, describe incidents where she was sleepy, confused, not walking well and eating little. This was during the week Ms B returned to New Zealand. However, it is clear that on the morning of 24 November, Mrs C was able to participate in a planned outing and, although her frailty was noted by Dr D, who saw her that afternoon, her treatment was to prescribe a mild diuretic and send her home.

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I note that the rest home is a retirement home and daycare centre with ISO 9002 accreditation. The patient records demonstrate that Mrs C's health status was carefully observed and reported on. Whilst it is clear that Mrs C's developing chronic heart failure was not detected during her stay, I am satisfied that the signs were not easily detectable by nursing staff and that the failure to refer Mrs C for medical assessment was not unreasonable in the circumstances. It would appear, with the benefit of hindsight, that Mrs C developed the first definite signs of chronic heart failure gradually, in the days preceding her discharge. The acute episode, which precipitated Mrs C's admission to the public hospital, appears to have developed rapidly on 25 November 2000, as explained by my advisor.

It is easy to be critical with the benefit of hindsight. Although Ms B's concerns about her mother's deterioration are understandable, I am satisfied that the rest home provided nursing care consistent with Mrs C's needs. I do not consider that the rest home should be held accountable for failing to adequately monitor Mrs C's deteriorating condition or to refer her for medical assessment during her final days of her stay at the rest home. In these circumstances, the rest home did not breach Right 4(3) of the Code.

Other comment

To ensure that it is quite clear that residents who elect their own general practitioner to care for them while resident at the rest home will not be reviewed by the general practitioner contracted by the rest home, I recommend that the rest home provide a clear explanation in writing, separate from the Admission Form, that sets out for residents and/or their families the rest home's requirements for medical oversight. It may also be appropriate for the rest home to formally advise the relevant general practitioner of the resident's admission, and of the fact that the resident and/or his or her family have elected the general practitioner to provide the resident's medical oversight while in the rest home, together with the rest home's requirements in this regard.

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

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