Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 20HDC00940)

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Introduction

1. The Health and Disability Commissioner received a complaint from a man about the care provided to his father, Mr A, by Nurse Maude. The complaint was made on behalf of his father and was submitted by the man and his siblings. The complaint concerns in-home care provided by Nurse Maude between July 2019 and 31 March 2020 and the failure of Nurse Maude to change Mr A's catheter or maintain oversight of his ability to administer his own insulin.

2. This report is the opinion of Dr Vanessa Caldwell, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. Mr A was under the care of Nurse Maude home-based nursing services from July 2018 until 31 March 2020. He resided in an independent living unit at a care home from June 2019 until his transfer to hospital when he became acutely unwell. Following discharge from hospital, he required rest-home level care within the care home. Mr A's family believe that failures by Nurse Maude caused or contributed to the decline of his health to the extent that he could no longer live independently. Sadly, Mr A has since passed away and I offer my condolences to his family for their loss.

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

4. The following issues were identified for investigation:

- *Whether Nurse Maude provided Mr A with an appropriate standard of care between July 2019 and March 2020, particularly with respect to the discontinuation of insulin management in July 2019 and his discharge in November 2019.*
- *Whether the care home company provided Mr A with an appropriate standard of care on 31 March 2020, when Mr A used his emergency call bell.*

Background and information gathered

5. Mr A was diabetic and was fitted with an indwelling catheter. During the events described below he was aged in his seventies and was living in an independent apartment.

6. Since July 2018, Mr A had been receiving home-based care through Nurse Maude, an independent provider of district nursing and home-care services. This included visits to check that he was self-administering his insulin correctly and to change and maintain his catheter and bag. Paragraphs 7–22 specifically outline the cares provided to Mr A from 26 June 2019 to 31 March 2020.

7. Mr A moved into his new residence at the care home on 26 June 2019, following the passing of his wife earlier in the month. He asked the district nurse to return the following day. This is noted in Nurse Maude's progress notes.

8. Mr A's Nurse Maude progress notes show that on visiting the following day, 27 June 2019, the district nurse discovered that Mr A had not had his insulin for two days, as he was still unpacking boxes and had been unable to locate his insulin syringe. The nurse found the syringe in the 'pantry' and advised Mr A not to administer any insulin until the following morning.

9. On 28 June 2019, Mr A took his blood-sugar level and self-administered his insulin. The Nurse Maude progress notes state: '[T]o continue daily oversight until he is settled.'

10. On 29 June, 30 June, and 1 July 2019, Mr A's Nurse Maude progress notes all indicate that Mr A took his blood-sugar level and self-administered his insulin without issue.

11. On 2 July 2019, Mr A's Nurse Maude progress notes show that Mr A was unable to administer his insulin without assistance because he could not replace the vial into the insulin pen. Notes entered by the nurse state: '[H]ave shown how but may require further input for next time.'

12. On 3 July 2019, Mr A's Nurse Maude progress notes show that Mr A self-administered his insulin prior to the district nurse arriving. At this visit, the nurse documented: 'Discussed with him reducing [district nurse's] visit down to 3x weekly or a phone call.'

13. On 4 July 2019, a Nurse Maude district nurse telephoned Mr A. Mr A advised the nurse that he had self-administered his insulin. The nurse recorded in the progress notes: 'Will reduce visit gradually as he is independent and can be relied on with his insulin administration.'

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14. Entries in Mr A's Nurse Maude progress notes on 5, 11, 12, and 15 July 2019 show that Mr A completed his blood-sugar level and insulin self-administration prior to the nurse's visit.

15. Nurse Maude progress notes record that the visits to check Mr A's insulin administration were discontinued following a visit on 19 July 2019 because Mr A was successfully self-administering his insulin. A decision was made to monitor Mr A's self-administration of insulin only during his scheduled catheter care visits.

16. Nurse Maude provided the following rationale for this decision:

> 'Rational[e] for reducing insulin oversight in July 2019 is documented in multiple nursing progress notes where the nurses have identified he was independently managing his diabetes and insulin administration, as he had for the previous 25 years. Reducing his insulin oversight visits was in keeping with the aim to maintain his independence.'

17. On 9 October 2019, documentation from Mr A's visit to his GP indicate 'concerns about taking his medication'.

18. Following a visit to change Mr A's catheter bag on 14 November 2019, no further catheter care visits took place. Nurse Maude attributed this to human error in the discharge process, as no further visits were scheduled in the electronic patient management system after 14 November.

19. The Nurse Maude administrator who processed the discharge told HDC that she believes she most likely received Mr A's paper file in her district nurse discharge filing box and processed the discharge accordingly. At that time, Nurse Maude had transferred from a paper discharge process to an electronic discharge process, but the administrator said that some nurses still followed the paper discharge process, and in Mr A's case, no electronic discharge advice was completed. No electronic discharge advice can be found for Mr A.

20. Nurse Maude told HDC that its policy is to contact the GP when a client is discharged. Historically this was done by fax and is now done by email. Nurse Maude did not have the email addresses for all GPs, including Mr A's GP, so an email notification did not occur.

21. On 23 December 2019, Mr A telephoned Nurse Maude to request that his catheter bag be changed. Nurse Maude documented that a request was made on 23 December 2019 for catheter care for Mr A. However, Nurse Maude told HDC that no visit was scheduled due to human error. Nurse Maude's internal investigation revealed that the request was emailed internally to the inbox of a Nurse Maude registered nurse, not the appropriate team inbox, and then the request was forwarded to the home-care team. On 24 December 2019 the home-care team queried by reply email whether the request was meant for the home-care team, to which the nurse replied: 'Yes, homecare do cath[eter] care.' There is no evidence that the request was actioned after that point.

22. On 31 March 2020, Mr A was transferred to hospital because he felt unwell. The care home company provided HDC with information regarding the event immediately preceding Mr A's admission to hospital. Mr A's call bell was activated on 31 March 2020 at 6.52pm. A senior

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caregiver attended to Mr A within 5 minutes and 52 seconds of the call bell activation. The caregiver tested Mr A's blood-sugar level, administered NovoRapid insulin, and repeated a blood-sugar test. The caregiver then informed the registered nurse for review and follow-up. The caregiver's actions are documented in the progress notes provided to HDC.

23. No progress notes were completed by the registered nurse who subsequently reviewed Mr A, and the care home company has been unable to identify definitively which staff member attended Mr A, as two registered nurses were on duty on 31 March 2020.[1] In a written statement provided to HDC, a registered nurse recalled attending an independent resident with high blood-sugar levels and calling an ambulance but cannot confirm that this was Mr A. The care home company said that normal practice is for a progress note update to be made, and the registered nurse did not use the progress note created for this event.

24. An ambulance was called at 10.05pm and arrived at the care home at 10.19pm (as documented in the Ambulance Care Summary). Mr A was transferred to the Emergency Department at the public hospital, where he was found to be in a hyperosmolar hyperglycaemic state (HHS)[2] secondary to missed insulin doses. It was also found that he had not received catheter cares since November 2019 and that he was suffering from a urinary tract infection (UTI). Some cognitive decline was also noted. Mr A was admitted to the General Medicine ward on 1 April 2020 and then transferred to a facility for rehabilitation on 17 April 2020. Following his discharge on 29 April 2020, Mr A required rest-home level care.

25. In April 2020, Nurse Maude provided an apology to Mr A's family identifying that Mr A had been discharged from all cares in error after the 14 November visit. Nurse Maude also apologised that the phone request for a catheter bag change was not actioned.

Further information

26. In respect of the discharge of Mr A from all cares on 14 November 2019, Nurse Maude told HDC:

> 'This occurred as a result of human error and we apologise unreservedly for this. This has been a clear failure of our processes and as a result of this incident we have reviewed how we do things and made changes to scheduling practi[c]es.'

27. The family expressed their distress at the consequences these events had on their father, including his stay in hospital and reduced independence upon his discharge. They stated:

> 'He doesn't recall the 4 weeks he spent in hospital or recall how and why he was admitted into hospital. Memory loss is so severe that Dad doesn't recall his independent apartment, where he lived for nearly a year …

[1] One of the registered nurses on duty that night at the care home has since retired.

[2] A life-threatening complication of diabetes that occurs when blood glucose (sugar) levels are too high for a long period, leading to severe dehydration and confusion.

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> Dad now, is no longer allowed to drive which has reduced his independence. Dad doesn't remember names including family and what he has been doing during the day or where he has been. Dad is often upset and feels terrible for what this has done to the family. He is frustrated with not being able to remember simple things.'

Responses to provisional opinion

28. The family, Nurse Maude, and the care home company were given the opportunity to respond to the provisional opinion.

29. Nurse Maude did not submit a response to the provisional opinion.

30. The care home company confirmed to HDC that it had no further comments on the provisional opinion.

31. Mr A's children reiterated their distress at the events of July 2019 to March 2020, their father's deterioration and hospital admission, and his subsequent passing. They each expressed their wish that Mr A's providers be held accountable for the failings in his care, saying that they want to 'ensure that no other family experiences the same heartache and suffering' that they have.

Opinion: Nurse Maude — breach

32. To investigate the care provided to Mr A, HDC obtained in-house clinical advice from GP Dr David Maplesden (Appendix A) and external advice from RN Barbara Cornor (Appendix B).

Discharge from insulin management

33. Nurse Maude told HDC that Mr A's insulin visits were discontinued in July 2019 because Mr A was successfully self-administering his insulin, and the intention was for oversight of his insulin management to be maintained at Mr A's weekly catheter visits.

34. RN Cornor advised HDC that there is insufficient evidence to conclude that it was appropriate for Mr A to be discharged from intensive insulin management in July 2019. RN Cornor stated:

> 'There is some reasonableness documented and associated with the decision to discharge [Mr A] from insulin oversight but there are also reasons identified and documented to provide reason for him not to be discharged. Unfortunately, these issues were not followed up. This is a serious departure from accepted practice.'

35. I accept RN Cornor's advice that documentation in Mr A's progress notes also identifies reasons to consider that Mr A would require ongoing management, including clinical and psychosocial indicators, such as Mr A's move to a new unit, the recent passing of his wife, an unresolved query as to whether he was able to change the vial himself, and a recent series of days on which Mr A could not self-administer his insulin correctly. Nurse Maude has provided evidence that some of these concerns were followed up through patient education.

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36. Both Dr Maplesden and RN Cornor agree that even if it had been clinically appropriate to discharge Mr A from the insulin management portion of the care he had been receiving, with the intention to provide more casual oversight concurrently with continued catheter cares, Nurse Maude's discharge process in July 2019 was insufficient, as staff did not communicate their intention to Mr A's primary care provider, his GP.

37. Dr Maplesden advised:

> '[Mr A's] GP should have been notified of any intention to reduce the level of medication oversight so poor adherence to the insulin regime could be considered as a factor if there was a deterioration in [Mr A's] glycaemic control.'

38. RN Cornor stated:

> 'This is a serious departure from accepted practice especially in a community situation where the GP is an important part of the health team to ensure continuity of care for [Mr A].'

39. I accept Dr Maplesden's and RN Cornor's advice that the failure to notify Mr A's GP when the insulin management service was reduced to an oversight service is a serious departure from accepted practice. I am critical that Nurse Maude did not inform Mr A's GP of the reduction to an oversight service, particularly given the indications that Mr A might require ongoing help with his insulin management.

Discharge from Nurse Maude District Nursing Service

40. Nurse Maude acknowledged that Mr A should not have been discharged from ongoing necessary catheter cares. Nurse Maude attributed this to human error, exacerbated by a transition to an electronic client management system that occurred at the time of these events. Nurse Maude stated:

> 'In [Mr A's] case it is now clear the electronic process was not followed, and administration staff followed the old paper-based process which did not include the checks required to ensure the discharge was appropriate.'

41. Nurse Maude acknowledged that staff should have notified Mr A's GP when Mr A was discharged from the District Nursing Service.

42. RN Cornor is critical of the discharge process in place at the time. She stated: 'It seemed by the push of a button a client could be discharged, without any discussion with any other clinical person.'

43. I accept RN Cornor's criticisms of Nurse Maude's discharge process at the time of these events. The erroneous discharge, caused by an inadequate process at Nurse Maude at the time, created the situation where Mr A was not receiving any district nursing care for months, while his family and GP were unaware that the visits had ceased. With no clinical intervention, Mr A's subsequent deterioration and hospital admission was not unexpected.

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Request for catheter care

44. Mr A called Nurse Maude on 23 December 2019 to request that his catheter bag be changed. However, Nurse Maude did not act on this request. Nurse Maude told HDC that the request became lost to follow-up in emails between staff members.

45. As a long-term catheter care client, Mr A's need for catheter cares should have been identified by Nurse Maude staff, and a home visit should have been scheduled immediately and the earlier erroneous discharge recognised. The failure to action Mr A's request for catheter cares likely played a role in his subsequent deterioration.

46. RN Cornor stated:

> '[W]as it because [Mr A] had 16 different nurses' visits in that period, that not one of those nurses could be responsible to query why [Mr A] was no longer part of their client task list. If he had had a "case manager" or one nurse responsible for him … [Mr A] would not have fallen through the hole created by that one human electronic error.'

47. Dr Maplesden raised concerns regarding the use of personal emails to communicate clinical issues and noted that it appears that these were not monitored adequately. I agree that the use of personal email to communicate a clinical request was inappropriate and contributed to Mr A falling through the cracks.

Conclusion

48. I find that Nurse Maude failed to provide services to Mr A with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), for the following reasons:

- The inadequate clinical assessment of all the issues impacting Mr A's wellbeing and lack of subsequent formulation supporting the reduction in Mr A's insulin management oversight in July 2019;
- The lack of notification to Mr A's GP upon deciding to reduce his insulin management;
- The inadequate discharge process in November 2019, which caused Mr A to be discharged from the District Nursing Service in error and resulted in the cessation of Mr A's necessary catheter cares;
- The lack of case oversight, which:
  a) after one visit to Mr A in July 2019, resulted in a unilateral decision by a registered nurse to reduce his insulin management significantly; and
  b) resulted in no staff being aware that Mr A, a long-term patient of this critical catheter-care service, had been discharged from both catheter care and insulin management in November 2019;
- The use of email between staff to communicate clinical requests; and
- The failure to follow up on the 23 December 2019 request for catheter cares.

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Opinion: Care home company — adverse comment

Call-bell activation response and documentation

49. I accept RN Cornor's advice that the response to Mr A's emergency call-bell activation appears to meet accepted practice. Mr A was assessed by an appropriate caregiver with the necessary medication and insulin competencies, within 10 minutes of the call-bell activation. There is adequate documentation from the caregiver. However, there is no documentation from the subsequent registered nurse review that occurred three hours after the call-bell activation. The care home company has relied on the caregiver's and the registered nurse's recollection of the events of 31 March 2020.

50. In further advice obtained from RN Cornor following the care home company's response to HDC, RN Cornor identified that there is no explanation for the three-hour delay that occurred from when Mr A activated his emergency call bell and was attended to by a caregiver, to the time when a registered nurse attended and the ambulance was called.

51. RN Cornor advised that this situation highlights the importance of contemporaneous clinical progress notes. She stated:

> 'I understand it is difficult for those staff involved to remember events of three years ago and the number of clients they will be caring for in this period will be vast. This only emphasises the fact, that everything done or managed by clinical staff must be documented at the time in the progress notes of that client.'

Conclusion

52. I am critical of the adequacy of the clinical documentation of the subsequent review by the registered nurse, and I will make recommendations to address my concerns.

Changes made since events

53. Nurse Maude conducted an internal investigation in response to the issues raised by Mr A's family. Nurse Maude acknowledged that the process of Mr A's discharge was human error and advised that a new policy has been implemented to remedy this. The new policy requires the Registered Nurse Coordinator to review the instruction (in the CRM electronic system) from the district nurse to discontinue services and to confirm that discharge is appropriate. As per the policy, a reason for discontinuation of services is to be entered, and the Registered Nurse Coordinator is to contact the client by phone and document this. RN Cornor advised that the new discharge policy should ensure that what occurred in Mr A's care should not happen again.

54. The Quality Improvement Plan provided by Nurse Maude in 2022 shows that paper-based discharge processes were discontinued in response to Mr A's incident, with administration staff instructed to process a discharge only when there is an electronic discharge advice in the CRM. The plan also includes Nurse Maude's intention to commence three-monthly audits to ensure that the policy is working as it should.

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55. In March 2021 Nurse Maude confirmed to HDC that work was underway to ensure that it has in its system an email contact for all GPs, and the clinical contact for each GP practice. In February 2022, Nurse Maude confirmed that it had put in place an automated notification from the CRM system to the GP's email address to occur when a client is discharged.

56. Nurse Maude also told HDC that in 2020 it provided education to all its nurses on progress note documentation, in the form of a handout from the Clinical Nurse Educator, which was given to all nurses when they attended a mandatory education session in February 2020. I commend Nurse Maude on the changes it has made.

Recommendations

Nurse Maude

57. I recommend that Nurse Maude:

a) Provide a formal written apology to Mr A's family. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

b) Develop a system for the oversight and central coordination of the care of clients requiring catheter care. Nurse Maude is to report back to HDC with evidence of having completed this, including providing a copy of any policy or procedural documents developed, within six months of the date of this report.

c) Provide HDC with a report of the results of the three-monthly audits (as per the Quality Improvement Plan) of the District Nursing Discharge Procedure, from 2022 to the present, to confirm that all discharges have reasoning for discharge documented and were approved by the Registered Nurse Coordinator, and that notification was sent to the GP. A summary of the audit findings with corrective actions implemented should non-compliance be identified is to be provided to HDC within three months of the date of this report.

Care home company

58. I recommend that the care home company:

a) Provide education/training to its staff on clinical documentation. Evidence showing the content of the education/training delivered and the attendees is to be provided to HDC within three months of the date of this report.

b) Audit adherence to its Response to Call Bells and Assistance in an Emergency procedure, over a six-month period, to ensure that the call bell is responded to in a timely manner and that adequate documentation is completed. A summary of the audit findings with corrective actions implemented should non-compliance be identified is to be provided to HDC within seven months of the date of this report.

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Follow-up actions

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

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Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from Dr David Maplesden (GP):

'I have reviewed the information on file.

1. There appear to have been significant deficiencies in the processes in place at Nurse Maude prior to this complaint, but without the original process documents it is difficult to state whether the issue is failure to follow process or deficiencies in the processes themselves. Concerns could be raised about the following issues:

    - No template completed for regular IDC changes at the time [Mr A] was admitted to NM services
    - Incorrect discharge procedure followed and no communication with [Mr A's] primary care provider regarding the discharge (even if discharge was intended only from intensive insulin oversight, this should have been discussed with or communicated to the GP)
    - Use of personal e-mails (which appear to have been inadequately monitored) for clinical issues
    - Either inadequate documentation, or inadequate oversight, of [Mr A's] glycaemic control, at the weekly to fortnightly catheter-related visits after 19 July 2019 when he was discharged from intensive insulin management but there was an intention to continue some general oversight of his insulin management

2. The decision to discharge [Mr A] from intensive insulin oversight on 19 July 2019 might have been reasonable if NM staff were confident in [Mr A's] ability to correctly administer his insulin and monitor his blood glucose levels (BGL), and there was objective evidence (stable BGLs within an acceptable range) of this ability. However, I believe [Mr A's] GP should have been notified of any intention to reduce the level of medication oversight so poor adherence to the insulin regime could be considered as a factor if there was a deterioration in [Mr A's] glycaemic control. The CH notes refer to an HbA1c level of 92 in October 2019 which indicates poor glycaemic control. I am unable to determine what action was taken by the GP in relation to this result and/or if the GP was under the impression [Mr A] was still receiving NM oversight at this time. There is no written record to suggest NM staff were providing the (apparently) intended general oversight of [Mr A's] glycaemic control at the weekly to fortnightly catheter care reviews between 19 July and 4 November 2019.

3. I am not qualified to comment on the standard of processes in place at NM prior to this complaint but I do believe this issue requires expert advice which may be best coming from a nursing advisor with experience in community nursing care (eg district nursing). NM should be asked to provide a copy of all relevant policies in place at the time of the events in question (eg catheter care, discharge processes, use of e-mail or other communication policies etc), and a full copy of [Mr A's] electronic notes (only a limited portion has been provided). The expert might be asked to comment on the following:

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- The standard and adequacy of the relevant processes in place at NM at the time of the events in question
- Adequacy of NM staff documentation
- Adequacy of [Mr A's] insulin oversight, particularly once he had been discharged from intensive oversight to more casual oversight at the time of catheter care visits
- Quantification of departure from accepted practice with respect to management of [Mr A's] catheter cares
- Adequacy or remedial measures undertaken since the complaint
- Any additional recommendations'

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Appendix B: Independent clinical advice to Commissioner

The following advice was obtained from RN Barbara Cornor:

'6 April 2021

Barbara Cornor
RN, Master Nursing

Complaint: Nurse Maude

Ref: C20HDC00940

Background

[Mr A] was receiving district nursing support from Nurse Maude for catheter care and intensive oversight of his insulin management. In July 2019, a decision was made to reduce [Mr A's] intensive insulin oversight to monitor his diabetes. [Mr A] was discharged from all services and no further visits were scheduled from this date. There is no documentation that reflects that attending nurses were monitoring or having oversight of [Mr A's] diabetes between July 2019 and November 2019.

On December 23, 2019, [Mr A] called Nurse Maude to request catheter care. However, no visit was scheduled. On 31 March 2020, [Mr A] was admitted to hospital due to high blood pressure and sugar levels. It was found that he was in hyperosmolar hyperglycaemic state (HHS) secondary to missed insulin doses and that he had not received catheter cares since November 2019.

Expert advice requested. In particular, please comment on:

1. Reasonableness of the decision to reduce [Mr A's] insulin oversight

On 29 August 2018 [Mr A's] goal for care under Nurse Maude was to have his memory return so he was able to self-care, feel more relaxed and be able to manage at home. This entry was "modified" on 24 May 2019 but there is no further documentation of the management or progress of all these specific goals or outcomes for the client or reflections from the client.

On 29 August 2018 it is documented by Nurse Maude staff, [Mr A] has "limited recall of recent event" and "cognition diminished judgement".

The recent event was an admission to hospital 16 August 2018, with hyperosmolar hyperglycaemic non-ketonic state (HHS), a urinary tract infection and delirium. It is documented in the discharge letter from the hospital that his "delirium" had improved. Several of [Mr A's] medications were changed by the medical specialists (including Insulin) and ongoing support was requested of the District Nurses to support the required titration (dosage according to the level of glucose in [Mr A's] blood) of this newly prescribed insulin.

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A plan was documented of the processes to be implemented to provide diabetes support and introduce the new insulin regime. The plan was written in conjunction with indwelling catheter (IDC) care which [Mr A] was also receiving.

Unfortunately, I found the plan very difficult to follow. The date management for "visits starting" and "ending by" was confusing in that some starting, and finishing were the same date, or different dates, and another planned task was to have "ended by" before the starting date. If using this template daily I assume the staff using it may find it easy to understand but for me, not so much. The plan (very task oriented) indicated who would be involved in the tasks of "Catheter care, diabetes support, Medicines, monitoring blood sugars" as the "District Nurse, Diabetes Support or Home Carer".

2. [Mr A] signed a service agreement for "catheter cares and insulin support", but there is no indication of a plan of care that includes input from either the client or family members. Neither is there a document for the client to have in the home to relate to.

3. [Mr A] was to be provided support to complete his Blood Glucose Level (BGL) and self-administer his insulin in accordance with the prescription and medical instructions. The BGL is identified by pricking the finger and adding a small drop of blood to a machine which will determine the glucose level in that blood, which in turn will provide the base measurement of insulin required to reduce or maintain the glucose level. Insulin is given subcutaneously via a syringe into the abdomen (or identified skin area) to reduce the glucose level. Many diabetics, following training, support of their disease, the process of completing their BGL and drawing up and giving, will inject themselves regularly and confidently, with insulin.

Nursing documentation from progress notes identifies [Mr A's] increasing ability to document his BGL and self-administer his insulin in accordance with instructions. It is documented [Mr A] is "feeling confident to self-manage his diabetes" on 08/02/2019 and suggested instead of daily, "fortnightly DN (district nurse) oversight could be provided".

The next visit on 20/02/2019 [Mr A] "states he should be managing after 25 years".

On 16/05/2019 when the nurse was visiting, [Mr A] advised his wife was in hospital and the DN enquired about his managing his food and identified his BGL as "consistent" in the mornings.

30/05/2019 a district nurse documented "short memory loss evident". There is no further documentation as to why this had been recognised, no red flag of acknowledgement to other health care providers, no plan to follow-up or referral to any other service.

26/06/2019 [Mr A] was moving out of his home to another residence and asked the DN to return the following day. On visiting the following day 27/06/2019 the DN discovered [Mr A] had not had his insulin for two days as he had "lost" his insulin syringe during the shift. His BGL was 16.1 mmol. High but not life threatening. The nurse found the syringe

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in the “pantry” and advised [Mr A] not to administer any insulin until morning. The next morning when the district nurse visited [Mr A], he had done his BGL and self-administered his insulin. It was documented to continue to visit daily until [Mr A] was “settled”.

The following two days [Mr A] had self-administered his insulin prior to the nurse arriving. On the 02/07/2019 [Mr A] was unable to administer his insulin until the district nurse came because he was unable to replace the vial into the insulin pen. Propophane Insulin as prescribed by GP is dispensed in vials which are inserted into the insulin pen for injecting the required dose. The district nurse documented “have shown how but may require further input for next time”. There is no further documentation to confirm, or not, that [Mr A] could change the vial.

03/07/2019 [Mr A] had self-administered his insulin prior to the district nurse arriving. At that visit, the nurse “discussed” reducing the visits to three times per week. The nurse documented [Mr A] was “independent, oriented where things are, has a routine”. The documentation does not include any response from [Mr A], so it is unknown if he agreed or not, to the proposed plan.

On 04/07/2019 [Mr A] was telephoned. He advised the nurse he had self-administered insulin dose and when visited 05/07/2019 he again had self-administered his insulin prior.

The documentation on 08/07/2019 states “consistent recording of BGL and self-administration of insulin” and documents to “reduce visits to once per week”. Again, there is no documentation of discussion or agreement and understanding from the client or anyone else.

The final documentation relating to self-care and administration of insulin is documented 19/07/2019 where it is said there is no need for DNs to visit as [Mr A] has “done everything before arrival and consistently self-administered his insulin”. It was documented to reduce the diabetic visits to “catheter related visits”. Again, there is no evidence of discussion or agreement to the change of plan with [Mr A] or what [Mr A] should do if he had any issues. Further catheter care related visits continued after this date with no further diabetes management documented.

As evidenced in the documentation of the daily client record, from February to July 2019, [Mr A] had been visited by 16 different District Nurses. Some visited him only once, others twice and three up to five times.

Documentation reflects the district nurses continued to visit [Mr A] for catheter care following his July “discharge” from diabetes care. Were those nurses different from the those who had been visiting for his diabetes care? Why did they not query why [Mr A’s] diabetes was no longer part of their care?

This writer queries, is it because their plan for their day as a district nurse is so task oriented that the diabetes care [Mr A] was having, was no longer thought of as part of

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the holistic patient's general well-being or continuity of care that is a standard for every nurse?

There is some reasonableness documented and associated with the decision to discharge [Mr A] from insulin oversight but there are also reasons identified and documented to provide reason for him not to be discharged. Unfortunately, these issues were not followed up. This is a serious departure from accepted practice.

4. The adequacy of communication with [Mr A's] general practitioner (GP)

There is no evidence of any communication with [Mr A's] GP. There are occasional references in nursing documentation as to [Mr A] making an appointment with his GP but there is no follow-up documentation to reflect this was done or any outcomes. Prescription and administration orders on a medication sheet signed by the GP indicate the GP is aware of [Mr A's] requirements for his diabetic control.

This is a serious departure from accepted practice especially in a community situation where the GP is an important part of the health team to ensure continuity of care for [Mr A].

5. The adequacy of staff documentation

Staff documentation is inconsistent and at times poorly reflects the client holistically, but more as a task. E.g., BGL documented for that day, Insulin given for that day, catheter care provided by change of leg bag. There was minimal documentation to reflect [Mr A's] understanding of his condition, the state of his injection site, general wellbeing, visits to GP or other requirements. The majority of the "patient record title" commenced with "Routine Visit — No change in client's condition, no concerns".

The New Zealand Nursing Council states "Good documentation helps to protect the welfare of patients/clients by promoting:

- High standards of clinical care
- Continuity of care
- Better communication and dissemination of information between members of the multidisciplinary care team
- An accurate account of treatment, care planning and delivery
- The ability to detect problems, such as changes in the patient's/client's condition, at an early stage (Collins, Cato et al. 2013)".

Documenting all relevant information ensures others (16 district nurses) know what is observed and what nursing interventions were undertaken. Documentation must show evidence of clinical judgement and escalation and/or referral as appropriate and documenting evaluation of the care provided. If care is not recorded, then it is assumed the care was not given.

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When addressing any issues or changes in care delivery, nurses are recommended documenting the rationale for any decision that is made and be written with the involvement of the client or their family/whānau/carer. In [Mr A's] case, there is no evidence this occurred. It is documented [Mr A] "continues to show a good understanding of his diabetes management" but what did the nurse base that on and did [Mr A] agree?

Provision of clear evidence of the planned care, decisions made, the care provided, and the information shared with rationale for the action was not reflected (therefore assumed not provided) for [Mr A]. There are several entries in the patient record stating [Mr A's] diabetes/insulin support could be reduced or discontinued because [Mr A] was managing his self-care but there are also several other entries reflecting, he "could not change the syringe vial" or was showing evidence of "short term memory loss", and "didn't remember my phone call". All red flags that things might not be as they seem. These problems that arose had no action or plan found to rectify them, nor evidence they had been resolved.

The patient record template is completed electronically but does not appear to provide enough space/room for the nursing staff to document as per the standards required e.g. rationale for decisions, and an improved understanding of the client and continuity of care.

Although some documentation would meet accepted practice it has not been met consistently and does not reflect any continuity of diabetes care of [Mr A], which is a serious departure from the required standard of care.

Suggestion for change:

I have been part of and am aware of many health teams who work in a community situation and do not see each other and will discuss clients by attending a regular multi-disciplinary team (MDT), also called Peer group meetings which are led by a clinical leader/manager. These meetings provide an opportunity for all staff to get together to discuss clients. Information of the progress of the clients are discussed and decisions for changes in plans of care made within that team. In this case [Mr A] had 16 different district nurses visit him from February to July. If all those nurses were in an MDT meeting to decide how often he should be visited or could be discharged from the support service, all the identified issues could be discussed, and processes implemented to resolve them, resulting in the whole team being part of and aware of the required outcome. The discussion and outcome are documented, discussed with the client and/or family for their consent prior to commencement of any change. Documentation of the plan is then shared with the client, GP and any other staff involved. This creates a solution where everyone benefits, where everyone is aware of the changes and expected outcomes.

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6. **The adequacy of [Mr A's] insulin oversight, particularly once he had been discharged from intensive oversight to more casual oversight:**

The evidence documented of [Mr A's] management of insulin oversight is discussed in the earlier question. Unfortunately, there is no oversight documented from 19/07/2019 when a district nurse visiting [Mr A] for the first time said, "No need for DN visits for insulin [Mr A] had done everything befor i arrived and it seems in his drug chart he is consistently self-admining visits should be reduced to cath related visits only at which time a general check of him could be done". "Seems" to be "consistent in self-administering" does not provide adequate rationale for reducing visits. No discussion has been held with [Mr A]. [Mr A] has moved to a new facility, had an extremely sick wife who had died and has some evidence of short-term memory loss. These facts support far more than just diabetes care but do not appear to have been taken into consideration from a holistic point of supporting his general well-being.

There is no evidence as to why [Mr A] stopped taking his insulin, resulting in a hospital admission but the number of red flags identified during his visits which were not followed up, may have been the catalyst … or not.

This is a serious departure from the required standard of care.

7. **The adequacy of the discharge process in place at Nurse Maude prior to this event and the adequacy of any changes that have been made since the event**

There was no sign of any discharge information being shared with the client, family, or GP. Reading the documentation received and the outcome for [Mr A], it is clear he did not know he had been discharged.

It seemed by the push of a button a client could be discharged, without any discussion with any other clinical person. I wonder was it because he had 16 different nurses' visits in that period, that not one of those nurses could be responsible to query why [Mr A] was no longer part of their client task list. If he had had a "case manager" or one nurse responsible for him and his diabetes control, [Mr A] would not have fallen through the hole created by that one human electronic error.

Nurse Maude have admitted the process of discharge was human error and have quickly provided a new policy to remedy this. The policy provides a clear indication of the reason for the discharge. Communication of the decision and rationale to discharge, and follow-up requirements include the client and/or family and the GP. The new discharge policy ensures this situation cannot occur again.

Regular audit of the discharge policy against all further discharges will also provide further back-up that the failed discharge of [Mr A] will not occur again.'

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The following further advice was received from RN Cornor:

'11/07/2023

Thank you for your email dated 26/03/2023 and further documents provided by [Nurse Maude] and [the care home company].

Nurse Maude:

1. Identified the documentation that provides full evidence of the care for [Mr A] was not included or presented in the best format in the original documentation I received. Further documentation reveals —

   - The Care Pathway provided a care plan. This information was not available in the original documentation. Latest documentation reflects the care was relevant for the service and did indicate [Mr A's] needs.
   - The "visit template" sits under the Care Pathway and provides task/care interventions provided by an appropriately trained enrolled nurse or non-regulated staff who require a competency to change his catheter.
   - An audit by external auditors, … measured against Home and Community Support Services Standards reflects Nurse Maude does meet the needs of the service and is compliant with health records standards and service delivery requirements.

This further documentation, reference to electronic client records and recent audit states "the service plans are presented in a clear and easy to read format" provides evidence of effective record keeping and further information to determine [Mr A] was holistic.

2. Catheter management is identified as being appropriate for the service through the latest documentation received —

   - Staff who are trained in catheter management are identified and allocated to those patients.
   - The statement received from [a caregiver] identifies her role in [Mr A's] catheter management and as a caregiver for Nurse Maude.

This clarifies and provides evidence that catheter management guidelines were adequate and appropriate for [Mr A].

Documentation from Clinical Nurse Specialist [at Nurse Maude] provides clear evidence of the changes that have been implemented following this review. This includes the discharge process, updating and providing communication on documentation requirements of Registered Nurses and caregivers.

Continuous quality improvement also reflects improved communication with General Practices to ensure all health care providers are supporting their clients through shared information. Nurse Maude should be commended on these changes.

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[Care home company]:

1. After reading the further documentation provided by [the care home company], the response to [Mr A's] emergency bell activation appears to meet accepted practice. It is what follows that remains unknown.
   - [The care home company's] policy following activation of a call bell for clients living in an independent facility has been followed.
   - If a member of the public activates a 111 call an ambulance is dispatched. If that person activates a medical alarm, they are phoned and if there is no response an ambulance is dispatched. This does not realistically differ from [Mr A's] case where he was assessed by a "senior" health caregiver within 10 minutes. This caregiver was competent in medication and insulin competencies.
   - Unfortunately, the three-hour timeframe from caregiver, to Registered Nurse (RN) attendance and ambulance arrival cannot be explained. Although treatment was provided by the caregiver following initial assessment, there is no documentation to support the RN's process.
2. Again, there is no documentation, but a reliance on memory, re the confirmation by the RN of [Mr A's] family being notified.

I understand it is difficult for those staff involved to remember events of three years ago and the number of clients they will be caring for in this period will be vast. This only emphasises the fact, that everything done or managed by clinical staff must be documented at the time in the progress notes of that client.

Barb Cornor
Registered Nurse, Master Nursing
051169'

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