A Rest Home

A Rest Home Company

General Practitioner, Dr D

Principal Nurse, Ms E

Dietitian, Ms F

A Report by the

Health and Disability Commissioner

(Case 04HDC18516)

Parties involved

Mr A	Consumer (deceased)
Mr B	Complainant/Consumer's son
Ms C	Consumer's daughter
A Rest Home	Provider/Rest Home and Hospital
Dr D	Provider/General Practitioner
Ms E	Provider/Principal Nurse
Ms F	Provider/Dietitian
Ms G	Hospital Clinical Co-ordinator
Dr H	Consultant Physician
Ms I	Weekend Supervisor and Quality and Education Co-ordinator
Ms J	Contract Manager, a District Health Board
Ms K	Social Worker, a District Health Board
Ms L	Contract Manager, a District Health Board
Ms M	Rest Home Manager
Ms N	Registered Nurse

Complaint

On 12 November 2004, the Commissioner received a complaint from Mr B about the care provided to his father, Mr A. The following issues were identified for investigation:

Dr D
The adequacy and appropriateness of care provided by Dr D to Mr A from December 2003 to October 2004, including the management of Mr A's weight loss.

A Rest Home and Hospital
The adequacy and appropriateness of care provided to Mr A by staff of a rest home and hospital from December 2003 to October 2004, including:

- *the management of Mr A's nutrition*
- *the management of Mr A's weight loss*
- *the management of Mr A's fluid intake*
- *the management of Mr A's urinary catheter*
- *the adequacy of the level of Mr A's supervision.*

- *The adequacy of the communication between rest home staff and Mr A's son, Mr B.*

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Principal Nurse Ms E

- *The adequacy and appropriateness of care provided to Mr A by Principal Nurse Ms E from December 2003 to October 2004, including:*
  - *the management of Mr A's nutrition*
  - *the management of Mr A's weight loss*
  - *the management of Mr A's fluid intake*
  - *the management of Mr A's urinary catheter*
  - *the adequacy of the level of Mr A's supervision.*

- *The adequacy of the communication between Principal Nurse Ms E and Mr A's son, Mr B.*

An investigation was commenced on 21 January 2005.

Ms F

On 23 February 2005, the Commissioner extended the investigation to include dietitian Ms F and the following issue:

- *The adequacy and appropriateness of care provided to Mr A by Ms F, dietitian, from December 2003 to October 2004.*

Information reviewed

Information from:

- Mr B
- Ms C
- Dr D
- Ms E
- Ms G
- Ms F
- Dr H, Consultant physician
- The Coroner
- Ms J, Contract manager, a DHB
- Ms K, Social worker, a DHB
- Ms L, Contract manager, a DHB
- A Rest Home Company (owners of the rest home and hospital)
- A DHB
- New Zealand Police

Independent expert advice was obtained from Dr Tessa Turnbull, general practitioner, Ms Jan Featherston, nursing and rest home advisor, and Mrs Janelle Wallace, dietitian.

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Information gathered during investigation

Overview

Mr A, 77 years of age, was admitted to a rest home and hospital (the rest home) on 16 December 2003, requiring a significant level of nursing care as he had previously suffered a stroke. Although Mr A was mobile with an electric wheelchair, he had a permanent urinary catheter, required full assistance with his hygiene care, and suffered from some dementia and depression.

During his residency at the rest home, Mr A suffered from recurrent urinary tract infections and abdominal pain, which on two occasions required admission to a public hospital. On the first occasion, mild pancreatitis was diagnosed; on the second, the cause of the abdominal pain was not confirmed. The abdominal pain was not fully investigated, as it was decided at a family meeting with Mr A's GP, Dr D, that it would not be in Mr A's best interests to put him through the discomfort of invasive investigations.

Dr D requested that Mr A be referred to a dietitian on 22 September 2004; his weight had fallen from 59.1kg on admission in December 2003, to 43.7kg in September 2004.

On 31 October 2004, Mr A left the rest home in his electric wheelchair unescorted. While attempting to negotiate a road curb outside the rest home grounds, Mr A fell from his wheelchair. An ambulance was called and Mr A was admitted to a public hospital.

Following Mr A's admission to hospital, a complaint was made to the District Health Board (DHB) by a social worker concerned about Mr A's condition. The social worker's main concern was Mr A's general malnourished condition.

Mr A died a short time later in hospital. The autopsy report described bronchopneumonia as the cause of death, and inanition[1] as a secondary cause.

Background

The Rest Home and Hospital

The rest home provides 47 hospital level and 100 rest home level beds, and is owned by the rest home company. The rest home company is certified to provide healthcare services at the rest home. References to the rest home in this opinion include the rest home company. The Compliance Manager for the rest home company responded to questions asked of the rest home based on information provided by Ms M.

[1] Inanition: A condition of exhaustion caused by lack of nutrients in the blood, arising through malnutrition or intestinal disease.

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Roles and responsibilities
Ms M was the manager of the rest home. On behalf of the rest home company, the operations manager stated that as manager Ms M had an obligation to ensure that quality care was provided and there was effective communication amongst the health-care team and families. In Ms M's absence, Ms E, the Principal Nurse, assumed the role of manager. As Principal Nurse, Ms E was required to "accept responsibility for the quality of nursing care provided by self and team". She also stated in response to notification of the complaint on 21 January 2005 that she was responsible for the "oversight of clinical care provision". In her absence, a registered nurse assumed the role of Principal Nurse. Ms E worked under the direction of Ms M.

The Principal Nurse's job description includes the following key clinical task:

> "To assist with ensuring the maintenance of safe, efficient and therapeutically effective Nursing and Care-giving Practices."

Ms E submitted that her responsibility for maintaining the safety of residents was confined to the provision of physical resources. She stated that her involvement in clinical care was limited to instances where she was called upon for expert clinical care or assistance.

The key indicators in her job description relating to clinical issues were:

"• Ensures that each new patient is assessed on admission and at regular intervals as appropriate. …

- Ensures that each patient has a Lifestyle/Care Plan based on a comprehensive, documented assessment.
- Ensures Lifestyle/Care Plans are implemented and evaluations recorded frequently. …
- Assists in the co-ordination of treatment, health promotion and health intervention activities for each patient. …
- Ensures security of patients, staff and facility is safeguarded. …
- Accepts responsibility for the quality of nursing care provided by self and team. …
- To maintain effective communication networks at all levels."

Hospital Clinical Co-ordinator (and registered nurse) Ms G was responsible for oversight of clinical care on a day-to-day basis in the hospital area of the rest home. Her hours of work were Monday to Friday, 6.45am to 3.15pm. She was appointed on 17 February 2004. In the absence of Ms G, the hospital-based registered nurses assumed responsibility for oversight and provision of clinical care. Ms G commenced work in March 2004, and was on leave from the rest home for two months in the period covered by this report, returning in September 2004.

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Ms I was the Weekend Supervisor and Quality and Education Co-ordinator, reporting to Ms E and Ms M.

The rest home stated:

> "The Registered Nurses continually assess, review and evaluate care and liaise with allied health care professionals as part of the health care team. … It is the responsibility of all Registered Nurses on duty to make relevant decisions relating to residents' care as determined by that resident's needs at that time."

This report relies on a number of sources for the information obtained from the rest home. A record of Mr A's care was documented in the following rest home documents:

- Progress notes*:* completed on each shift by the caregiver or registered nurse responsible for the patient. They describe the events of that shift.
- Weight book*:* records the weight of all patients/residents at the rest home. This record is subsequently transferred to the individual patient's weight chart.
- Doctor's book: used by nursing staff to pass information on to visiting doctors, usually Dr D on her regular rounds.
- Communication book: used by nursing staff to pass on information to each other.
- Medical notes: the general practitioner's record of the assessment of each patient, kept at the rest home. Also used by on-call medical staff to record their assessment out of hours.
- Duty summary: completed at the end of each shift to communicate significant clinical information, such as a patient receiving antibiotics or requiring specific treatment.
- Diary: additional method by which nurses at the rest home communicate relevant information with each other.
- Physiotherapy communication book.

Chronology

December 2003 to October 2004 – The rest home
On 16 December 2003, Mr A was transferred from a residential care facility to the rest home to be closer to his family. Mr A's daughter, Ms C, was a regular visitor to her father, and Mr A's son, Mr B, held an enduring power of attorney for their father. Mr B stated that he and his sister had been managing their father's affairs for some years by the time he was admitted to the rest home. However, there had been no formal assessment that Mr A was incompetent to manage his affairs.

Mr A was accepted as a subsidised resident at the rest home. Included in his fee were treatment programmes prescribed by his general practitioner, such as physiotherapy, respiratory therapy, occupational therapy, speech therapy, dietetics, and podiatry.

Mr A's admission assessment was performed on 16 December 2003. Although Mr A required significant assistance with his hygiene needs, and was mobile only in his electric

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wheelchair, he was assessed as being able to feed himself and was on a normal diet, although any meat had to be cut up. The care plan stated that he was to have at least 1500ml of fluids in a day. In the section of the plan relating to controlling pain, "No Pain" was recorded, with the stated plan that "Pain will be controlled over next 6 months". Analgesia was described as being required occasionally.

Two days after Mr A's admission to the rest home, Dr D performed Mr A's medical admission assessment. She identified the following: incontinence (managed by a supra-pubic catheter); pain (non-specified type); an increased risk of a urinary tract infection (UTI); and mobile using an electric wheelchair.

On 20 December, Mr A developed a raised temperature and abdominal pain. A urine sample tested at the rest home indicated that he probably had a UTI, and a sample was sent for off-site laboratory testing. Mr A was encouraged to drink fluids, although the progress notes describe him as rather reluctant to drink. Two days later the urine sample was reported as a heavy growth of bacteria, and antibiotics were prescribed by Dr D.

A "Resident Lifestyle Plan" was completed for Mr A on 7 January 2004. The objective relating to "Eating/Drinking" stated, "Weight will be maintained over next 6 months." He weighed 59.1kg on admission. The plan indicated that Mr A was on a normal diet, used a lipped plate, and needed his meat cut up.

On 28 January, Mr A developed severe abdominal pain, and had a raised temperature. He was given analgesia and fluids were encouraged. Registered Nurse (RN) Ms N contacted Dr D, who recommenced antibiotics. Dr D reviewed Mr A in person on the following day and referred him for an abdominal ultrasound scan.

Mr A complained of further abdominal pain on 3 February. A registered nurse recorded that Mr A's supra-pubic catheter site was reddened, and a discharge was noted. On 6 February the catheter was recorded as "oozing pus", and Ms N gave analgesia for abdominal pain with "eventual relief". On the following day, Mr A had further abdominal pain and a raised temperature, and the urine test showed signs of a UTI. Dr D prescribed codeine phosphate for the pain.

On 10 February (as a result of Dr D's referral on 29 January), Mr A had an abdominal ultrasound as an outpatient at a public hospital.

Two days later, Mr A had further abdominal pain that was unrelieved by the analgesia prescribed (Acupan). Dr D was contacted, and Mr A was given morphine sulphate, which relieved the pain. Dr D also reviewed the ultrasound report, stating that there was "nil obvious" from the report. A fluid balance chart was commenced after Ms N noted that only a small amount of very concentrated urine was draining from Mr A's catheter;[2] Ms N also commenced a pain assessment chart, which was maintained until 19 February.

[2] The fluid chart was maintained until 18 February. See Appendix 1 for the record of Mr A's fluid intake as recorded on the fluid balance charts.

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On 21 February, because of severe abdominal pain (unrelieved by analgesia), a raised temperature and vomiting, Dr D admitted Mr A to the surgical team at the public hospital. Mild pancreatitis was diagnosed, and Mr A was treated conservatively and discharged back to the rest home on 25 February. A fluid chart was started following Mr A's return from the public hospital, and maintained until 16 March.

Dr D reviewed Mr A the following day, and decided that if he had further abdominal pain of a severity that required morphine to settle, he should be transferred again to the public hospital.

Mr A was not weighed in February. The rest home stated:

> "[Mr A] was unwell and experiencing severe abdominal pain at intermittent intervals during February 2004. It is speculated that [Mr A] may not have been weighed due to his absence from [the rest home — 21 to 25 February] or presenting clinical state."

Mr A had further severe abdominal pain on 4 March, which was unrelieved by the analgesia prescribed by Dr D, and there was "purulent oozing" from the supra-pubic catheter site. Mr A was transferred to the public hospital at Dr D's request, with a suspected recurrence of pancreatitis.

Mr A was assessed and commenced on antibiotics for a urinary tract infection. He was discharged back to the rest home the following day. The discharge letter written to Dr D by a medical registrar, stated:

> "This 77 year old man with severe cerebrovascular disease and mild dementia and who is in a hospital level of care rest home was admitted to hospital for abdominal pain and a raised amylase. The diagnosis was probably some mild pancreatitis. It was noted that he had a very mild suprapubic catheter site infection. He was seen by the surgeons and refused admission by them because he would be for conservative treatment only. He was admitted overnight under the General Medical team and observed. In the morning after discussion with [Mr A's] daughter and amongst the team it was decided that this man should be sent home without further investigation. …
>
> It would be our feeling that in future if he does get abdominal pain … then the most appropriate way to treat this would be conservatively. This would mean some [subcutaneous] fluids if he requires them and liberal doses of analgesia to keep him comfortable."

Ms N recorded in the progress notes:

> "Son states that the hospital felt that [Mr A] was in possible toxic shock from UTI rather than severe pancreatic pain (as amylase levels not high) and hospital feels that he should be treated with regular analgesia to prevent pain reaching acute stage."

Mr A had further abdominal pain on 6 March, and it was noted that the supra-pubic catheter site was leaking, and no urine was draining into the catheter bag. Following

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adjustment of the position of the catheter, "large clots [and] purulent matter" drained from the catheter, and the nurse recorded that Mr A was to be encouraged to drink more.

On 7 March, a can of Ensure (a nutritional supplement drink) was recorded in the progress notes as having been given "to supplement [Mr A's] diet".

As a result of Mr A's most recent admission to hospital, Dr D met with Mr A's son and daughter-in-law on 11 March, and a management plan was agreed to avoid further admissions and to provide comfort care. Dr D made a record of the meeting in the medical notes, and advised:

> "I met with [Mr A's son Mr B] … to hear his concerns about medical intervention and its impact on his father's quality of life. The notes of the meeting record his concern that the last hospital admission was 'very stressful' and that they were keen to avoid further admission. [Mr B] held his father's power of attorney and with him we formulated a management plan to avoid further admissions and aim for comfort cares … This plan was discussed with [Mr A] who confirmed that he didn't want any more painful procedures."

Mr B stated:

> "As a result of the meeting it was agreed that if Dad had subsequent bouts of pancreatitis he would be managed at [the rest home] under the care of the GP."

In response to the provisional opinion, Ms E stated that at this meeting Mr A's family rejected the use of subcutaneous fluids, as they wanted only comfort cares to be given. Mr B's recollection of the meeting was that only in the event of an acute and life-threatening event would the family want only comfort cares. He stated:

> "There was never any suggestion that [subcutaneous] fluids would not be used in the context of my father not drinking, or not being able to drink … because of his chronic illnesses."

Dr D reviewed Mr A on 18 March, ordering that fluids be encouraged as Mr A had some haematuria (blood in the urine) following recent "local trauma" to the catheter.

Ms N performed a "multidisciplinary assessment" on 20 March. The changes to the care plan that she made were to encourage fluids, to "flush catheter when necessary", and to use a pain management plan. Weight loss or nutrition were not recorded. Ms N stated that Mr A "goes for walks outside in his motorised wheelchair".

Dr D recorded a three-monthly review of Mr A on 25 March, using a standardised form. Dr D noted that there were no changes in Mr A's daily activities. The section for Mr A's

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weight was left blank. Dr D said that she was shown Mr A's March weight from the weight book during the assessment[3]

Mr A required analgesia for abdominal pain on 25, 27, 28 and 29 March. On the latter date, Mr A also vomited, and Dr D was contacted. She decided, in light of the plan decided with Mr A and his family, not to admit him to hospital, and morphine was given with good effect.

The rest home stated that Mr A was not weighed in March:

> "It is speculated that due to [Mr A's] presenting clinical state that the decision may have been made not to weigh [Mr A]."

During a routine assessment on 1 April, Dr D diagnosed Mr A as having peripheral vascular disease, noting poor circulation in his feet. Mr A had further abdominal pain on 1 April and the subsequent two days, and required morphine on one occasion to settle the pain.

On 7 April, Mr A attended the outpatients department at the public hospital on account of his recurrent abdominal pain. He was seen by a consultant gastroenterologist. On 14 April, the consultant gastroenterologist wrote to Dr D, stating his opinion that the pain was due to either constipation, the supra-pubic catheter, Mr A's sitting position in the wheelchair, or possibly diverticulitis, polyps or a mass. The consultant gastroenterologist had taken bloods, and recommended that Mr A have regular laxatives and catheter care. A barium enema was to be organised, but this was subsequently cancelled by Dr D following discussion with Mr A's son. Dr D stated:

> "I was concerned that this investigation although helpful diagnostically is an invasive procedure and sometimes painful. I therefore felt that it might not be a procedure that [Mr A's] family and [Mr A] wanted him to undergo. I asked the nursing staff at [the rest home] to ask [Mr B] if they wanted this test to go ahead — the message I received was that it was to be cancelled."

On 18 May, Ms G noted in the progress notes that Mr A's weight had fallen (from 52.6kg in April to 46.65kg). She recorded in the progress notes that Mr A was to have a can of Ensure daily and extra desserts. Mr A's care plan was not amended.

A week later, Mr A was seen by the on-call doctor because of abdominal pain. The on-call doctor changed Mr A's catheter as it had become blocked, and queried whether Mr A had bowel cancer, describing him as "cachectic"[4] in his clinical record of the visit. Two days

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[3] The weight book indicates a weight for March, but it was a weight recorded at the end of April, and erroneously placed in the March column of the book.

[4] Abnormally low weight, weakness and general decline, commonly associated with malignant disease.

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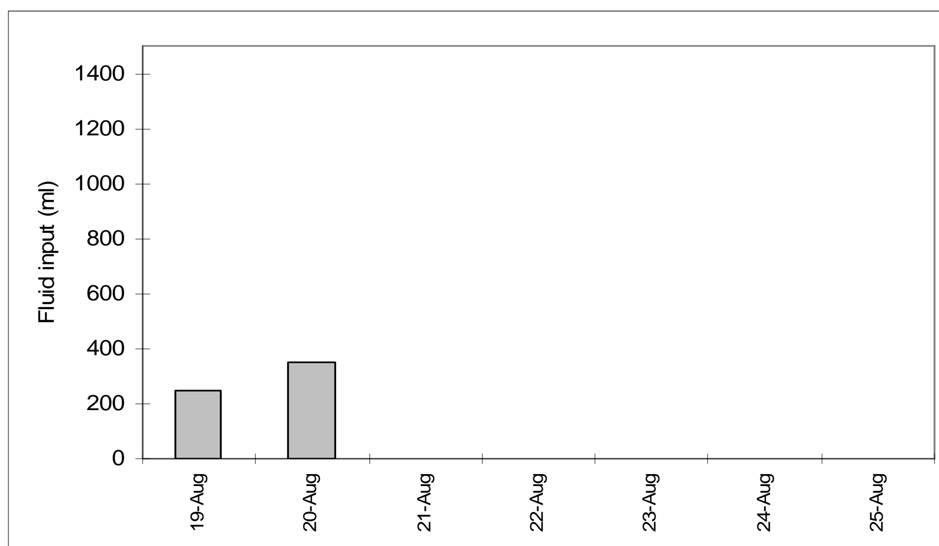
later, on 27 May, Dr D performed a regular review of Mr A. Dr D's order for Mr A's care remained unchanged.

A six-monthly evaluation was performed on 5 June. In the section "Eating/Drinking" was recorded "Weight [down] Needs encouragement". The "pain" section recorded "controlled with analgesia".

Dr D performed a further routine three-monthly check of Mr A on 12 August. The sections of the standardised form relating to Mr A's blood pressure, pulse and weight were not completed. Dr D said that she was shown the weight book on this visit; Mr A's weight recorded in the weight book for August was 45.8kg, having been 49.5kg in July. Dr D noted that there had been no changes in Mr A's treatment plan, and made no reference to any nutritional difficulties or weight loss.

Mr A was moved on 13 August to a room closer to the nurses' station, as his condition appeared to worsen — the progress notes stated: "[Mr A] does not look well at all."

On her next regular visit on 19 August, Dr D noted that Mr A had a "poor fluid intake" and ordered that fluids be encouraged, and that Mr A was to have a fluid balance chart to record his intake and output. The chart below shows Mr A's recorded fluid intake from 19 to 25 August, as noted on the fluid balance charts. The rest home provided a copy of the guide given to patients with indwelling urinary catheters. It refers to the need to drink 2-3 pints (1000-1400ml) of fluid a day.



A week later, on 26 August, Dr D recorded "managing better with fluids — continue encouragement", and the progress notes record that Dr D requested a fluid balance chart be commenced. The chart below shows Mr A's recorded fluid intake from 26 August to 2 September, as noted on the fluid balance charts.

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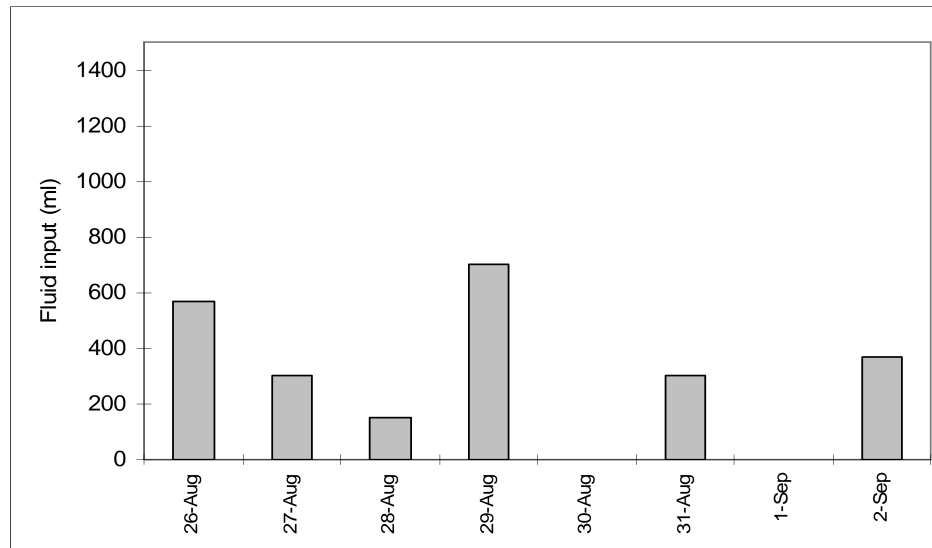

No fluid balance charts were used to monitor Mr A's fluid intake after 2 September. The rest home stated:

> "It is speculated that the records were discontinued in response to an improvement in [Mr A's] personal health … [Mr A's] fluid intake was monitored via Fluid Balance Chart during periods of increased medical frailty."

Mr A's care plan was re-evaluated on 8 September, with no changes made. Ms E stated in response to the provisional opinion that Mr A's failure to achieve his weight goals should have been noted, but was not.

Dietitian

At a routine review on 22 September, Dr D noted that Mr A required encouragement with eating, and requested that a dietitian review him. The request for a dietitian referral was recorded in the progress notes on 23 September.

On 26 September, a registered nurse recorded in the progress notes that Mr A had suffered diarrhoea, "so will need fluid replacement orally or sub cut". No fluid chart was commenced. The rest home stated:

> "A review of [Mr A's] progress notes for the period in question does not indicate that [Mr A's] diarrhoea continued and on this basis it is speculated that a fluid balance record was not commenced."

Ms F, the dietitian to whom residents of the rest home were referred, was informed of Dr D's request for Mr A to be seen by a dietitian on 29 September, when Ms G requested that she review Mr A. Ms G advised Ms F that Mr A was having two cans of Ensure each day.

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Ms F stated:

> "On 29 September 2004, I had only allowed 1 hour for the above visit to see two other patients as requested, and had another appointment to attend after [my visit to the rest home]. … I did briefly read his notes, and discussed the case with [Ms G]. I instructed her to continue with the Ensure Plus supplements which they had already initiated, at a rate of 2 cans a day … This was important when his regular food intake was small."

The rest home stated that no changes were made to Mr A's plan of care following Ms F's visit, and that staff were advised to "continue with what they were doing".

On 30 September, Dr D noted in the medical notes that Mr A had been seen by the dietitian, was to have Ensure, and that food and drinks were to be encouraged.

Ms G reviewed Mr A's "Resident Lifestyle Plan" on 1 October. She instructed on the care plan that Mr A was to have one to two cans of Ensure daily, extra sandwiches and desserts, and that Ms F had advised that he was to have "2Cal Ensure". Ms G recorded that "[Mr A] is able to mobilise himself downstairs to have a cigarette."

On the night of 4 October, Mr A was recorded as having vomited, requiring Stemetil 12.5mg to treat his nausea. He was described by the registered nurse in the progress notes as looking "extremely frail". On 5 October, the progress notes recorded that he had further diarrhoea.

On 5 October, Ms F returned to review Mr A. She stated:

> "I discussed my care plan with nursing staff and advised that I was going to apply to Pharmac for a more concentrated nutritional (2CalHN), and that I would forward copies of my correspondence when I had completed this. However, I left some samples of 2CalHN for the staff to give [Mr A], and, as always, suggested that if they were worried, they should contact me."

Ms F required a consultant physician to complete the application to Pharmac, and wrote to Dr H, a physician at a second public hospital, who approved the application.

Ms F stated that she was informed by Dr H's office that the application had been turned down by Pharmac. She further stated:

> "I did not contact [the rest home] about [Mr A] over the ensuing three weeks, until I heard that the application had been declined. I then contacted the Health Benefits Centre by telephone to inquire why the application had been turned down. Experience is that it is difficult to obtain approval for this product, as it is more expensive than higher volume, lower energy ones.
>
> I discovered that it had been declined on a technicality. I had ticked the box that said 'increased nutritional requirements', but not the one that says 'patient has substantially

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> increased metabolic requirements'. … We had to make another application, through [Dr H], and this was done on November 1."

Ms F did not make a further visit to see Mr A as she felt that there was an appropriate protocol in place, and did not consider the need for a further visit. Ms F stated that the rest home staff knew that they could contact her if there were any further concerns.

It was recorded on 6 October in the Doctor's Book that Mr A was receiving Fortisip and Ensure daily.

A review of Mr A's activities of daily living was performed by a registered nurse on 7 October. The registered nurse recorded that Mr A was able to feed himself and needed a "lipped" plate. On the same day, Dr D noted that Mr A needed encouragement to eat and drink, and prescribed calcium and vitamin D supplements, as suggested by Ms F. The progress notes record that Mr A had three cans of Ensure Plus, and that his appetite was "minimal". The progress notes also record that Ensure Plus was given on 10 and 14 October (three cans on the latter date).

Mr A was weighed by Ms G on Sunday, 17 October, in preparation for Dr D's round on 21 October. His weight (41.25kg) was recorded in the Doctor's Book by Ms G, but not on the weight chart or in the weight book. Since being weighed in September, Mr A had lost a further 2.45kg, a fall of 5.6% in one month.

On 18 October, the progress notes recorded that Mr A was not feeding himself, and on the following day Ms G decided that Mr A would be fed by the rest home staff for a trial period of a week, recording her decision in the progress notes. There was no change to the care planning documents. The diary on 20 October recorded that Mr A was to be fed in the lounge. The rest home stated:

> "A one week trial of [the rest home staff] feeding [Mr A] commenced 19th October 2004 … due to [Mr A's] level of opposition to being fed an early review was completed and the intervention discontinued."

There was no reference in Mr A's clinical record that the plan to feed him was to be discontinued. It is not clear if Dr D or Ms F were made aware of Mr A's refusal to eat, the plan to feed him, or the failure of the plan.

Mr A was weighed on 20 October. The weight was recorded in the weight book and on the weight chart as 41.55kg.

On 21 October, the last time she reviewed Mr A, Dr D noted that his weight continued to fall.

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The progress notes (in full) on 28 October state:

> "[am] Showered, all care given. No concerns.
>
> pm usual cares given."

The progress notes (in full) on 31 October state:

> "am All cares given — no concerns.
>
> Up and dressed — urine very gunky — cloudy."

No entries were made in Mr A's progress notes on 21, 26, 27, 29 and 30 October.

Admission to the public hospital — 31 October 2004
On 31 October 2004, Mr A left the rest home in his electric wheelchair unescorted. Staff had observed Mr A heading for the lift and had told him not to go too far as dinner was nearly ready. While attempting to negotiate a road curb outside the rest home grounds, Mr A fell from his wheelchair. An ambulance was called and Mr A was admitted to the public hospital.

A registered nurse recorded in the progress notes that at 5.25pm a neighbour had called reporting that Mr A had fallen from his wheelchair. The neighbour subsequently called an ambulance, and Mr A was taken to hospital, where he was admitted.

Mr A's son, Mr B, stated:

> "The nurse [at the rest home] stated that Dad had gone out of the grounds down [the first street], into [the second street], and on the corner of [the second and third streets] he lost control of his wheelchair, resulting in him being tipped out and his wheelchair falling on him."

At a subsequent meeting held with the management of the rest home on 4 November, Mr B was told that his father did not go out onto [the first street], but went out via the back entrance into [the third street]. Mr B stated:

> "This information was far more damning in that the main dining room overlooks the rear entrance. If this is the case why did no staff notice Dad leaving the grounds at that time? Dinner was being served and staff were present. Likewise it is beyond comprehension that when Dad did not go to dinner no one checked on his whereabouts! Indeed they noticed he was not at the table but elected to feed the residents, clean up after the meal and then they would go looking for him.
>
> When I queried the apparent lack of supervision whereby a frail hospital resident can wander off unsupervised, we were told 'We do not want to restrict the freedom of our residents'. This attitude shocked the family as we viewed this as an appalling dereliction of professional standards of care. We believe it is appropriate for rest home level care residents to enjoy as much independence as possible. However, when

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> someone in Dad's frail state, who has been moved closer for increased supervision, is allowed to go unsupervised out into the neighbourhood, this suggests the rest home have demonstrated inadequate appreciation of risk assessment and professional supervision. …
>
> The Nurse Manager claimed to have seen Dad in the neighbourhood (in his wheelchair unsupervised) on regular occasions. When pressed she modified her claim to some weeks ago, then months. It appeared that they were attempting to suggest that it was normal for Dad to be out in these circumstances."

In response to the provisional opinion, the rest home company stated that "[Mr A] would have had to have used the front door at [the rest home] as it is an automatic door opening allowing wheelchair access/egress".

Ms E stated that "[Mr A] would regularly leave the building to smoke and to take a short ride in his wheelchair around the block".

In his original letter of complaint, Mr B stated:

> "To our knowledge (based on my sister's daily visits) Dad NEVER left the grounds without my sister in attendance."

The rest home stated:

> "Restricting [Mr A's] access to and use of his motorised wheelchair would have severely hampered [his] level of mobility and impacted negatively upon his psycho-social wellbeing. … No incidents indicating [Mr A] was unable/unsafe to utilise his … wheelchair are present."

There is no record of Mr A's use of his wheelchair being assessed.

Following assessment in the Emergency Department, Mr A was admitted to the public hospital. A medical registrar assessed Mr A. She stated in the clinical record:

> "Apparently tried to 'escape' rest home and took off on mobility scooter. Fell out of it and has grazes and bruises. Son no longer present but reportedly unhappy about current social situation."

Having discussed Mr A's condition with his son, the medical registrar completed the form to state that Mr A was not for resuscitation, referred to as "comfort care only" in the clinical record.

A specimen of urine was sent for culture as it was described as "odour offensive". This was reported on 1 November as having a "large number" of bacteria, including "mixed Coliform bacillus, non-haemolytic streptococcus and alpha-haemolytic streptococcus". On the same day, the clinical notes record that Mr A was drinking well with encouragement, and managed a "good amount" of food when fed by the ward staff.

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Mr A was referred for speech and language therapy to assess his swallowing difficulties. The plan recorded was:

> "Dysphagia — prolonged oral stage and disco-ordination of swallow [secondary to] dementia and fatigue.
> [Recommend]:
> Puree diet – small amounts …
> Grade 1 thickened fluids — sips
> Full supervision with all oral intake and assistance as necessary
> Discontinue oral intake if [patient] coughs after oral intake
> Ensure [patient] is alert and seated upright for oral intake
> Ensure [patient] remains upright for 20–30 minutes after oral intake
> Provide optimal oral care."

On 1 November, Mr A's recorded weight was 30kg.

Ms K, social worker, contacted the rest home on 1 November 2004 to discuss Mr A. She spoke to Ms G, who informed her that Mr A had had "significant weight loss over the last 12 months". Ms K also recorded that Ms G stated that she would like to stop Mr A from using his electric wheelchair.

Ms G denied this:

> "I have no recollection of a conversation with a Social Worker on 1 November 2004 or making the statement that has been quoted [as saying that I would like to stop Mr A using his electric wheelchair]."

There is a record in the rest home clinical record, written by Ms G on 1 November, the same day that Ms K called the rest home:

> "Spoke to [the public hospital]."

Ms K spoke with Mr B on 1 November and recorded:

> "Son — reports huge concerns about quality of care and supervision — have encouraged him to investigate other … homes and document concerns formally.
>
> Phone call to Planning and Funding."

Ms K then contacted Ms J, contract manager for the DHB, and informed her of concerns about the care provided to Mr A by the rest home.

On 2 November, Mr A was given some Ensure through a straw; the hospital record states that he enjoyed it. Mr A was also assessed by a dietitian, with the reason for referral being "underweight and malnourished". The dietitian recommended extra Complan to replace the Ensure. Later on the same day, the nursing record notes that Mr A managed to eat his meal

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well when fed, and on the following day the nursing record stated that Mr A was eating "good amounts of pureed diet".

On 4 November, the nursing record states that Mr A was "eating well with full assistance", and his weight was recorded as 33kg. The speech and language therapist reviewed Mr A on the same day, and stated that he had "managed [a] bowl of fruit and Complan and Grade I fluids very well". Mr A was referred to a geriatrician, for further care. However, the next day Mr A's condition rapidly deteriorated and his regular medications were discontinued. Morphine was prescribed as required.

The geriatrician assessed Mr A on 6 November, following which he met with Mr A's son and daughter. The geriatrician recorded in the clinical notes:

> "Seen with family. … [Mr A] unable to actively participate in conversation due to severe illness, morphine infusion and dying.
>
> Issues for family — general lack of care at [the rest home], lack of communication to family of changes in [Mr A's] health (despite requests to do so), inadequate care with progressive weight loss, dysphagia (and concern over how this was managed), urinary catheter management, development of pressure areas.
>
> The final straw for family was [Mr A's] accident, resulting in his admission to hospital. …
>
> I note [house officer] note on admission that [Mr A] did not wish to return to [the rest home] … where he has resided for last year. [Mr A] unable to offer an opinion on this today.
>
> Exam (seen 7 days after admission and now clearly dying.)
>
> Very cachexic, dehydrated … marked muscle wasting.
>
> Family raise some worrying concerns and I have encouraged them to formally contact [Ms J] in MOH. I agree that when he dies, coroner should be contacted. Moving him to another hospital is not appropriate at this stage as he is dying. Family are appreciative of the care and attention given here at [the public hospital].
>
> With involvement of [Ms J], and coronial involvement, the care issues at [the rest home] should be adequately followed up. I will discuss further with colleagues re any further action required."

On 6 November, a morphine pump was commenced. Mr A's condition gradually deteriorated until he died a short time later.

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The medical registrar completing the Record of Death, stated:

> "Admitted after leaving rest home on motorised scooter and falling near arterial road. Sustained minor grazes to scalp and lower limbs. Admitted with gross malnutrition and aspiration pneumonitis [secondary to] dysphagia. Has background [history] of [stroke] affecting [right] upper limb and swallow. Appetite was not decreased and did not wish to return to rest home."

On 12 November, the regional forensic pathologist, stated in his provisional autopsy report:

> "My provisional finding is that death was due to:
>
> bronchopneumonia complicating cachexia and inanition. Weight loss has occurred in the context of previous stroke with difficulty swallowing and advanced chronic obstructive airways disease."

Other relevant issues

The District Health Board review
As noted above, Ms J, contract manager for the DHB, was contacted by Ms K, social worker, as she was concerned about Mr A's condition. Ms J stated:

> "I was called by [Ms K] on 1st November 2004, who wanted to make a complaint regarding the condition of [Mr A] when he arrived at the Accident and Emergency Department of [the public hospital] on the evening of 31st October 2004. [Mr A] had been out in his electric wheelchair and had crashed, injuring his head. The doctor in A&E was concerned at his condition on presentation and why he was out in a wheelchair when he was so frail. …
>
> On 2nd November 2004 I called [the service manager at the second public hospital] and asked her to arrange for a clinician to visit [the rest home] and review the care [Mr A] was receiving.
>
> On 3rd November 2004, I was called by [a social worker] on [the ward] … [the social worker] advised me that the ward also wished to make a complaint about the care [Mr A] had received at [the rest home] …
>
> On 6th November 2004, [the geriatrician] … saw [Mr A] at [the public hospital]. [The geriatrician] called me on 8th November and advised that he did have concerns regarding the condition of [Mr A]. He couldn't easily say whether it was 'poor health or poor care but I suspect it's both'. …
>
> On 10th November 2004, [Ms L], Contract Manager, and I visited [the rest home] to review [Mr A's] notes and tour the facility. The principal nurse, [Ms E] and registered nurse, [Ms G] were interviewed. … In summary, [Mr A] lost a lot of weight over a very short period of time. A referral to a dietitian was not formally made by [the rest home]

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> or by [Mr A's] General Practitioner. We called the dietitian, [Ms F] who advised that a referral was not made to her to see [Mr A]. [Ms F] was seeing another patient … and was asked to see [Mr A] 'while she was at [the rest home]'. [Ms F] said that it was far too late for her to be seeing [Mr A] and that he was the worst case of starvation she had seen in an aged care facility."

In response to the provisional opinion, the rest home stated that if Ms F considered that Mr A was so severely malnourished, she should have taken more action, including discussing Mr A with Dr D, providing follow-up, instructing staff to weigh Mr A more frequently, commence food and fluid charts, urgently apply for supplements, and documenting her concerns.

At the meeting between Ms G, Ms J and Ms L, a page from the progress notes was reviewed. The copy provided to my Office is dated 10 November 2004, and signed by Ms G:

> "[Mr A] was trialled for a feed — but refused to be fed — said he wants to do it himself. Can feed himself but very slowly. This was [Mr A's] wish. The staff in the dining room have also tried to assist [Mr A] with feeding, but [he] will refuse his food — if he is pushed in any way. Every effort has been made to encourage [Mr A] with food and fluids — But we cannot force people to eat."

Ms L made a record of Mr A's weight from the rest home records as follows: February (58kg), April (47kg), October (43.7kg) and November (43.7kg), and added Mr A's weight as measured on admission to [the public hospital] (30kg). Ms L recalls that these were the only weights recorded for Mr A. She stated that she asked Ms G "Is this all there is?" Ms L was certain that these were the only weights recorded, and that had there been more weights recorded, she would have written them down.

Coroner

As part of the Coroner's inquiries, a police officer took a statement from Ms G on 11 November 2004. She stated:

> "When I first arrived at [the rest home] in March [Mr A] would refuse to eat, said he wasn't hungry and had no appetite. He would get aggressive, not nasty, but agitated if we tried to encourage him to eat.
>
> After he wouldn't eat I would get him a food supplement for him because he wouldn't eat his meals … we would always try to encourage [Mr A] to finish his supplements. …
>
> [Mr A] would only get cross when we tried to feed him or assist him to eat and he would get annoyed.
>
> He was always offered the three nutritious meals a day, if he wasn't in the dining room we would always go and get him and he would happily come along. …

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> [Mr A] went to [the public hospital] because he took himself out for a cigarette in his motorised wheelchair, he must have fallen out of his wheelchair onto the road. …
>
> We are not a secure unit and [Mr A] was free to go and come as he wished. He had been out in his wheelchair since he arrived here to have a cigarette without incident. …
>
> We provided every possible form of care for [Mr A] here at [the rest home], everything was monitored for [Mr A] and we did everything we could to get sustenance into him."

Involvement of family
Mr B stated:

> "On numerous occasions over the last four months [July to October 2004] we commented to staff about Dad's weight loss and increasing frail state. The staff acknowledged our concerns by advising us that the concerns would be passed on. My sister also advised the staff on numerous occasions that he was failing to eat his meals and was reluctant to drink clear fluids. Again she was informed that her concerns would be put in the communication book to be acted on by the Nurse. Dad's reluctance to drink sufficient amounts of fluid was an ongoing concern for the family."

There are nine references to Mr A in the communications book, the first dated 6 February and the last with an unclear date; the penultimate record is dated 18 March. There is no reference in any of the nine messages to the concerns raised by family about Mr A's fluid or food intake, weight, or any difficulty with swallowing. Mr A's family was not informed about the plan to feed their father, nor about the discontinuation of the plan.

Ms C stated that she had told staff over the previous three to four months that her father had been having difficulties with choking after attempting to swallow food. The rest home stated in their response to the complaint:

> "Indications of decreased/impaired swallowing reflex were not present."

Ms E stated, in response to the provisional opinion, that she had received no communication about Mr A's family's concern about the standard of care prior to November 2004, and that "had she been informed she would have been able to ensure appropriate action was taken."

Mr B stated that because of his sister's hearing difficulties, he was to be the first point of contact, and that he told the rest home this on his father's admission. Ms E does not recall this. She confirmed that for "day-to-day care", the rest home contacted Mr A's daughter.

Ms F, dietitian
Ms F recalled:

> "Unfortunately, [Mr A's] rights to appropriate nutrition intervention occurred when there was a failure to request a dietitian review when weight loss was first noticed by

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> the family or staff. … I was not notified until the patient had lost 26% of his baseline body weight.
>
> After the doctor made the request for the dietitian review, it was one week before I was notified, and then it was a casual request while I was at [the rest home] as arranged to see two other patients. …
>
> Once a very frail elderly person reaches the state of severe malnutrition that I found in [Mr A], a positive outcome is rare. Dietary intervention to curb weight loss and effect weight gain in the frail elderly needs to be initiated as early as possible, and I have guidelines that I have published (at least twice) in my quarterly newsletter to all clients (including the rest home)."

Ms F stated that she obtained the weights in her dietitian record from Mr A's case notes. She recorded weights of 58kg in February, 52.6kg in April, and 43.7kg on 6 October. Although Ms F cannot recall which document she obtained the weights from, it had "gaps", indicating months when Mr A was not weighed.

On 15 October 2003, Ms F sent Ms M (the manager of the rest home) a menu review that she been commissioned to perform. In the review Ms F stated:

> "Fluid intake is … important, and even though it is not addressed by the menu, it is pertinent to draw attention to the need for older people to drink [1500–2000ml] per day of a variety of fluids. …
>
> Monthly or more frequent weighing is the minimum observation required … People for whom there are concerns should be monitored more frequently. Focused nutrition screening with a nutrition screening tool can assist in identifying people who need more aggressive nutrition intervention. …
>
> Individual monitoring is important to ensure these individual needs are met. Where there are concerns, you should contact your dietitian for individual assessment and appropriate intervention."

Ms F stated:

> "I have been a Consultant Dietitian to [the rest home] … on an 'as required' basis for the past four years, i.e. I respond to requests for dietetic services (both foodservice management and clinical dietetics). As my services are chargeable, I do not have free access to the facility. My time spent at the facility is totally dependent on the staff contacting me when they identify a need."

Ms F and her colleagues produce regular information pamphlets and booklets for their clients, including the rest home. The December 2001 edition of "[their newsletter]" stated:

> "Involuntary weight loss must be investigated when a resident experiences:

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- Weight loss exceeding 10% of normal body weight in 6 months
- Weight loss exceeding 7.5% of normal body weight in 3 months
- Weight loss exceeding 5% of normal body weight in 1 month
- Weight dropping to 35kg or less
- Changes or limitations to dietary intake for any reason."

The September 2002 edition repeated the above guidance, and added:

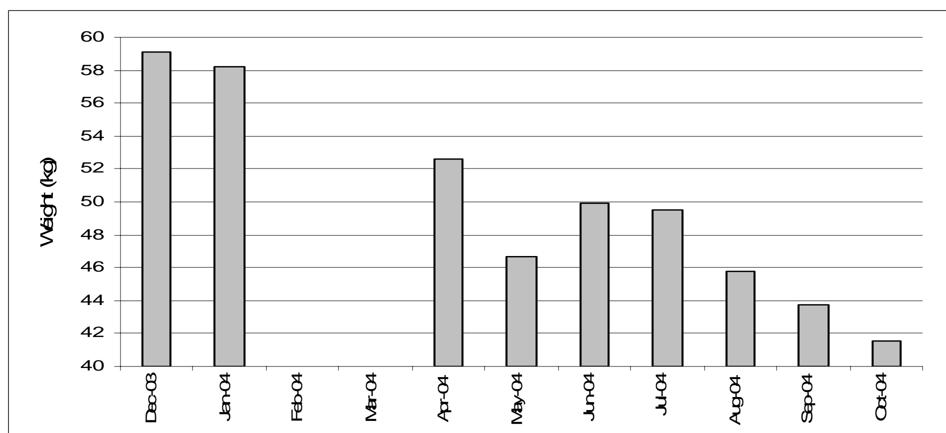
> "It is … critical to have a protocol to ensure nutrition and hydration that will achieve the best possible outcome for a person whose health is compromised."

The June 2004 edition stated:

> "Regular monitoring of weight is critical — 5 to 10% weight loss has a detrimental effect on health. The rate of weight loss is more important that actual weight, although very light and frail people have a higher risk if they are tiny to start with."

The rest home record of weight

The chart below indicates Mr A's weight recordings on the weight chart and in the weight book. The weight measured at the end of April was erroneously recorded as March, both in the weight book and on Mr A's individual weight chart.



The rest home stated that Mr A's weight was "closely monitored" and "recorded monthly".

The precise date (as opposed to month) when Mr A was weighed was recorded only on three occasions[5] — 16 December 2003 (on admission), 18 May 2004, and 20 October 2004. It is not known on what dates the weights in January, April, June, July, August and September were recorded.

---

[5] Excluding weight recorded by Ms G on 17 October 2004.

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The rest home stated that the process for the recording of weights was that the weight was initially recorded in the weight book, then transferred to the individual weight charts, usually by the night staff.

The rest home acknowledges that Mr A's weight fell during his residency, but submits that his "appetite was poor [and] as a result his food intake was variable with refusal occurring at times".

Mr B stated:

> "At the time of Dad's last admission to [the public hospital] [4 March 2004] it was noted that he had not been weighed for the previous two months. At the meeting with the GP this was noted and it was agreed that he needed to be weighed monthly.
>
> In October, my sister spoke to a bureau nurse on duty enquiring as to his current weight, as she had become seriously concerned about his frail state. The nurse reported to my sister that according to his chart the last recorded weight was in July, again he had not been weighed for two months, August and September. Dad's weight continued to fall (without us being advised of the situation) and the staff continually offered assurances that he was eating well and they were encouraging him to drink."

At the meeting held on 4 November between Mr B, Ms M and Ms G, the clinical records were provided. Mr B stated:

> "Dad's case notes were on the meeting table and it appeared that the missing monthly weights were now written up."

The rest home stated:

> "[Mr B's] claim that the weight chart and/or weight book was subsequently altered, showing [Mr A] had been weighed for all months from June to October, is strenuously and strongly denied."

The rest home further explained why a referral to a dietitian was not instigated by nursing staff prior to Dr D's referral:

> "The rest home was continuing to utilise in house strategies to maintain Mr A's weight, these strategies included:
>
> - Encouragement to eat, bearing in mind that Mr A wished to maintain his independence and maintain his autonomy around the quantities of food he consumed, what and when he ate.
> - Provision of a nutritious diet of preferred food options.
> - Provision of alternative foods including finger foods …
> - Provision of nutritional supplements (Ensure) commenced 7 March 2004, the amount provided increased to three cans a day by 7 October 2004.
> - Fortisip and Diabetic Resource were provided as alternatives to Ensure. …

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- Provision of a lip plate for main meals."

The rest home was asked why a food chart was not used to monitor Mr A's intake. The rest home stated:

> "At the time [Mr A] was a resident at [the rest home], it was [the rest home's] custom and practice to implement a food chart for patients/residents who were not eating at all or whose nutritional intake was minimal.
>
> As [Mr A] was eating and drinking implementation of this chart was not deemed necessary."

The rest home referral process

In July 2003, in relation to a previous complaint made to the Commissioner about the care of "[another resident]", the rest home stated that they would develop "a referral process for the provision of Allied Health professionals care". A referral process was not implemented until 19 months later, in February 2005. It comprised a one-page referral form and an accompanying page describing the process, as follows:

> "**Objective:** Staff will adhere to the following in order to access allied health services
>
> - The following are considered allied health services:
>   - Dietitian
>   - Physiotherapy
>   - Occupational Therapist
>   - Speech [and] Language Therapist
>   - Podiatrist
> - Referral may be made by nursing staff in conjunction with medical staff
> - Staff complete the attached form and forward to relevant agency
> - Referral form is retained in the clinical file and entry made in progress notes."

Lifestyle plan

In September 2003 the Disability Services Directorate of the Ministry of Health commissioned an audit of the rest home under section A15.3(b) of the funding agreement between the Ministry of Health and the rest home. The audit was initiated because of concerns about the care provided to "[another resident]" (see above). A quality improvement action plan was developed by the rest home in November 2003. In relation to the initial lifestyle plan for residents of the rest home, the quality improvement action plan was to update the lifestyle plan "in line with any changes in care provision", and was to be implemented immediately.

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Guidelines
The rest home provided a copy of the "Protocol for compromised nutrition and hydration" dated August 2002 that is currently in place; however, there was no protocol in use at the rest home at the time of Mr A's residency. A nutritional screening form, designed by Ms F and her colleagues in August 1999, is also now used at the rest home to assess nutritional status.

Subsequent events
The rest home advised that since November 2004 the following changes have been introduced:

- implementation of a protocol for compromised nutrition and hydration
- implementation of nutritional assessment policy
- nutritional assessment incorporated into the admission process
- nutritional reviews post admission completed using nutritional assessment form
- nutritional assessment training given to registered and enrolled nurses by Ms F (17 December 2004)
- residents now weighed by registered or enrolled nurses
- food intake chart developed and implemented
- staff caring for residents write in progress notes a "broader range of observations e.g. dietary intake, family visits"
- catheter care information made available.

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Independent advice to Commissioner

Nursing advice
The following expert nursing advice was obtained from Ms Jan Featherston, nursing and rest home advisor:

"Background

[Mr A] entered [the rest home] on the 16th December 2003. He required Hospital level care due to his medical and nursing care [needs].

His medical diagnosis is listed as:

- CVA (L) hemiplegia
- Deaf
- Supra-pubic Catheter
- Depression
- Previous cholecystectomy
- Previous op for bowel adhesions

[Mr A] required assistance with his activities of [daily] living and maintained his mobility with an electric wheelchair

Please comment generally on the nursing care provided to [Mr A] from December 2003 until the end of October 2004
Nursing care is reviewed by examining documentation. This includes the admission documents. Care plans, progress notes and supporting documentation, such as fluid balance charts, pain charts etc.

Admission documentation includes:

Resident profile
This form includes patient details, Next of Kin information, and photograph of [Mr A].
The other side of this form lists medical diagnosis, current medications, and allergies.
End of life information.
This form was not signed by the person who collected the information. The date on the form was 16 December 2003.

New admission information
[This] form lists general administration information, such as community service card information; again next of kin is listed [on] the second part of this form, [which] includes brief information of family. This form is signed and dated 15 December 2003.

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[An untitled form]
Is a form which states that it must be completed on the day of admission. It is a brief tick box which covers:

Assistance with eating
Meals
Type
Drinks
Strong Dislikes

This form was completed but there is no signature of the person who completed the form.

[The] Admission Recording checklist
Vital signs are recorded:
Blood Pressure 123/87; Pulse 61; Temperature 36.6; Respirations 19; Weight 59.10kg; Urinalysis — showed leucocytes, positive, nitrate, trace protein, mod blood.

[The] Resident admission/discharge form
This again is administrative information. It lists the community services card number.
The doctor is listed.
Medications are listed as Medico Pack — this form appears to be the form that the facility faxes to the pharmacy. This form is not signed.

[The] Activity of Daily Living form
This page covers:

1. Mobility /Safety plan
2. Hygiene
3. Nutrition
4. Topical Skin Care

This form is completed by the nursing staff either writing what is required or using a highlighter pen.

In relation to mobility — care is listed as requiring assistance [of] two for mobility, transferring, toileting, bathing. *'Immobile'* is listed under Mobility. Own wheelchair is highlighted.

Hygiene — shower chair, sponge AM and PM all days except bath days, 6-weekly haircuts, dentures upper, lower this information is highlighted. S.P.C. (supra-pubic catheter) is listed, as are small pads.

Under the heading *special needs* — Supra-pubic catheter. Catheter bag to be emptied 2–3 hourly, Catheter site cleaned daily.

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Nutrition — fluids, feeds self are highlighted and lipped plate is written.

Topical Skin Cares — pressure area daily — sacrum, hips, ankles, knees. Report any red or broken areas to the RN.

At the bottom of the page three is an entry — Please report any cloudy or offensive urine to the RN.

This form is signed by the person who completed it with the designation RN; it is dated 17 December 2003.

There is a signature under the reviewed line. This signature does not have any designation and is dated 7 October 2004.

Initial Nursing Assessment
The next 6 pages are the Initial Nursing Assessment

This form is a more thorough assessment. It is dated 16 December 2003.

The first page is about Past Life — Tell us about yourself. This includes [Mr A's] family personal history and his occupation.

The second page lists Interests and Hobbies, Religious Denomination, Cultural Needs, Nutrition — this is completed by including information that [a] small meal is preferred, [and] would appreciate meat being cut up.

The third page includes Hygiene, Oral Hygiene, Skin Care/Nail Care, Hair Care, and Dressing.

The fourth page includes Bowel and Bladder Needs, Mobility, Ability to Transfer.

The fifth page includes Bed Routine, Eye-sight, Hearing and Senses, Communication and Speech.

The sixth page includes Breathing, Orientation and Mental State, Anything else relevant to care and treatment, and Goals.

The final area is [for] Baseline recordings; these include BP, Temperature, Pulse, Respirations; all these are completed. Weight, Urine, Other — this section is not completed. Finally there is a section for Allergies, General appearance.

It is my opinion that this form is completed adequately and that [Mr A] was involved in completing this form.

Supporting information is included; these are individual pages with separate assessments

- Continence Assessment — dated 17 December 2003.

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- Skin Assessment Form — includes a Waterlow Score. This is listed as 18 High Risk. There is an anatomical picture which shows staff have documented skin integrity. This is dated 17 December 2003.
- Minimizing the Risk of Pressure Areas — there are several of these forms … these are dated 8 September 2004, 13 March 2004 — reviewed on this form 8 September 2004. [Pressure area form] is not dated. [A further pressure area form] dated 1 October 2004. This form includes statements such as encourage with fluids, R/V sacrum heels and ankles daily cream to be applied to heels, legs daily, Sheep-skin boots to be worn 24 hours.
- Minimizing the Risks of Falls.
- Pain Assessment Chart — dated 12 February 2004 — there is a numerical scale on the other side of the form. This is completed with dates ranging from 12–19 February 2004.
- Restraint assessment form relates to seat belt; [a further restraint assessment form] relates to bed rails. Both of these are dated 20 March 2004.
- Restraint review forms dated 25 March 2004 and 16 September 2004. These are signed by the GP.
- LSP — Six-monthly Evaluation Sheet dated 5 June 2004: this sheet lists daily activity. Down the left side of the sheet staff have written 'goal met' and a summary of the issues. These are brief statements.
- Multidisciplinary Assessment is dated 20 July 2004. It lists changes to the care plan — staff have written *Push fluids, Flush catheter when necessary, Pain management plan.* It also asks whether Family Goals are being met: staff have written '*yes family seem happy with his care'*. The review is signed by [Ms N], afternoon RN.

Initial Lifestyle Plan
This two-page document is listed with cares and staff highlight what cares will be given.

Resident Lifestyle Plan
The Resident Lifestyle Plan (4 pages) lists the activities of daily living (ADLs). Staff have written the Objective/Expected outcome.

> Personal Cleansing and dressing: '*Will have help with all ADLs over next 6 months'*
> Eating /Drinking: *'Weight will be maintained over next 6 months'*
> Skin Integrity: '*Skin will remain intact over the next 6 months'*
> Mental Behaviour: '*Will continue to interact with others over next 6 months'*
> Controlling Pain: *'Pain will be controlled over next 6 months*'
> Expressing Sexuality, Grieving and Dying: '*Will feel free to express himself in these areas over next 6 months'*
> Medical Requirements: '*Will have contact with GP PRN and regular assessments over next 6 months'*
> Eliminating: '*Will remain continent of bowels over next 6 months'*

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Breathing: *'Will have no difficulty over next 6 months'*
Sleeping: *'Will continue to sleep well over next 6 months*'
Mobilizing: '*Will continue to receive assistance over next 6 months and remain independent in his electric wheelchair'*
Communication: *'Hearing and vision will remain stable over next 6 months'*
Activities '*Will participate in activities of choice over next 6 months'*
Expressing Spirituality: *'His beliefs will be respected over next 6 months*'
Maintaining a Safe Environment: '*Will remain free of falls over next 6 months'*

Other information included is:

- Bowel charts
- Catheter Record Sheet
- Injury/wound management Form.

Progress notes are documented from the date of admission until [Mr A] was admitted to the public hospital.

It is my view that the documentation system used for admission and ongoing care was adequate and very similar to assessment processes in most private hospitals. Most of the forms are completed and dated. The information written on the forms appears to be in line with the condition and requirements of [Mr A]. There is evidence that [Mr A] was included in the assessment process.

An area which is lacking is [that] the staff designation is not usually written beside each signature in a lot of the documentation.

The care plans, although generic in nature, are personalized to [Mr A].

The care plans are brief and do not identify the severity of the problems that [Mr A] was suffering. [The following are examples of this.]

Pain
Throughout the progress notes it is evident that [Mr A] experienced a large amount of acute pain. The care plan does not explain thoroughly enough nursing interventions that would either help with assessment interventions or evaluation of pain. The only evaluation in the care plan was on 1 October 2004 when the entry states '*Acupan for pain analgesic. Cod.phosphate gives [Mr A] constipation'*.

There are entries in the progress notes but they are generally retrospective. There does not appear to be any pro-active nursing management of pain. No other relief of pain alternatives appear to have been tried.

Due to the severity of [Mr A's] pain I would have expected to see a referral to a pain clinic or a specialist to assess and support staff in managing the pain. It is my

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opinion the amount of analgesic was minimal. Panadol was charted once a day and stronger pain relief was charted when needed. It appears that [Mr A] would have to be in severe pain before analgesic was administered.

There is an entry on the 14 March 2004: '*All cares given as per care plan. Painful (L) side (stroke side) pain RN informed'*. It does not appear that any analgesic was given.

Again on the 3 April 2004 PM: '*All cares given [Mr A] complaining of pain'*. No analgesic appears to have been given on the PM shift.

The documents presented show that pain was assessed using a recognized assessment tool. This was from 12 to 19 February 2004. With the amount of entries in the progress notes that relate to pain it would have been good practice to have used an assessment tool on an ongoing basis. This would have shown a much more accurate assessment and allowed a more through pain management system.

It is my opinion that pain relief management was not adequate. It is a simple nursing and medical task to ensure patients have adequate pain relief and as such I consider this a major failure in care.

Mobility

On admission the documents show that mobility was documented.

All of these entries state that [Mr A] had an electric wheelchair. The care plan states: '*[Mr A] is able to mobilize himself downstairs to have a cigarette.*'

There was no accurate assessment of how safe [Mr A] was in his wheelchair. He obviously was able to get himself around but there is no accurate documentation [of such matters] as to how often he went outside [and] what support he needed.

It would be common when doing 3–6 month re-evaluations to look at how [Mr A] was managing his chair and if it was still appropriate he travelled independently. This would be a safety issue. If staff identified that he was unsafe, then it would have been appropriate for staff to discuss this with the family and [Mr A]. An informed decision would have been made and documented to allow [Mr A] to travel around independently, but all involved — staff, patient and family — would have been aware of the risks.

It is my opinion that management of [Mr A] in his wheelchair was inadequate.

Communication

The progress notes show cares that were given to [Mr A]. I acknowledge that [Mr A] had multiple medical problems and would require a large amount of nursing input from both caregivers and registered staff.

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What is not documented is the communication with the family. [Mr A] obviously deteriorated during his stay at [the rest home]. There was no evidence in the progress notes of a family review. A family review involving the multidisciplinary staff would have given the family a chance to sit and have staff explain what cares were needed. It also gives the family a chance to ask questions and express their concerns if any.

Documenting these meetings records what was explained and it also documents what goals the patient and family have. There were several admissions to the public hospital. These may have been avoided if the family had [had] an accurate explanation of options and were able to make an informed decision based on facts.

I consider the lack of communication between the team at [the rest home] and [Mr A's] family to be a major failing.

Please comment generally on the management of [Mr A's] fluid balance from December 2003 until October 2004.
[Mr A] was admitted with a supra pubic catheter. There are a number of essential cares that are required to keep the skin integrity intact and the catheter patent and draining.

The recommended fluid intake for a patient with a catheter is between 1500–2000 ml a day. It must be noted that many elderly patients have difficulty drinking this amount and it can sometimes be a real challenge for staff to encourage an adequate fluid intake. Ideally the type of fluid would be water, but that may not be possible and every encouragement must be made to find what the patient would like to drink. It does not appear that this was actively examined.

The other option — where an adequate fluid intake is required and the patient is reluctant to drink — is an intervention such as [administering] sub-cutaneous fluids. This is usually done overnight so as not to disrupt the daily living activities. This must be charted by a doctor, but can be easily administered by Registered Nurses. It is the preferred option in aged care as there are minimal complications as opposed to IV fluids.

The first fluid balance chart was implemented on the 12 February 2004; [the rest home staff] continued to [add to] this page till the 18 February 2004. At the top of the chart is written '*Accurate output please*'.

The fluid chart is poorly completed. The only day that appeared to be fully completed is the first day, 12 February 2004.

All other days are poorly filled in; they do not reflect an accurate output or accurate 24-hour clock. The orders were for accurate output and several entries have '*approx*' written beside them. This is not acceptable in that it may have been one nurse or caregiver 'guess'. There is limited usefulness for such an inaccurate fluid chart.

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In aged care the charts are usually completed by caregivers who give 90% of daily care. That does not take away the Registered Nurse's responsibility to ensure data is collected accurately so that interventions can be put in place if goals are not met.

The relevance in measuring urine output is to ensure there is adequate output to keep the catheter patent and draining. [Mr A] also had recurrent urinary tract infections [UTIs]. Many entries state that the urine was concentrated and the catheter blocked frequently. An adequate fluid intake–output would have assisted and been pro-active in reducing the blockages and UTIs.

It is my opinion that the fluid balance charts were very poorly completed. They were inaccurately filled in and not enough emphasis was placed on fluid input and output.

Supra-pubic catheters require regular interventions e.g. 2–4 times a day to ensure that complications are kept to a minimum. It is my experience that the most common complaint is a breakdown in skin integrity. This can happen for several reasons. One is that the patient's skin is not kept clean and dry and that any moisture is a medium for bugs and this means an increased risk of infection.

Second a blocked catheter can cause leaking around the site which also increases the risk of poor skin integrity.

A patient's positioning also can cause blockages and pulling on the tube. If a patient is sitting up-right with the tube kinked for several hours then the urine does not flow and again this is a risk to complications. Also many confused patients may pull on the tubing and cause trauma to the site.

Catheter care should be documented in the nursing care plan so that it can be accessed by all staff and especially agency nurses and caregivers.

Documentation presented showed an *Injury/wound management* form. This form was completed irregularly. It was initially commenced on 30 March 2004 and completed every four to five days until 4 May 2004 when it was completed daily until 18 May 2004. It was then commenced again on 20 May 2004 and following this on average of 2–3 times a week.

On this form is an area which states 'Next Review'. Often it is written daily, but this did not occur.

The organization should have up-to-date policies and procedures which outline the interventions and rationales used for the care. Polices may vary in what cream or skin care solutions are used but the principles would be the same. It is always an advantage to display the care requirements in the patient's room as this reminds

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staff. I would expect to see a policy and procedure within the nursing manual. This was not included in the documentation presented.[6]

It is my opinion that the catheter care was inadequate in that it was inconsistent and poorly documented. When documented it was appropriate, but the documentation lacked regular reviews and evaluation.

I consider this lack of a simple nursing action to be a major failure.

Nutritional Needs
On admission [Mr A] weighed 59.1kg. His height was not documented, but the coroner noted height as 172cm.

The care plan lists the objective of care as '*Weight will be maintained over next 6 months'*. The interventions written in the same handwriting are '*Cut up meat and lip plate.'*

The first entry in the progress notes which relates to food intake is on 7 March 2004: *PM 'did not eat dinner'*. On 28 March 2004 *'c/o abdo pain at lunch time. Didn't want to eat'*.

The weight chart if correct indicates that [Mr A's] weight was 52.6 kg at the end of April. This is a weight loss of 6.5kg since admission. Once this amount of weight loss had occurred, it would have been appropriate that [Mr A] be put on a weekly weigh.

Appropriate nursing care for a patient who had lost 6.5kg in a short period of time would include

- weekly weights
- food chart
- evaluation of needs in relation to assistance
- medical referral
- dietitian referral
- family consulted.

At this time, none of these actions took place. The progress notes show that [Mr A] was given a can of Ensure (a high-calorie food supplement) on 7 March 2004. This one action is appropriate but one can [of Ensure] on its own would not provide any long-term benefit.

Although [Mr A] spent a number of days in hospital in February and March, it is not acceptable that he was not weighed … he should have been weighed on his

[6] In response to the provisional opinion, the rest home company stated that there are comprehensive policies and procedures contained in the Care Services and the Practical Procedures folders.

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return. To say that if a patient is not in the facility on the date of weighs he does not get weighed is unacceptable.

I am of the view that [Dr D] should also have identified that [Mr A] had lost weight. There were examinations before admission to hospitals. As stated, such a weight loss would have been obvious.

Most aged care facilities have a so-called primary nurse for a number of patients. This ensures that such issues as reviews etc are undertaken on a regular basis. Registered nurses in my opinion are able to refer to a dietitian. It is not just a medical order. Appropriate policies would have Registered Nurses being able to refer on. Most referrals are in writing and a copy kept in the patient's record. Multidisciplinary team work would indicate that, following assessment, goals would be set, and in [Mr A's] case weight would have been defined as a problem.

All aged care facilities should have policies and procedures for patients who have compromised hydration and nutritional needs. All text books identify the issues. Guidelines are readily available.

Assessment processes should identify at-risk patients and intervention be implemented to manage this. Dietitians would be able to assist in this, and if there was a dietitian attached to a facility then part of their role in the team should be to assist staff to develop policies and procedures.

Food charts allow the health team to assess what type of food a patient is eating and also the amount. A patient who has limited or no protein will have problems with wound healing etc. It would have been good practice for a food chart to have been implemented once staff had identified that [Mr A] had lost so much weight.

The other issue which I wish to mention is what assistance patients need to complete their meals. Staff had identified that [Mr A] required a lipped plate. Following this there was no mention that any assistance was required. Many patients who are frail manage to feed themselves breakfast but become fatigued during the day and do not manage to feed themselves dinner. Some patients eat quickly, others take time and staff may need to take the meal back to the kitchen to reheat.

I fully agree with the dietitian's view that she was called in far too late and that any intervention she implemented would have had limited success.

Many elderly [people] will lose weight, and many patients, although not suffering from cancer, will at the end stage of their life become unable to eat or have their diet compromised. What is vitally important is that accurate assessment identifies this and strategies are put in place which attempt to set interventions to manage the issues. If families are kept informed and all options identified, the patient/family is then assured that all care is being taken.

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It is my opinion that [Mr A's] nutritional management was poorly done. I consider this a breach of [Mr A's] rights. The facility had the available resources, whether in house or through the public system, to achieve a much better outcome for this patient.

I consider this lack of assessment and care to be a major failure.

Other issues

Weight scales should be calibrated [every] 6–12 months. It is pretty obvious if scales are a number of kilograms out. Usually hospitals have mobile scales and they are able to be moved around. This can cause bumps, knocks etc.

It is my opinion that scales should be calibrated when all other medical equipment is, such as oxygen concentrators etc.

As stated previously, there is an issue of assessing [Mr A's] safety in his wheelchair. If patients are mentally alert and able to express their views and acknowledge that they have been explained the risks, then it is my opinion that they are free to go where they wish. I am surprised that [Mr A] travelled so far in such a frail medical condition. Going by the progress notes he would not be someone I would have expected to leave the building.

Agency Staff

As there is a chronic shortage in aged care and a real difficulty in attracting Registered Nurses, agency nurses are being used far more than the common occurrence of just filling gaps or replacing staff on sick leave. The agency nurses may be the only option for many facilities, in shifts that are difficult to fill e.g. PM at weekends. The cost of agency staff is far in excess of what facilities pay their permanent staff. Most facilities only hire agency staff to fill the need to meet the requirements in relation to safe staffing.

Agency nurses are able to function in all aged care situations but they may only work one shift and then not come back again. It is difficult for them to do much more than provide a safe environment and administer medications etc which are specific RN duties. Ongoing assessment and planning of care are left to the permanent staff. The progress notes show that when a registered nurse did assess and document, the entry was accurate and appropriate to the situation. What it also showed is that many of the issues and orders were not followed. It is a very frustrating situation for all permanent staff to be in. It also leads to sub-optimum care which was the case of [Mr A]. I was not presented with a roster nor an account of the number of agency staff but the complainant's letter indicated that agency staff were used with some frequency."

General practitioner advice

The following expert advice was obtained from Dr Tessa Turnbull, general practitioner:

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"Expert Advice Required

Please comment generally on the care provided to [Mr A] by [Dr D] from December 2003 until the end of October 2004.

[Dr D] was [Mr A's] GP from December 2003 until October 2004. She is employed as a long-term locum at [a medical centre] and is a visiting GP at [the rest home]. She is a member of [an overseas College of GPs] and a Fellow of the RNZCGP.

On 16 December 2003, [Mr A] was transferred from [a private care facility] to [the rest home] as he was unable to care for himself due to a previous stroke causing right-sided weakness and requiring his right arm to be supported. He was known to suffer from cerebrovascular and peripheral vascular disease. Mobility was achieved through an electric wheelchair.

[Mr A] continued to smoke but in small to moderate amounts. Depression was an ongoing problem since the death of [Mr A's] wife and his stroke and this was treated with the antidepressant fluoxetine.

[Mr A] had a suprapubic catheter to manage incontinence.

The management of this should be as follows:

The catheter should be changed every 4–6 weeks but can at times be left for 8 weeks.

The catheter should be flushed weekly with about 200ml of normal saline or a similar fluid to reduce the infection rate.

The presence of the catheter will inevitably be associated with concurrent urinary infections. These are treated with antibiotics if they cause systemic symptoms such as fever, pain and general debility. A urine specimen is taken to ensure an appropriate antibiotic is given.

[Mr A] had dementia but this was mild and during his stay at [the rest home] and the early part of his admission to [the public hospital] he could clearly convey to others his needs and wishes.

[Mr A] suffered from recurrent attacks of abdominal pain during his stay at [the rest home]. In the past he had had a cholecystectomy and a laparotomy for bowel adhesions.

[Mr A] was a hospital category patient. He was known to have a high risk of falls. Deafness was a background health problem.

[Dr D] does a weekly ward round at [the rest home]. As a hospital category patient, [Mr A] would normally be reviewed monthly, have a three monthly medication review and be seen as requested by [the rest home] staff for acute problems or for follow up of these problems. The method of notifying acute visits at [the rest home] is by a 'doctor's

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communication book' which is read by visiting staff on their arrival. After hours calls were handled by the after hours service or by contacting [Dr D] by telephone.

[Dr D] reviewed [Mr A's] past medical history and current clinical state on 18/12/03 soon after his admission to [the rest home]. She then visited [Mr A] on a regular basis, both for regular review and for acute health problems. She was contacted for telephone advice during surgery and after hours on a number of occasions and other after hours calls were appropriately handled by the after hours service both by telephone and visits.

Suprapubic catheter care

On admission the directions for the care of [Mr A's] suprapubic catheter were:

1. The catheter was to be changed 12 weekly unless it was blocked.

I note that the catheter was changed 5 x between January and August 2004.

2. There was to be regular cleaning of catheter site. An infected catheter site was noted on 6/2/04. There is also recorded treatment of catheter site with liquid nitrogen.

I conclude that care of the catheter site was regular and reasonable.

Flushing of the catheter is mentioned throughout the progress notes but I cannot be sure that this was at the recommended rate. It may have been done and not recorded.

Urinary infections were an ongoing problem as expected. They were often mixed infections such as the pseudomonas and streptococcus recorded on 18/12/03. [Mr A] was allergic to penicillin, which excludes some antibiotics that may have been appropriate. Mixed infections often mean that there is not a single antibiotic to which they were both/all sensitive. Noroxin was most commonly used for [Mr A] as this is available to GPs in short courses and very often works for urinary infections. Ciprofloxacin was most commonly used by [public hospital] staff as this is available to them but cannot be prescribed by GPs under normal circumstances.

Intercurrent infection and debility — some examples:

On the evening of 20 December 2003, [Mr A] became acutely unwell with fever, rigor and abdominal pain. [Dr D] was contacted and ordered a course of Noroxin to be given.

Severe pain and fever was reported on 7 February 2004. The After Hours Doctor was contacted and antibiotics were prescribed.

On 12 February 2004, [Mr A] developed severe abdominal pain and dark urine at 10 pm. [Dr D] was telephoned at 11.30 pm and ordered IM morphine and Stemetil and his symptoms slowly resolved.

The After Hours doctor on 25 May 2004 saw [Mr A] with a purulent discharge from the catheter site and the catheter was changed.

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A suprapubic catheter specimen taken on [Mr A's] final admission to [the public hospital] grew mixed organisms including coliforms, nonhaemolytic streptococcus, alpha haemolytic streptococcus and a coagulase negative staphylococcus. To treat this infection, [hospital] staff changed the catheter, used antibiotics and undertook daily bladder washouts.

I conclude the management of [Mr A's] suprapubic catheter and concurrent urinary infections causing fever, [Dr D] appropriately managed pain and/or debility.

Management of Abdominal Pain

Abdominal pain was an ongoing and challenging clinical problem.

Abdominal pain was reported on [3, 10, 17, 19, 19, 20 January 2004] in the progress notes. [Dr D] reviewed [Mr A] on 22 January 2004 in view of the recurrent pain. Bloods were undertaken and were normal in most parameters apart from severe hyponatraemia (low sodium), low serum folate and raised amylase, which could have originated from pancreatic disease.

On review on 29 January 2004, the sodium and amylase levels were repeated and showed some improvement especially in the sodium level. Folic acid was prescribed and an abdominal X-ray and ultrasound ordered. These were undertaken on 10 February 2004, and were unable to ascertain any particular problem in any of the organs reviewed.

[Dr D] reviewed [Mr A] on 11 February 2004 and ordered further blood tests, which were done on 13 February. These showed the sodium level to have returned to normal and the amylase to have further slightly fallen.

On 21 February 2004, [Mr A] developed vomiting, diarrhoea and severe abdominal pain. [Dr D] asked for his transfer to [the public hospital] where he was assessed for 4 days. The discharge summary from [the medical registrar] to [Dr D] at her surgery, noted that the diagnosis was 'probably some mild pancreatitis' with a very mild suprapubic catheter site infection and 'probable urinary tract infection'. The suprapubic catheter did not need to be changed and [Mr A] was treated empirically with 500 mg ciprofloxacin. Surgical treatment was not considered an option and it was felt that 'if in the future he does get abdominal pain which he has had in the past then the most appropriate way to manage this would be … subcutaneous fluids if required and liberal doses of analgesia to keep him comfortable'.

On 3/3/04, [Dr D] reviewed [Mr A], at that time believing the hospital diagnosis to be pancreatitis. Her plan of action as detailed in her clinical notes was to avoid morphine as it may have masked pancreatitis and should severe pain recur he should be readmitted to [the public hospital]. Later that day, [Mr A] developed severe abdominal pain and was readmitted to [the public hospital].

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[Dr D] met with [Mr B] and his wife on 11 March 2004, and a management plan to avoid further admissions was agreed upon with the aim being care and comfort for [Mr A].

[Dr D's] action plan for [the rest home] staff is detailed in [Mr A's] notes. This was to be followed with the aim of keeping [Mr A] at [the rest home] rather than transferring him to [the public hospital]. It was agreed that the pain could be originating from a number of causes and [Dr D] detailed these as pancreatitis, urinary sepsis or diverticulitis.

The first step was to administer oral analgesia and dip stick the urine. If the pain did not settle, IM stemetil and morphine were to be given. For nausea alone, IM stemetil was to be given.

If the symptoms were atypical or new, discussion with the after hours doctor was needed.

As part of this plan it was also agreed that monthly weights would be recorded.

[Mr A] was in agreement with this.

This plan was enacted and seemed to work well. Severe pain was recorded on [25, 27, 28, 29, 31 March and 1–5 April 2004]. Morphine and Stemetil were given.

[Mr A] was followed up in the gastroenterology OPD on 7 April 2004. The conclusion was that the attacks of pain were likely to be multifactorial ie 'constipation, suprapubic catheter, positional in the wheelchair, or possible bowel pathology ?diverticulosis, polyps or a mass'. More blood tests were ordered along with a barium enema. When the appointment for this arrived, [Dr D] and [Mr A] agreed that the test be cancelled.

In the middle and later part of the year, attacks of pain were recorded and managed according to the agreed action plan.

My conclusion is that [Mr A's] recurrent abdominal pain was appropriately managed and from April 2004, followed the action plan agreed on between [Dr D] and [the family].

Hydration and Nutrition

[Mr A's] care plan on admission indicated that he wished 'small, normal meals and would appreciate his meat being cut up'.

[Mr A's] weight steadily fell during his time at [the rest home].

Recorded weights:

Jan 04: 58.2kg

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Feb and March 04: not weighed

April 04: 52.6kg

May 04: 46.6kg

June 04: 49.9kg

July 04: 49.5kg

August 04: 45.8kg

Sep 04: 43.7kg

Oct 04: 41.55kg

Nov 04: 43.7kg

Nov 04: 41.25kg at [the public hospital]

Postmortem weight 35kg

[Dr D] and [the rest home] were aware of this steady weight loss. The rest home's evaluation on 20 March 2004 indicated the need to push fluids and on 5 June 2004 noted that [Mr A's] weight was down and that he needed encouragement with eating/drinking ie the 'goal was not met'.

Supplement nutrition by way of Ensure was provided in May and in September from [the rest home] supplies to boost [Mr A's] nutrition.

Dr D referred [Mr A] to [the rest home] dietitian on 22 September 2004. [Ms F] saw [Mr A] while she was visiting 2 other patients at [the rest home] on 29 September 2004.

[Mrs F] considered [Mr A] to be severely malnourished, 'a frail man who was starving', and concluded that this was on a multifactorial basis such as pancreatitis, inadequate energy intake and small appetite.

[Ms F] read [Mr A's] case notes, noted the huge weight loss, recommended at least 2 cans of Ensure Plus daily and because of time constraints arranged a full review on 5 October 2004.

At this visit she noted the weight to be 43.7kg and BMI to be 13.8 — well below the recommended 18.5. In view of the background problems of pancreatitis and malnutrition, she considered the best option would be a high protein, high calorie supplement such as 2CalHN with supplements of vitamin D. This nutritional care plan was discussed with the registered nurse and documented in the case notes.

[Dr D] prescribed the Vitamin supplements.

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[Mrs F] then sent an application form to [Dr H] for 2CalHN for countersigning on 7 October 2004. This was declined on a technicality (a missing tick in one box).

A further application was made on 1 November 2004.

[Ms F] notes the delays and frustrations in obtaining approval for nutritional supplements through Pharmac.

I reiterate this very strongly. Although GPs and dietitians for frail or ill people may think nutritional supplements appropriate, the method of obtaining funding for these through Pharmac is cumbersome and slow. The application has to be made by a specialist physician, who in this case and in many others, will take of the word of the GP/dietitian on faith and make the appropriate application. Minor technicalities, as in this case, may block the application. This means that the originator of the referral, in this case [Mrs F], may be unaware for some time that the application has been disallowed.

In this case, the approval arrived after [Mr A] had been admitted to [the public hospital].

On 31 October 2004, [Mr A] was admitted to [the public hospital] as a result of injuries sustained when he fell from his wheelchair outside [the rest home] grounds. He was picked up by [an ambulance] and sustained significant abrasions and scalp lacerations.

The medical registrar and other admission notes reported [Mr A] to be 'extremely cachetic' and 'dehydrated and generally in poor nutritional condition'. He had a poor swallow [reflex]. His weight was 41kg and the urine was very offensive. The sacral skin was intact; he had an infected ulcer on his left great toe and fresh abrasions to his elbows, right shoulder and toes.

It was reported that he did not wish to return to [the rest home].

A speech therapy swallowing assessment was done on 1 November 2004:

'Tolerating sips of thickened fluids in tsp amounts, very fatigued, ill fitting dentures, full supervision with all oral intake and assistance if needed.'

[Mr A's] condition generally deteriorated and in the latter stages he was given palliative care until his death.

Postmortem Findings

Bronchopneumonia due to swallowing difficulties from the previous stroke, possibly dementia, severe cachexia and inanition. Coexisting severe COAD.

[Ms F] notes that since [Mr A's] death she has worked with [the rest home] to develop policies and staff training relating to nutrition screening, monitoring weight and follow-up together with a format by which a patient's food intake is recorded.

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My conclusion is that [the rest home] and [Dr D] failed [Mr A] in not recognizing his state of malnutrition at an earlier stage. However, for both parties this has to be tempered by [Mr A's] concurrent and deteriorating medical problems. Nutritional supplements were provided at an earlier stage than the dietitian referral. Nutritional supplements are difficult to access as detailed.

[Dr D's] colleagues would view this with mild disproval in view of her impeccable management of [Mr A's] general health problems.

2. Please comment generally on [Dr D's] management of [Mr A's] fluid balance from December 2003 until October 2004.

A fluid balance chart was initiated on 12 February 2004 and continued until 18 February 2004. The recommended input was 1500ml.

Inputs seem to be reasonably accurate on the whole but the outputs vary a lot in accuracy.

Fluid balance was recommenced on 25 February 2004 and ran through to 11 March 2004. Again inputs and outputs are very variably recorded.

Further recordings were undertaken in early March with the same result.

In late August, further fluid balance charts were done again with the same outcome. [Dr D] asked for this to be undertaken when alerted to [Mr A's] poor fluid intake on 9 August 2004. She then noted that he seemed to be drinking well on 26 August 2004.

My experience with fluid balance charts in rest homes is that they are primarily a tool to encourage staff to push oral fluids. In very sick patients such as in hospital care, accuracy with inputs and outputs is important or critical. In [Mr A's] case fluid balance charts were a tool to encourage staff to focus on and push fluid intake.

If not commented on before, please respond to these specific points:

3. What is the recommended daily fluid intake for a patient with a permanent supra-pubic urinary catheter?

A supra-pubic catheter is a device to avoid/control urinary incontinence and retention. The fluid intake for someone with a supra-pubic catheter is the same as for anyone else ie about 1500ml daily.

4. Please comment on the relevance, if any, of measuring the urine output of a patient with a permanent supra-pubic urinary catheter.

There is no real relevance except in cases where measurement of fluid input/output is requested.

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5. Were [Dr D's] instructions to nursing staff in relation to fluid balance management appropriate? Please give reasons for your view.

[Dr D] asked that [Mr A] be monitored and encouraged to drink via a fluid balance chart and be given help with eating and drinking if needed. Instructions were given to the RN doing the ward round and then passed on to other [rest home] staff at the nursing handovers.

This seems entirely appropriate.

6. Were [Dr D's] actions appropriate in response to the measurements as recorded on the fluid balance charts? Please give reasons for your view.

7. Were the fluid charts sufficiently accurate to allow [Dr D] to assess the adequacy of [Mr A's] fluid intake? If no, what other instructions, if any, would it have been appropriate for [Dr D] to have given?

As previously noted, the fluid balance charts were not kept accurately. However, they were intended as a tool to encourage nursing staff /caregivers to push oral fluids rather than as an accurate input/output measure. They were reasonably successful in doing this ie encouraging fluid intake. [Dr D's] actions, therefore, were appropriate. The inaccuracy in record keeping does not mean that other instructions from [Dr D] should have been given.

[Dr D] reviewed [Mr A] on 19 August 2004, requesting a fluid balance chart for [Mr A]:

8. Were the fluid balance charts following this review of an acceptable standard? Please comment.

No, the accuracy was generally poor.

9. Please comment on the number of days that the fluid balance chart was maintained.

I don't think this has a lot of importance. As mentioned previously, although [Mr A's] fluid intake was noted to be poor, it seemed to improve by the staff focusing on this by way of the fluid balance charts. The big issue was [Mr A's] poor nutritional status.

10. Please comment generally on [Dr D's] management of [Mr A's] nutritional needs from December 2003 until October 2004.

SEE QUESTION 1 FOR THE DETAIL:

My conclusion is that [the rest home] and [Dr D] failed [Mr A] in not recognizing his state of malnutrition at an earlier stage. However, for both parties this has to be tempered by [Mr A's] concurrent and deteriorating medical problems. Nutritional supplements were provided at an earlier stage than the dietitian referral. Nutritional supplements are difficult to access as detailed.

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[Dr D's] colleagues would view this with mild to moderate disproval but needs to be balanced by her impeccable management of [Mr A's] general health problems.

If not commented on before, please respond to these specific points:

11. Would it have been appropriate for [Dr D] to record [Mr A's] weight routinely on the medical assessment/continuation notes? Please give reasons for your opinion.

It does not matter a lot where [Dr D] records the weights as long as they were recorded, were available to and used at her reviews. They were available to [Dr D] after the family conference in March apart from a non-recording that month.

12. On 30 May 2004, [Dr D] reviewed [Mr A]. What actions would it have been appropriate for her to have taken in response to [Mr A's] most recent weight?

I suspect that the recorded weight of 46.6kg in May was inaccurate (such inaccuracies occur for a number of reasons in rest homes and a glance at the same page will see other variations including an unlikely weight loss of 10kg in one month in another person). Overall, [Mr A] showed a steady weight loss over time.

April 04: 52.6kg

May 04: 46.6kg

June 04: 49.9kg

July 04: 49.5kg

August 04: 45.8kg

If this was indeed a real weight loss in May, dietitian referral should have occurred at this point.

13. What actions would it have been appropriate for [Dr D] to have taken in response to [Mr A's] weight measured in August 2004.

I wonder whether this figure was entirely accurate as well.

May 04: 46.6kg

June 04: 49.9kg

July 04: 49.5kg

August 04: 45.8kg

Sep 04: 43.7kg

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[Mr A] had oral thrush at [Dr D's] visit on 12 August and she noted his poor fluid intake on 19 August and asked for recordings of fluid input and output at that time. I assume that she must have been aware of [Mr A's] weight loss.

This seems to have been a poor month health-wise for [Mr A] and it was during that time that a transfer in rooms occurred.

Dietitian referral at this time would have been appropriate.

14. Please comment on the appropriateness of [Dr D's] response to the fall in [Mr A's] weight from December 2003 until October 2004. Weight and nutritional needs are tied together, hence my conclusion that [the rest home] and [Dr D] failed [Mr A] in not recognizing his state of malnutrition at an earlier stage. However, for both parties this has to be tempered by [Mr A's] concurrent and deteriorating medical problems. Nutritional supplements were provided at an earlier stage than the dietitian referral but on an ad hoc basis.

15. When during the period December 2003 to October 2004 would it have been appropriate for [Dr D] to have referred [Mr A] to a dietitian? Please give reasons for your decision.

I have some concerns about the accuracy of some of the weight records, which makes this question difficult to answer empirically. Unlike many rest homes, [the rest home] has access to good nutritional advice, which is a real bonus. Attempts were made to boost [Mr A's] nutritional status by supplying him with Ensure from [the rest home] stock in May 2004. A dietitian referral at that time would have given the nutritional supplement some status and allowed it to be charted like a medicine.

Other matters:

16. Was the 25 March 2004 three-monthly assessment report completed to an appropriate standard? Please give reasons for your opinion.

I like the assessment form and the concept behind it — it allows a stock take of the previous [three months], highlights problems and takes a look ahead. However, it is used in conjunction with the ongoing clinical notes so that the information may be duplicated. The assessment seems to have been done to a reasonable standard.

17. Was the 12 August 2004 three-monthly assessment report completed to an appropriate standard? Please give reasons for your opinion.

The consultation notes of 12 August 2004 in the continuing record show that [Dr D] did a reasonable assessment of [Mr A] at this visit although the detail on the assessment form is incomplete. Filling in a form, or not, does not mean that the clinical state was not discussed or an appropriate examination undertaken.

Recording of the weight on the assessment sheet, assuming this was accurate, would certainly have highlighted [Mr A's] weight loss. I am pleased to see that this is now standard practice at [the rest home].

18. What other referrals, if any, do you consider would have been appropriate for a general practitioner to make in [Mr A's] care? Please give reasons for your opinion.

[Dr D] was readily available to [the rest home] nursing staff for medical advice and management. She had access to further medical advice from [Mr A's] hospital admissions and OPD appointment. She did appropriate investigations herself.

I think that [Dr D] medically managed [Mr A] very well in a general sense especially in his pain management. I do not think that any further referral, beyond an earlier dietitian referral, was needed.

If, in answering any of the above questions, you believe that [Dr D] did not provide an appropriate standard of care, please indicate the severity of her departure from that standard. To assist you on this last point, I note that some experts approach the question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

19. Are there any aspects of the care provided by [Dr D] that you consider warrant additional comment?

No."

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Dietitian advice
The following expert advice was obtained from Mrs Janelle Wallace, dietitian:

"Independent Advisor's Report for the Office of the Health and Disability Commissioner

I, Janelle Wallace, NZ Registered Dietitian, have been asked to provide expert advice to the Commissioner on case number 04/18516. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

Appendix H of the Guidelines states that any professional connection such as working at the same hospital as the provider under investigation must be disclosed at the time the advice is sought. I worked with [Ms F] for part of […], when I was Dietitian in Charge at [a public hospital] and she was on my staff. … I felt this did not constitute any conflict of interest which could prejudice my advice.

I have been a NZ Registered Dietitian since 1965, working primarily in clinical dietetics since registration. In 1978 I was appointed to the post of Senior Clinical Dietitian at Waikato Hospital, and held this position of manager until 2003. Since retiring from hospital service I have worked part time in private practice, which my partner and I began in 1995.

I am experienced in all aspects of clinical dietetics; staff leadership, training and management; management of nutrition service contracts to rest homes and hospitals; and care of individual patients with special nutritional requirements in rest homes and hospitals and in the community.

In 2000 I was contracted to audit the clinical dietetic practice of Auckland, Starship, Green Lane and National Women's Hospitals. This project was followed by a professional review of clinical dietetic services at Christchurch Hospital in 2004.

As Chair of the Dietitians Board from 1989–94 I was responsible for instigating a trial Continuing Competence Programme for the profession, which now forms the basis of the current model.

Instructions from the Commissioner

Purpose
To provide independent expert advice about whether Dietitian [Ms F] provided an appropriate standard of care to [Mr A].

Background
On 16 December 2003, [Mr A] was transferred from [a private care facility] to [the rest home] as he was unable to care for himself due to a previous stroke. This had left [Mr A] requiring significant assistance with his activities of daily living, mobility through the use of an electric wheelchair, and with a supra-pubic catheter to manage incontinence. [Mr A] also suffered from dementia.

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On admission assessment, [Mr A] was described as ‘feeds self’, and on a normal diet, although any meat needed to be cut up.

On 21 February 2004, [Mr A] was admitted to [the public hospital] with pancreatitis, being discharged 25 February 2004. A further admission with abdominal pain occurred from 4 to 5 March 2004. Following these admissions, [Dr D] met with [Mr A’s] son and daughter-in-law and a management plan to avoid further admissions and to provide comfort care was agreed on.

On 20 March 2004, a multidisciplinary assessment was performed.

On 25 March 2004, [Dr D] performed a regular three-monthly assessment report. No record was made about [Mr A’s] weight, or difficulties with nutrition. According to [the rest home], [Mr A] was not weighed in February or March 2004: the weight recorded on the chart for March was recorded at the end of April, and erroneously recorded as March in the weight book and on the weight chart.

On 5 June 2004, a six month evaluation was performed, which recorded that [Mr A’s] weight was falling and he needed encouragement.

[Mr A] weighed 43.7 kg in September 2004, down from 59.1 kg in December 2003, on admission. On 22 September 2004, Dr D referred [Mr A] to a dietitian, [Ms F]. This referral was not communicated to [Ms F] until 29 September 2004, when, while assessing other patients at [the rest home], [Ms F] was asked if she could assess [Mr A]. [Ms F] recommended that [Mr A] have at least two cans of Ensure Plus daily, and arranged a further appointment to perform a full assessment.

On 5 October 2004, [Ms F] performed a full assessment recommending supplements of Vitamin D. [Ms F] wrote to [Dr H], geriatrician, with an application for 2Cal HN.

On 31 October 2004, [Mr A] was admitted to [the public hospital] having had an accident while driving his electric wheelchair in the street. [Mr A died a short time later in the public hospital], weighing 35 kg at his post-mortem. Inanition was given as a secondary cause of death.

Complaint
The adequacy and appropriateness of care provided to [Mr A] by [Ms F], dietitian, from December 2003 to October 2004.

Supporting Information:

* Complaint

* Notification letters

* [Dr D’s] response to complaint

* Dietitian [Ms F’s] response to complaint

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* [The rest home] response to complaint

* [The DHB] review

* Police documentation

* Coroner documentation

* [The rest home] admission documentation

* [The rest home] care planning documents

* [The rest home] progress notes

* [The rest home] medical records

* [The rest home] 'Doctor's Book'

* Weight book and chart

* Fluid balance charts

* [The DHB] clinical notes

* Job descriptions, Principal Nurse and Clinical Co-ordinator, [the rest home]

Expert Advice Required
1. Comment on the standard of care provided by [Ms F] to [Mr A] from the period 29 September to 31 October 2004.

2. Comment on the standard of assessment performed by [Ms F] on 29 September 2004.

3. Comment on the standard of assessment performed by [Ms F] on 5 October 2004.

4. Comment on the appropriateness and adequacy of the follow-up actions taken by [Ms F] following her assessment on 5 October 2004, with particular reference to the prescription of 2Cal HN.

5. By what mechanism should a referral to a dietitian occur within a rest home/hospital.

6. Comment on the method of referral of [Mr A] to [Ms F].

7. Comment on the time period between the decision being made by the GP for referral, and the referral being actioned.

8. Give an opinion on whether [Mr A] should have been referred to a dietitian, giving reasons for that view.

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9. Comment on the referral made by [Ms F] for 2Cal HN via [Dr H].

10. Comment on the standard of record keeping for [Ms F's] assessments on 29 September and 5 October 2004.

If [Ms F] did not provide an appropriate standard of care, indicate the severity of her departure from that standard. Consider if the provider's peers would view the conduct with mild, moderate or severe disapproval.

Expert Advice

Standard of care provided by [Ms F] to [Mr A] from the period 29 September to 31 October 2004.

The NZ Dietetic Association does not have formal professional standards of care for referral and management of patients with nutritional problems in rest homes/hospitals.

I discussed this with [a senior member] of the Dietetic Association, who is also the Manager of the Clinical Dietetic Services at [a public hospital].

I also conferred with [the manager] of the Clinical Dietetic Services at [another public hospital] and a partner in [a dietetic consultancy] who have the contract with [another private care facility].

Both agree that formal standards would be ideal but that, in their absence, the detail of contracts and the actual patient management are the responsibility of the dietitian concerned.

The standard of care provided by [Ms F] was mildly unsatisfactory in this case.

She reviewed [Mr A's] clinical notes on 29 September after a verbal referral from the nursing staff, but did not carry out any further assessment until a week later, despite the severity of his condition.

Following the progress check on 5 October, [Ms F] accepted what she was told by the nursing staff that [Mr A] was being given Ensure Plus. She did not confirm her own knowledge (with food/fluid charts) that this was actually the case before applying for another nutritional supplement.

During the three weeks it took to receive a response from Pharmac, there were no further phone calls or visits to check on [Mr A's] progress.

Standard of assessment performed by [Ms F] on 29 September 2004
In response to the last minute verbal request [Ms F] read the clinical notes and noted [Mr A's] history of pancreatitis and weight loss. She relied on the word of the nurses that [Mr A] was having two cans of Ensure Plus daily, when in fact there is no evidence from the records kept that this was the case.

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Under the circumstances, given the lack of time, her assessment and advice to continue with Ensure Plus is acceptable.

Standard of assessment performed by [Ms F] on 5 October 2004
On this occasion there was more time to perform a thorough review of the patient, together with the medical and weight history in the clinical notes. The use of Body Mass Index gives a guide to ideal weight but is not as relevant in the elderly as it does not provide a clear picture of muscle mass/loss.

The comments on the dangers of refeeding syndrome are pertinent.

However there is no evidence that [Ms F] actually saw [Mr A]. Had she done so, there would have been an opportunity to assess the degree of malnutrition at the bedside and to assess [Mr A's] version of his eating/drinking problems.

The use of food and fluid records to accurately analyse past oral intake is essential. If [Mr A] had in fact been taking two cans of Ensure Plus as claimed, the 700 calories would have made a difference to his weight.

It is prudent for dietitians to prescribe the type and dosage of nutritional supplements in the drug chart, so that the administration has to be carried out and signed for.

[The dietetic consultant] and I agree that the prescription of 2Cal HN is unnecessary and inappropriate in this situation as Ensure Plus, if ingested, would be adequate.

We also believe that dietitians are responsible for requesting and reviewing blood results that give an indication of nutritional status. These include serum pre albumin, albumin, iron studies and serum folate. By November all [Mr A's] results were abnormal and showed clear signs of malnutrition.

Appropriateness and adequacy of follow-up actions taken by [Ms F] following her assessment on 5 October, with particular reference to the prescription of 2Cal HN.

As I said in the previous paragraph, Ensure Plus would have been adequate for the job had [Mr A] actually taken it in sufficient amounts in addition to his food. His minimum energy requirement was 30 kilocalories/kg and the supplement would have contributed approximately 50% of this.

There is no mention of [Mr A] having a Health Benefit from Pharmac for Ensure Plus. I assume there was some in stock at [the rest home], either from another resident or having been purchased.

[Ms F's] letter to [Dr H] is in accord with her judgement that 2Cal HN was indicated.

Unfortunately it is not possible to be sure that Pharmac approval will be automatic for nutritional supplements, especially one with special conditions such as 2Cal HN.

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However the staff at Pharmac will fast track approval of nutritional supplements in response to a phone call if the matter is deemed appropriate and urgent.

I am concerned that during the three weeks it took for the failure of Pharmac to approve 2Cal HN to be realised, there was no communication between the nursing staff, [Dr D] and [Ms F] about [Mr A's] progress.

Mechanism by which a rest home/hospital should refer patients to a dietitian
There should be written protocols in place about when patients should be referred and under what conditions. These would be developed by joint consultation between management and clinical staff and the dietitian.

Nursing staff should be oriented on appointment to the rest home/hospital and trained in the use of these protocols.

Ideally a senior nurse such as the clinical co-ordinator should have final responsibility for the referral. This should ensure it is appropriate and that all the information is included.

Staff should be encouraged to phone the dietitian to discuss the referral if in doubt. However telephone calls must not replace formal written referral.

The degree of urgency should be recorded on the referral.

The referral can be faxed, and its receipt should be acknowledged by the dietitian within one working day.

The referral should be made on a form designed specifically for that purpose.

It should include headings such as —

* Patient details (date of birth, NHI etc)

* Reason for referral

* Patient's doctor

* Medical history

* Relevant medical investigations

* Weight history

* Current method of feeding (oral, nasogastric, gastrostomy)

* Nutritional feeding regimens including supplements

* Impediments to normal feeding

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* Relevant blood results

* Food and fluid records

* Priority/urgency (urgent: one working day; otherwise five working days)

* Referrer's name and signature

Method and timing of referral of [Mr A] to [Ms F]
This was unsatisfactory for two reasons.

First, there was a delay of one week from when [Dr D] asked for dietetic involvement (Medical Notes 22 September) to the verbal request from nursing staff on 29 September.

This should have been attended to immediately, either by [Dr D] or nursing staff.

Ideally [Dr D] should have contacted [Ms F] to explain [Mr A's] condition and the degree of urgency.

Secondly the request was verbal rather than written. [Ms F] had no time to action the referral properly on 29 September, and had to reschedule for 5 October.

Appropriate time for initial referral of [Mr A] to the dietitian
In my opinion [Mr A] should have been referred for dietetic review when first admitted to [the rest home]. My reasons are —

* [Mr A] was already thin when he arrived

* [Mr A] was a smoker, which usually means a reduced food intake

* With a history of stroke it is reasonable to assume that feeding could be adversely affected. In fact it is recorded on the admission sheet that [Mr A] needed a soft diet with pureed meat and small quantities

* A history of depression and confusion, both of which can adversely affect appetite

* Unwillingness to drink adequate quantities of fluids

* Pressure areas which can reflect poor nutritional status

Referral made by [Ms F] for 2Cal HN via [Dr H]
Covered earlier

Standard of record keeping for [Ms F's] assessments on 29 September and 5 October 2004
The standard of [Ms F's] record keeping is satisfactory.

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However it is preferable to for all medical, nursing and allied health professional staff to write sequentially in the patient's clinical notes, so that the notes form an integrated record. Separate pages for staff such as dietitians can get overlooked.

Summary
[Mr A's] nutritional status was so poor by the time [Ms F] was asked to provide assessment and advice, nothing she could have done would have made a significant difference to [Mr A's] life expectancy.

Care and management of [Mr A] by medical and nursing staff at [the rest home]
In my opinion [Dr D] has failed in her duty of care. By not initiating appropriate treatment, which includes referral to a dietitian, [Mr A's] suffering from poor health, deteriorating nutritional status and increasing cachexia was compounded.

[Dr D's] record keeping in the Medical Notes and Doctor's Book was careless in view of the increasing severity of the problem of weight loss —

25/03/04: No problems with weight and nutrition noted

12/08/04: No problems with weight and nutrition noted

19/08/04: Start fluid balance because of concerns re poor fluid intake

22/09/04: Refer to [Ms F]

06/10/06: Ensure and Fortisip given daily, increase desserts

07/10/04: Needs encouragement to eat and drink

21/10/04: Weight decreasing despite supplements

There are no up-to-date requests for blood tests to check albumin and other nutritional markers.

There was no attempt to call a family meeting to discuss [Mr A's] poor nutrition, falling weight, poor fluid intake and the likely consequences. While I appreciate [Mr A's] family did not want to embark on heroic measures such as nasogastric feeding, they needed to meet with [Dr D], senior nursing staff and preferably the dietitian to discuss options and outcomes. In this way everyone is clear about the situation.

Nursing staff failed in many aspects of care.

They failed to communicate with family properly despite the family's concerns about [Mr A's] food and fluid intake.

They did not keep proper records of weights, fluid balance charts, food charts or even progress in the Progress Notes from a nutritional point of view. Statements such as 'No problems, no concerns, all cares given', which appear in the nursing notes frequently

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between May and August 2004 while [Mr A's] weight fell by 10 kg, do not reflect any understanding of the process of malnutrition and starvation.

Nursing staff appear not to have taken proper account of [Mr A's] weight loss or brought it to [Dr D's] attention.

They did not refer [Mr A] for nutritional review at the appropriate time.

They did not seek advice from the dietitian about how to use the Ensure Plus until formal referral in September.

There is no evidence that Ensure Plus was given to [Mr A] in regular or adequate doses.

Records from fluid charts from February to March 2004, and again in August 2004, list cordial, tea, juice, water, Milo, soup and lemonade only.

Records in the Nursing Notes show —

07/03/04: 1x Ensure Plus provided by family

15/07/04: 'Supps' [supplements]

05/08/04: 'Supps'

02/09/04: Ate and drank all fluids

07/10/04: 3x Ensure Plus given (I doubt that [Mr A] would have managed this volume)

10/10/04: Ensure Plus given

14/10/04: 3x Ensure Plus given

19/10/04: Needs to be fed

28/10/04: Breakfast: Half bowl porridge, 1x Ensure Plus. Morning tea: quarter egg sandwich. Lunch: pudding, 1x Ensure Plus (recorded by student nurse)

The job descriptions for the Deputy Manager/Principal Nurse and Clinical Co-ordinator outline the importance of and responsibility for excellence of care; delivery of safe nursing care; regular assessment and evaluation of patient care; professional behaviour; leadership and motivation of staff; identification of staff training needs; supervision of clinical teaching; confidential and accurate record keeping; communication with family in terms of changes in health status; ensuring referrals are delivered in a timely manner; and high quality, customer-focused care. The two staff members concerned failed to achieve a satisfactory standard.

I am appalled that [Mr A] fell victim to such poor care, where staff presided over increasing malnutrition and starvation which contributed significantly to his death."

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Further general practitioner advice
Following receipt of Mrs Wallace's advice, Dr Turnbull was requested to provide further advice:

> "I refer to your letter of 17 August 2005 regarding further advice to the Commissioner in the matter of the care provided to [Mr A] by [Dr D].
>
> In clarification to the points listed:
>
> *[Mr A's] weight on admission to [the public hospital]*
> I pondered over the figures originally as I had seen the figure 30kg recorded in [the public hospital] records. [Mr A] weighed 41.55kg at [the rest home] in October. His post-mortem weight was 35kg. I decided that these were accurate weights. Within [the hospital] records, I found a weight of 41.25kg recorded for [Mr A] in the social worker referral letter.
>
> [Mr A] was admitted to [the public hospital] on 31 October 2004 and died [several days later]. He was likely to have lost weight, not gained weight, during this time as he was clearly very ill prior to his death.
>
> I concluded, therefore, that the weight '30kg' was incorrect and had been transposed as an incorrect figure into the 3 separate areas listed.
>
> *Fluid balance charts*
> My conclusion regarding the fluid balance charts was that they were inaccurate in their details. In requesting them, [Dr D] was asking the staff to encourage [Mr A] to increase his fluid consumption as he had little natural inclination to drink or eat under his own steam. An adequate fluid intake was important both for his general health and also to assist in the management of the suprapubic catheter.
>
> My comments that the fluid balance charts seemed 'reasonably successful' i.e. in encouraging further fluid intake was an impression gained not from the charts but from [Dr D's] comments in the nursing records.
>
> *[Dr D's] awareness of [Mr A's] weight loss*
> Although [Dr D] did not record [Mr A's] weight in her continuation notes, I assume that the weight loss was a discussion point between [Dr D] and the registered nurse during a ward round. [Dr D] says that the weight recordings were shown to her in the ward book by the registered nurse. Weight gain/loss would be a normal part of a three monthly review but as part of the overall health assessment and evaluation.
>
> *Ensure supplementation*
> My comment about nutritional supplements were based on the records mentioned by you.

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[Dr D's] assessment on 25 March 2004
[Mr A] was not weighed in February or March 2004. Apart from this omission the medical review included a physical examination, medication review and an overview of [Mr A's] health status at that time. The assessment seems, therefore, to be of a reasonable standard.

Mrs Wallace's report.
In general, Mrs Wallace and I agree that [Dr D] and [the rest home] failed in their duty of care with regard to [Mr A's] nutritional status.

As previously stated:

Attempts were made to boost [Mr A's] nutritional status by supplying him with Ensure from [the rest home] stock in May 2004. A dietitian referral at that time would have given the nutritional supplement some status and allowed it to be charted like a medicine.

This is the point in time i.e. May 2004 that I believe a dietitian referral should have been made. Mrs Wallace indicated that [Dr D] did not 'initiate appropriate treatment, which includes referral to a dietitian'. Referral to a dietitian itself was the appropriate treatment.

Unlike Mrs Wallace, I do not feel that additional blood tests to check for nutritional markers were needed but a family meeting to discuss [Mr A's] nutritional status and other health problems would have been very helpful later in the year.

Mrs Wallace describes [Dr D's] record keeping as 'careless in view of the increasing severity of the problem of weight loss'. I disagree with this opinion as [Dr D's] notes are reasonably representative of her colleagues' record keeping in similar situations. The notes do not reflect the detail of the consultation and any examination that may have occurred. It is only when a medico-legal situation such as this occurs that the value of good record keeping (as opposed to good doctoring) becomes apparent.

I see [Mr A] as having multiple and complex health problems and apart from the deteriorating nutritional status, these were managed very appropriately by [Dr D]."

Responses to provisional opinion

The Rest Home Company
The rest home company stated:

"[W]e wish to convey that [the rest home company] … is genuinely concerned regarding any distress caused to [the family] as a result of shortcomings in our service.

[The rest home company] … takes this seriously and will now contact the family to take constructive steps to make a formal apology.

[The rest home company] … acknowledges that the care provided to [Mr A] was less than optimal. However, we do not consider that total responsibility for any care failings should be placed upon us and be the subject of a referral to the Director of Proceedings. We believe that your final report should place an appropriate and significant proportion of the responsibility in any perceived care failings upon one or more of the allied health professionals, namely [Dr D] or [Ms F]. …

[T]he circumstances of the incident, along with the associated management of [Mr A's] care and indeed the significant issues raised during the … investigation, led the senior staff at [the rest home] … and the management team from [the rest home company] … to seriously reflect on then current practice not only at [the rest home] but indeed at a group level. Consequent upon a review, changes to ensure that a situation like this could never happen again, have been implemented and a summary of these actions is attached, with the associated policies.

We acknowledge and regret that the standard of care afforded to [Mr A] at [the rest home] was less than optimal on occasions and that communication … with [Mr B] who held Power of Attorney could have been of a higher standard. …

We acknowledge that there were some deficiencies in the calibre of documentation, the robustness of policies, and a more cohesive internal and external management of [Mr A's] weight loss may have resulted in earlier action being taken to access dietetic advice and implement regular and ongoing nutritional support."

The rest home company stated:

- Ms L and Ms F had recorded a weight for February 2004, and thus Mr A had been weighed in February, but it was not recorded in the weight book, Mr A's weight chart, or his progress notes or care plan;
- based on Dr Turnbull's report, Mr A weighed 43.7kg and 41.25kg following his admission to the public hospital;
- weights are now recorded directly to the weight chart, and a weight book is not used;
- Mr A's weight loss was brought to Dr D's attention prior to September 2004;
- "[Mr A] was extremely resolute in his desire for independence and rejected staff attempts to assist him at mealtimes."

The rest home company advised the changes that have been introduced since November 2004:

- a new weight chart

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- a new weight loss policy
- the management of weight loss is now "included as a core item on the … education plan along with nutrition"
- the Nestlé Mini Nutritional Assessment tool is now used
- an educational pack on nutritional assessment to be delivered as part of the 2006 education plan
- additional training for staff in nutrition
- an updated Allied Health Services Referral Policy
- introduction of a specific dietitian referral form
- a policy for catheter care is being developed
- a family/whanau contact record has been introduced
- annual calibration of scales
- 6-monthly review of residents' mobility needs
- "The ongoing ability of a resident to mobilize safely in electric wheelchairs will be reviewed … with mobility needs."

The rest home company provided a copy of Ms E's inservice education record. This shows from September 1999 to March 2006 "approximately 157 hours of training and education, primarily with a clinical focus".

The rest home company advised that the clinical co-ordinator role (filled by Ms G) was created on 17 February 2004 "to accommodate the increasing needs of residents [of the rest home]".

A senior manager of the rest home company confirmed in a telephone call on 26 April 2006 that Ms E was responsible for clinical oversight at the rest home:

> "Clinical oversight is a pyramid arrangement with senior clinical oversight for the facility being the responsibility of the principal nurse."

The senior manager also confirmed that Ms G had some clinical responsibility for the management of Mr A's care "as the senior registered nurse" in the part of the rest home where he was being cared for.

Ms E
Ms E apologised for "the areas where [the rest home] and its staff failed in providing appropriate care and regrets that she was not able to assist [Mr A] further during his stay at [the rest home]".

Ms E advised that no issues in relation to Mr A's care or his condition were ever reported to her, and she was not aware of any concerns raised by Ms G to Ms M.

Ms E stated that although she "accepts responsibility for the quality of nursing care provided by herself and others, her personal responsibility and assessment of whether she breached the Code must be tempered" by a number of factors. These include the involvement of Ms G and Ms I in the management of the care of residents, and the

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presence of registered nurses who were providing care to Mr A. Ms E relied on Ms G for the oversight of clinical care, and in particular on "her obligation to report any changes in a patient's condition or any issues concerning service delivery to [Ms M]" or Ms E. There were only two occasions when Ms E was directly involved in Mr A's clinical care: 27 January and 15 March 2004.

Ms E submitted that Ms G was responsible for ensuring that the care plans and all documentation was kept up to date. The audit of care plans in the hospital section of the rest home was undertaken by Ms I.

Ms E said that she had previously raised with Ms M her concern that the management and administrative role had a negative effect on her ability to monitor staff and patients. According to Ms E:

> "[Ms M] was dismissive of [Ms E's] concerns. [Ms M's] view was that the registered nurses who were providing the clinical care of patients were responsible for the care being provided and it was reasonable for [Ms E] to rely on registered nurses in this regard and to respond to issues if and when they were raised."

Ms E stated:

> "The systems that were in place appear to have failed, in particular [Ms G's] failure to properly oversee the clinical care being provided and report any changes in a patient's condition or any issues concerning service delivery to the Manager or [Ms E], [and] the registered nurse failing to involve more senior staff member[s] when required and in the audit failing to pick up the falling weight. …
>
> [Ms M] did not permit [Ms E] or registered nurses to contact Allied Professionals without a doctor's referral. … The registered nurse appears not to have raised the issue with the doctor but likewise [Dr D] was not concerned about the weight loss being experienced by [Mr A]. For this reason, [Ms E] does not accept that the nursing staff can be held responsible for failing to refer [Mr A] to a dietician at an appropriate time."

Ms E stated that when she commenced as Principal Nurse, it was intended that she work 75% of her time in clinical work, with 25% on management responsibilities. However, when she found that she was required to work more than 10 hours a week in her management role, she approached her employers. They advised her that she should devote her time to management duties. As a result, her job "was almost entirely management with a very small proportion devoted to providing expert clinical care when required".

Ms E accepts that Mr A ought to have been weighed monthly and that the fluid balance charts were not appropriately maintained. However, she believes that the responsibility for ensuring that this was corrected lay with the registered nurses caring for Mr A, and with Ms I and Ms G, for failing to review the care provided.

Ms E has made changes to her practice, speaking to staff and reminding them of the importance of communicating changes in a patient's condition. Ms E has also attended

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further training in relation to the nutritional needs of patients. Ms E disagrees that Mr A should have been referred to a dietician on his arrival, as his nutritional status was not considered an issue. She noted that Dr D did not consider such a referral necessary. Ms E's lawyer summarised her response:

> "While it seems there were deficiencies in the care provided to [Mr A] our view is that [Ms E] is not at fault for those deficiencies. [Ms E] was not responsible for [Mr A's] clinical care nor was she responsible for the oversight of clinical care at [the rest home]. [Ms E] was the Principal Nurse and Deputy Manager whose job required her to assist in the management of the facility. She had put in place suitable systems which allowed individual staff members to demonstrate their professional competencies under direction, monitoring and evaluation by [Ms E] and other staff members at [the rest home] … When she had raised the issue of her work volume impacting upon her ability to keep up to date with all patients/residents, to be able to offer advice or assistance as well as to be aware of any changes earlier, she was informed by [Ms M] that she did not have sole responsibility in this area. The rest home company advised her that other staff members 'must also take action, demonstrate proactive care intervention' and, particularly, to 'pass on information' appears critical to the failure of [the rest home] in respect of [Mr A] particularly given the requirement in [Ms G's] job description to report regularly to the Manager and Principal Nurse and to advise of any changes in a patient's/resident's condition and any other relevant matters. Had [Ms E] been aware of the failures she would have been in a position to take action to ensure that [Mr A's] rights were protected."

Ms F

As Ms F believed that Mr A's weight was continuing to fall despite the administration of two cans of Ensure a day (which she was told by the rest home staff that Mr A had been receiving), she stands by her decision to prescribe 2CalHN.

Ms F clarified that she reviewed Mr A in person on both 29 September and 5 October 2004.

Dr D

Dr D stated that her working diagnosis was the same as the hospital's — chronic pancreatitis and cancer, even though it was not recorded in her notes. She believed that she was dealing with a "palliative care situation and the main priority was pain control".

Dr D stated that when she requested a fluid balance chart in August 2004, this covered food intake as well, as would be routine. She stated, "I am aware and regret that it is not explicitly recorded in the notes."

Mr B

In relation to the rest home's statement that his father's weight had been "closely monitored", Mr B stated:

> "If this is their position, given the fact that my father sustained life threatening weight loss in their care with the subsequent fatal outcome for my father, [the rest home's]

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contention is tantamount to pilots flying their aircraft into the ground whilst 'closely monitoring' their instruments and disregarding other visual warning signs of peril."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 6
Right to be Fully Informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —

(a) an explanation of his or her condition; …

Opinion: Breach — The Rest Home and Hospital

The provision of care in a facility such as the rest home requires the involvement of a number of health care providers, working cooperatively. Many registered nurses were involved in Mr A's care provision. Ms M, Ms E, Ms G, Ms I, and every member of registered nursing staff who cared for Mr A all, to varying degrees, had responsibilities in relation to Mr A's care planning. However, despite the involvement of so many staff, it is clear that there was a significant failure to respond to Mr A's weight loss, a failure to manage his fluid intake, a failure to ensure his safety through appropriate supervision, and a failure to communicate with his family.

The failings in Mr A's care point to a deficiency in the systems at the rest home. From the time Mr A was admitted, the rest home was on notice of the need to address some of the systemic shortcomings that compromised the care provided to Mr A. In July 2003, as a result of a separate complaint to my Office, the rest home was required to introduce a referral process for the provision of care by allied health professionals, including dietitians. The rest home failed to implement such a process until February 2005. The rest home was also aware of the need to improve its care plans to ensure they reflected any significant changes in a resident's care. As for a policy on caring for residents with compromised

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nutrition — there simply was not one. As an organisation, the rest home failed to develop and manage proper systems, and this failure contributed significantly to the failings in Mr A's care.

Having reviewed the information provided, and considered carefully the responses to my provisional opinion, although there is evidence that individual members of staff failed to provide Mr A with an appropriate standard of care throughout his stay at the rest home, I consider that the causes were mainly systemic. In my view, the rest home breached Rights 4(1) and 6(1)(a). The detailed reasons for my decision are set out below.

Nutrition and weight loss

Mr A was an elderly and frail man who died with evident signs of starvation. This is inexcusable, particularly given that he had been a vulnerable and dependent resident of a rest home, receiving ongoing nursing and medical care. Three independent experts have advised me on the care provided to Mr A over an 11 month period — a general practitioner, a nurse with experience in rest home care, and a dietitian. All three experts have identified failings in Mr A's care, specifically in relation to his nutrition. My general practitioner expert, Dr Tessa Turnbull, stated that "The rest home and [Dr D] failed [Mr A] in not recognising his state of malnutrition at an earlier stage". My expert nursing advisor, Ms Jan Featherston, stated that "[Mr A's] nutritional management was poorly done", and a "major failure". My dietitian expert, Mrs Janelle Wallace, was "appalled that [Mr A] fell victim to such poor care, where staff presided over increasing malnutrition and starvation which contributed significantly to his death".

That Mr A lost a significant proportion of his weight from December 2003 to October 2004 is not evidence on its own of a breach of the Code, as there are a number of reasons why a man in Mr A's circumstances may lose weight. What is relevant is whether the rest home staff monitored Mr A's food intake and weight adequately, and appropriately responded to changes in his condition. Once Mr A was admitted to the public hospital, it was recorded on a number of occasions that he was eating and drinking well, albeit with assistance. I therefore conclude that Mr A could eat with appropriate assistance, diet and encouragement.

Despite the rest home's assertion to the contrary, Mr A was not weighed on a regular basis. No weight recordings were taken from January 2004 to the end of April 2004. I do not accept the rest home's explanations that staff did not have the opportunity to weigh Mr A in February and March 2004, and agree with Ms Featherston's comment that "it was not acceptable that [Mr A] was not weighed". I am concerned that following the family meeting on 11 March 2004, when Mr A's family was assured that he would be weighed monthly, Mr A was not weighed until the end of April. I do not accept the rest home company's response to the provisional opinion, that because Ms L and Ms F had recorded a weight for February, Mr A had been weighed. I comment below on my concerns about the record of weights. The rest home company also stated, in response to the provisional opinion, that Mr A weighed 43.7kg and 41.25kg in the public hospital. I am satisfied that the record of Mr A's weight on 4 November of 33kg was correct. As he had received feeding and hydration in hospital for five days, I believe that it is likely he would have

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weighed more than at admission. Accordingly, I do not accept the rest home company's contention, based on Dr Turnbull's advice, that Mr A weighed 41.25kg or 43.7kg on admission to the public hospital.

Even when Mr A's weight loss was recorded, the actions taken by staff were, on the whole, inadequate. Ms Featherston advised that following the fall in weight recorded in April 2004, a number of actions should have taken place, including weekly weights, use of a food chart, an evaluation of needs in relation to assistance required, a discussion with Dr D, and a discussion with Mr A's family. None of these occurred. Dietitian Mrs Wallace also advised that there should have been a family meeting called to discuss Mr A's weight loss and poor fluid intake.

Mrs Wallace advised that Mr A should have been referred to a dietitian on his arrival at the rest home, in December 2003; Ms Featherston advised that the referral should have been made in April 2004; Dr Turnbull advised that the referral should have been made in May 2004. Ms G stated that Mr A had been refusing to eat since March 2004. This clearly indicated the need to refer Mr A to a dietitian. When his weight in April showed an 11% fall in four months, there was a further indication of the need for referral. In the six months from April to September 2004, Mr A's weight loss was such that each month he fitted one or more of the three criteria set by Ms F and her colleagues as requiring referral to a dietitian.[7]

The rest home stated that Mr A was not referred to a dietitian (prior to September 2004), as staff had been encouraging Mr A to eat, and that they had been providing him with Ensure since 7 March 2004. The progress notes of that date state: "Given one can of Ensure to supplement diet." There was no change in Mr A's care plan, and the entry appears to document a one-off administration of Ensure. Indeed, there is no further reference to Ensure being given to Mr A until Ms G's comments two months later, on 18 May, and no record of any further administration of Ensure until September 2004.

In light of the decline both in Mr A's general health and his weight over a number of months, the rest home nursing staff's failure to refer Mr A to a dietitian at an appropriate stage is a major failing in the management of his care. When the referral was finally made, as Mrs Wallace stated, "[Mr A's] nutritional state was so poor … nothing [Ms F] could have done would have made a significant difference to [Mr A's] life expectancy."

When Dr D finally made a referral for a dietitian review, the rest home staff failed to act in a timely manner. The policy was that a phone call would be made to Ms F passing on Dr D's request, but this did not occur. Staff waited until Ms F was attending other residents, and then asked her informally to review Mr A. For such significant weight loss, the referral should have been made immediately after Dr D's decision on 22 September.

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[7] 10% loss in six months; 7.5% loss in three months; 5% loss in one month.

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Even after the feeding trial had failed, and Mr A's condition was deteriorating, there was no record kept on most days from 22 September to 31 October of how much Ensure Mr A consumed. The progress notes record that Mr A was given Ensure on only four of the 40 days in this period.

Ms Featherston advised that "all age care facilities should have policies and procedures for patients who have compromised hydration and nutritional needs. All text books identify the issues. Guidelines are readily available." There were no such policies in place at the rest home at the time of Mr A's residency.

In July 2003, in relation to another complaint to the Commissioner about the standard of care, the rest home stated that it would develop a referral process for the provision of allied health professionals, including dietitians. A protocol was introduced in February 2005.

Following the complaint made in July 2003, an audit of the rest home was performed in September 2003 for the Ministry of Health, and a Quality Improvement Action Plan (QIAP) formulated in November. The QIAP stated that lifestyle plans would be immediately updated "in line with any changes in care provision". There is ample evidence that this did not occur in Mr A's case. It is therefore clear to me that the rest home failed to action a vital requirement of the audit.

It is also clear that Mr A's food intake was variable at best, often low, and occasionally he refused to eat. This poor food intake was present from March 2004. A food chart should have been used to monitor the extent of the problem. The failure to accurately monitor Mr A's food intake contributed to an inability to assess and review the planned treatment. The lack of any integrated care planning process meant that Ms G's plan following Ms F's assessment on 5 October was not recorded anywhere, resulting in there being no clear plan for staff to follow. Even when a plan had been formulated, on 18 May, 22 September, and 19 October 2004, the care plan was not amended, and the clinical notes did not record the outcome or effectiveness of these plans.

In response to the provisional opinion, the rest home company stated that "it is the responsibility of all registered nurses to make relevant decisions relating to residents' care as determined by that resident's needs at that time". I can only surmise that by spreading the responsibility for care management so widely, no single person appears to have grasped hold of the situation, considered Mr A's condition, and acted appropriately.

In my opinion, the rest home breached Right 4(1), as the actions taken to monitor and manage Mr A's continuing weight loss were seriously inadequate.

Pain management

Pain management was clearly a challenging aspect of Mr A's care. Dr Turnbull commended Dr D's treatment of Mr A in this respect. However, Ms Featherston criticised the standard of care planning by the nursing staff, considering their management reactive and inadequate, and opined that Mr A's pain management was "a major failure in care".

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The nursing role associated with pain management is different from that of a medical practitioner; although Dr D visited on a regular basis, she was reliant on the nursing staff to advise her of Mr A's condition, including his pain management. Ms Featherston advised that Mr A's care plan "[did] not explain thoroughly enough nursing interventions that would either help with assessment interventions or evaluation of pain". Ms Featherston identified only one evaluation, on 1 October 2004: "Acupan for pain ... Cod. Phosphate gives [Mr A] constipation." Ms Featherston also identified on two dates that Mr A had been in pain, but there was no evidence of analgesia having been given (14 March and 3 April 2004).

I am satisfied, guided by Ms Featherston that Mr A's pain management by nursing staff at the rest home was below the standard to be expected. Accordingly, the rest home breached Right 4(1) of the Code.

Fluid balance management

According to his care plan, Mr A should have been drinking around 1500ml of fluid every day. It is clear that he required considerable encouragement to drink, yet it can be seen from the fluid charts in mid-February 2004 that he was able to drink up to 1200ml a day, with assistance and encouragement. Similarly, staff at the public hospital found that Mr A could drink well. However, throughout most of Mr A's residency at the rest home, his fluid intake was low.

In response to the provisional opinion, Ms E stated that at the meeting held with Mr A's family on 11 March 2004, the use of subcutaneous fluids "was rejected by the family who wanted comfort cares only to be given". Mr B disagrees with Ms E's recollection (which is not supported by the contemporaneous record), saying that only if there was a life-threatening event would the family object to the use of subcutaneous fluids. However, he also stated:

> "There was never any suggestion that [subcutaneous] fluids would not be used in the context of my father not drinking, or not being able to drink … because of his chronic illnesses."

The record clearly shows that Mr A received an insufficient fluid intake, and that on many days, despite requests from Dr D, and clinical indications that it was appropriate, an accurate fluid balance chart was not maintained. I accept that it is likely that the completion of the fluid chart would have been done by the caregiver staff, but it was important that the registered nurses supervising the caregivers monitored their actions, and took steps to ensure that appropriate care was taken.

The rest home's statement that Mr A's fluid intake was "monitored via Fluid Balance Charts during periods of increased medical frailty", is true only in a very generalised manner. Dr D's clear requests on 19 and 26 August to monitor Mr A's fluid balance were not complied with. Mr A would have been deteriorating in late October 2004 as he had ceased to eat, yet no record was made of his fluid (or Ensure) intake. Despite Mr A's deterioration in condition, including three recorded bouts of diarrhoea, his refusal to eat,

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and Ms F's plan to give regular Ensure, there was no record of Mr A's fluid intake from 2 September until his admission to the public hospital at the end of October.

I can see no evidence that sufficient actions were taken to ensure either that Mr A received an adequate fluid intake or that his fluid intake was accurately measured. The rest home was responsible for this failure and thereby breached Right 4(1) of the Code.

Supervision

Ms G, when giving her statement to the police officer, stated that the rest home was not a secure unit, and that Mr A was free to come and go as he wished. However, there is a significant difference between maintaining a resident's safety, and restricting his or her independence. Mr A was known to suffer from dementia and confusion, and would have been becoming increasingly frail in late October 2004, as he had stopped eating. The rest home should have taken greater care in ensuring that he was supervised. I am also concerned that Mr A left the premises at a meal time. By 31 October the trial feeding had been discontinued, but the rest home staff were still responsible for monitoring his food intake and should have been cognisant of his whereabouts.

Ms Featherston advised that it would be common for a resident's use of a wheelchair to be evaluated at regular intervals. Although there is some evidence that there had been an acknowledgement in the care planning documents that Mr A used a wheelchair for mobilising (such as Ms N's assessment on 20 March that Mr A "goes for walks outside in his motorised wheelchair", and Ms G's comment on 1 October that "[Mr A] is able to mobilise himself downstairs to have a cigarette"), I do not feel that this is evidence that Mr A's use of his wheelchair had been adequately assessed during his residency at the rest home, especially as he became noticeably more frail.

Ms E, in her response to the provisional opinion, stated that "[Mr A] would regularly leave the building to smoke and to take a short ride in his wheelchair around the block". This conflicts with the recollection of Mr A's daughter, who visited on a daily basis — to her knowledge her father never left the grounds unaccompanied. Mr B also recalls that at the meeting held in November 2004 after his father's admission to the public hospital, he felt that the rest home management were attempting to claim that it was normal for his father to be out of the grounds, and that under questioning from him, they modified their recollection of Mr A being outside the grounds from recently, to some months ago.

Mr B was originally told that his father had left the rest home via the front entrance; at the meeting involving the rest home's management, he was informed that his father had left via the rear entrance. In response to the provisional opinion, the rest home company now state that Mr A used the front door. Whichever exit was used, Mr A received insufficient supervision.

By failing to ensure that Mr A was adequately supervised, the rest home breached Right 4(1) of the Code.

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Communication with Mr A's family
When Mr A was admitted to the rest home, Mr B and his sister held an enduring power of attorney for their father's care and welfare, which entitled them to receive information and make decisions on his behalf, although there had been no formal assessment that Mr A was incapable of making some decisions about his care. Clause 4 of the Code provides that for the purposes of Right 6, "consumer" includes a person entitled to give consent on behalf of that consumer.

Mr A's son and daughter stated that they regularly raised their concerns with nursing staff about their father's weight loss and frail state in the latter four months of his residency at the rest home. In particular, Ms C, Mr A's daughter, told the nursing staff of her concern that he was not eating and was having difficulty drinking, and she was told that her concerns would be passed on via the communication book. However, there is no record in the communication book or the clinical notes of any concerns ever having been raised by Mr A's family relating to his eating or drinking. Ms C visited her father regularly. I consider it probable that she could see, on a day-to-day basis, that her father was having difficulty eating and drinking, and that she raised these concerns in the manner she described. Thus, another opportunity to identify Mr A's poor food and fluid intake was missed.

As Mr B held enduring power of attorney for his father's care and welfare, staff at the rest home were required to inform him of significant changes in his father's condition. Ms G stated that Mr A had been refusing to eat since March 2004, and this had not been communicated to his son. Mr A's family were also not aware of the extent of Mr A's weight loss, the attempts by staff to feed him in early October 2004, and the subsequent failure of that plan.

Ms Featherston considered the lack of communication with Mr A's family to be a major failing. She stated:

> "A family review involving the multidisciplinary staff would have given the family a chance to sit and have staff explain what cares were needed. It also gives the family a chance to ask questions and express their concerns if any."

Subsequent to Mr A's admission to the public hospital, Ms G wrote that staff at the rest home had attempted to feed Mr A, but he had refused; she ended her entry in the progress notes, "But we cannot force people to eat". I am concerned that the rest home staff did not feel that there was more that could have been done to assist and encourage Mr A with his eating. The rest home staff should have discussed this issue with Mr A's family, both to communicate the difficulties, and to actively involve the family in finding a solution to the problem.

An effective system of communication between Mr A's family and nursing staff was required because of Mr A's complex care needs. No such system was in place. In my opinion, the rest home breached Right 6(1)(a) of the Code by failing to keep Mr A's family properly informed about his condition.

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Breach — Ms E, Principal Nurse

I have commented above on the failings in Mr A's care, and stated that although there were examples of suboptimal care by individual members of staff at the rest home, a major cause of the poor care provided to Mr A was systemic in origin. A key individual member of staff with responsibility for Mr A's care was Ms E, the Principal Nurse.

Ms E stated that Ms M did not allow nursing staff to make a referral to a dietitian without a doctor's referral. However, there is no evidence that Mr A's weight loss was mentioned to Dr D at any stage prior to the referral to a dietitian being made in September 2004. I am also concerned by Ms E's statement that she "does not accept that the nursing staff can be held responsible for failing to refer Mr A to a dietitian at an appropriate time". The inadequate care provided to Mr A at the rest home involved a number of health professionals. Ms E's argument that as Dr D did not make the referral to a dietitian at an earlier stage, nursing staff are blameless, raises concerns about Ms E's understanding of a registered nurse's responsibility in the management and delivery of care in a facility such as the rest home.

Ms E claimed that during the meeting on 11 March 2004, Mr A's son and daughter were opposed to their father receiving subcutaneous fluids. This is not supported by the contemporaneous record made by Dr D, or her responses during the investigation. In addition, Mr B stated:

> "There was never any suggestion that [subcutaneous] fluids would not be used in the context of my father not drinking, or not being able to drink … because of his chronic illnesses."

Had Mr A's family made a statement that Ms E now claims, I believe that it would have been documented.

Although Ms E advised in her response to the provisional opinion that she "accepts responsibility for the quality of nursing care provided by [myself] and others", she goes on to blame others for the deficiencies in Mr A's care, mentioning Ms G, Ms M, Ms I, and all the registered nurses who cared for Mr A. I agree with her that other members of staff also bore some responsibility for the failings in Mr A's care identified during this investigation, but she was the Principal Nurse, and as such must accept some responsibility for the standards of clinical care provided at the rest home.

Ms E's job description is specific on a number of points that were her responsibility; these were not matters for which Ms M (as manager) was responsible, and which Ms E assisted her with. In particular, I note three key performance indicators in Ms E's job description:

> "Ensures staff practice facility protocols and procedures. …
>
> Ensures that each new patient is assessed on admission and at regular intervals as appropriate. …

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Ensures Lifestyle/Care Plans are implemented and evaluations recorded frequently."

Ms E may have delegated these responsibilities to others (such as Ms G or Ms I) but she remained responsible for ensuring that these performance indicators were satisfied.

In response to notification of the complaint, Ms E stated that she was "responsible for the oversight of clinical care provision". This is a clear and unequivocal statement that was not amended from when it was made in February 2005, to when the provisional opinion was released in December 2005. Having been sent a copy of the provisional opinion, in which she was criticised for failing to provide adequate clinical oversight, Ms E amended her stance, stating that this responsibility was actually Ms G's. A senior manager of the rest home company stated that Ms E was responsible for the clinical oversight at the rest home, describing the structure of clinical responsibility at the rest home as a pyramid, with Ms E at the top, and the registered nurses who cared for Mr A at the base.

Summary
In my opinion, Ms E failed to provide Mr A with services of an appropriate standard by failing to provide adequate clinical oversight. I accept that a number of other registered nurses were involved in Mr A's care, and that a significant portion of her time was spent on non-clinical matters. However, her job description was specific on her responsibilities, and the rest home company has advised that clinical oversight at the rest home was her responsibility. It is clear that Mr A's care was mismanaged, and Ms E, as Principal Nurse, must accept responsibility for this failure. Accordingly, she breached Right 4(1) of the Code.

Opinion: Breach — Dr D

Dr D regularly reviewed Mr A throughout his stay in the rest home. Dr Turnbull stated that Dr D responded to and treated Mr A's pain, hydration and catheter care appropriately. However, Dr Turnbull identified a failure by Dr D to recognise Mr A's malnutrition, stating that Dr D's peers would view this failing with mild disapproval "in view of her impeccable management of Mr A's general health problems".

One very easy way to monitor a person's nutritional intake is to perform regular weighs. At the three-monthly reviews she performed on 25 March and 12 August 2004, Dr D left blank the space on the form for the weight to be noted. Dr D stated that nursing staff had shown her the weight from the weight book on 25 March. However, Mr A was not weighed in March — the weight recorded in the weight book was not taken until the end of April, and was erroneously written in the March column.

On 18 May Mr A weighed 46.65kg, a drop of 11% in a month (in fact, less than a month as, according to the rest home, Mr A was weighed at the *end* of April). A week later, Mr A was seen by the on-call doctor who described him as cachectic. Dr D reviewed Mr A two days after the on-call doctor, and made no comment on his assessment, or Mr A's weight loss. Dr Turnbull considered that Mr A should have been referred to a dietitian at this stage. I find it hard to understand why Dr D failed to react to (or even document) a

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combination of a weight loss of 23% in the eight months since Mr A's admission, an 11% loss in one month, and an assessment by a colleague days earlier describing Mr A as being so thin that cancer was suspected. Dr D took no action in May 2004, and in particular made no referral to a dietitian.

On 12 August, Dr D did not write Mr A's weight on the assessment form, but again stated that she was shown the weight book by nursing staff. From July to August 2004, Mr A had lost 3.7kg, a 7.5% fall in one month, and 23% since December 2003. However, this significant weight loss did not result in any actions from Dr D. Had she been shown such a weight fall, Dr D should have reacted in some manner, at the very least by recording such a marked weight loss and referring Mr A to a dietitian.

Dr Turnbull stated that she had assumed that the nursing staff and Dr D had discussed Mr A's weight loss prior to 22 September. As there was neither action taken prior to 22 September, nor documentation of any discussion in the clinical record, I conclude that there had been no discussion. Even if there was any discussion, no action was forthcoming, and it is this failure to respond to Mr A's weight loss of which I am critical.

Dr Turnbull also stated that the three-monthly assessments were of a reasonable standard apart from a failure to record the weight. In my opinion, the assessment in August 2004 was not to an acceptable standard, as no action was taken in response to the significant fall in Mr A's weight that was present on this occasion. As the assessment in August was almost five months after the earlier assessment in March, I also believe that Dr D should have made greater efforts to perform the "three-monthly" assessment in a timely manner.

In response to the provisional opinion, Dr D advised that when she requested a fluid chart to be maintained on 19 August 2004, she intended this to include a measurement of food intake. She now regrets not having explicitly recorded this in Mr A's notes. However, had Dr D intended that a record of the food intake also be maintained, it is of concern that following her subsequent visit to review Mr A on 26 August, she made no documented assessment of the lack of food intake. Indeed, on this date, Dr D documented "managing better with fluids", yet on the five days prior to this review, according to Mr A's fluid chart, he had had no fluid intake at all.

Summary

Dr Turnbull advised that, in mitigation, Mr A had "concurrent and deteriorating medical problems". However, there is no evidence, either in documents provided or actions taken, that Dr D considered Mr A's weight from December 2003 until 22 September 2004, by which stage Mr A had lost over a quarter of his admission weight. Nor did Dr D respond to the on-call doctor's assessment of Mr A. In my opinion, Dr D failed to recognise and respond to Mr A's state of malnutrition, and thereby breached Right 4(1) of the Code.

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Adverse comment — Ms F

When Mr A was first brought to Ms F's attention on 29 September 2004, she did not have time to see him. She accepted Ms G's statement that Mr A had been receiving two cans of Ensure each day, and she was satisfied, at the time, that this was appropriate. Consequently, Ms F arranged a time to fully review Mr A on 5 October. My expert, Mrs Wallace, advised that the assessment performed by Ms F on 29 September, and the instructions given, were appropriate.

On 5 October, Ms F decided, on the basis of Mr A's clinical record, that the best treatment would be the prescription of 2CalHN, a high protein, high calorie supplement. However, Mrs Wallace advised that this prescription was unnecessary and inappropriate. Mrs Wallace based her view on the fact that if Mr A had been receiving two cans of Ensure daily, this would have "made a difference to his weight". As his weight was falling, Mrs Wallace concluded that Mr A was not actually receiving the Ensure in the quantities that Ms F had been told about, and that (before considering 2CalHN) Ms F should have confirmed the administration of Ensure by a review of food and fluid records prior to considering another supplement.

Guided by Mrs Wallace, I believe that Ms F should have asked more questions about the care provided to Mr A. Had she reviewed the clinical records more closely, she would have seen the poor documentation of Mr A's nutritional care, including inadequate fluid charts and, in particular, no evidence that Mr A had been receiving Ensure in the quantities advised to her by Ms G.

Summary
Mrs Wallace summarised her advice on Ms F's care:

> "[Mr A's] nutritional status was so poor [that] by the time [Ms F] was asked to provide assessment and advice, nothing she could have done would have made a significant difference to [Mr A's] life expectancy."

Although in my opinion Ms F provided a less than adequate standard of care to Mr A by prescribing 2CalHN, and failing to confirm the amount of Ensure being administered, I do not believe that this failing warrants a finding that she breached the Code.

Adverse comment — The rest home, Dr D and Ms F

Following Ms F's request for 2CalHN to be approved by Dr H, there was no effort made by staff at the rest home to review the progress of the application to Pharmac. Staff at the rest home, and Ms G specifically, knew of this application, and failed to follow it up. Consequently, the fact that the application was turned down on a technicality was not known until over three weeks after the application had been made.

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I am concerned that, following her review on 5 October, Ms F did not subsequently follow up her application to Pharmac for 2CalHN, as Mrs Wallace has advised that Pharmac approval is not automatic, and Ms F herself stated that "it is difficult to obtain approval for this product". I accept Ms F's point that she did not have open access to the rest home, but she had been asked to review Mr A, and she had a professional duty to follow up her application.

Dr D reviewed Mr A twice after Ms F's application for 2CalHN (7 and 21 October 2004) and should have been aware of the application. In my opinion she should have checked whether the application had been approved, in particular at her review on 21 October.

Mrs Wallace stated:

> "I am concerned that during the three weeks it took for the failure of Pharmac to approve 2Cal HN to be realised, there was no communication between the nursing staff, [Dr D] and [Ms F] about [Mr A's] progress."

In my opinion, there was poor co-operation between the nursing staff at the rest home, Dr D, and Ms F, which resulted in the rejection of the application for 2CalHN not being noticed for over three weeks.

In order to adequately manage Mr A's complex care, in particular his nutritional needs, a multi-disciplinary approach involving nursing staff, general practitioner, and community dietitian was required. Although I accept that Ms F became involved too late in Mr A's care, it is clear to me that the clinical staff involved in Mr A's care did not work together effectively to ensure that he had an adequate nutritional intake.

Other matters

Catheter care

There is minimal record of the catheter care that Mr A received, and there is no specific entry in his care plan to describe the catheter care required. Ms Featherston advised that catheter care should be documented in the care plan so that it can be accessed by all staff, in particular the agency nurses and caregiver staff. I accept Ms Featherston's summary that when the catheter care was documented, it was appropriate, but overall the documentation relating to catheter care lacked regular review and evaluation.

The rest home record of weights

Ms C spoke to an agency nurse who was caring for Mr A in October 2004, raising her concern over her father's frailty. The nurse informed Ms C that Mr A had not been weighed in August and September. However, on 4 November 2004, at the meeting held with The rest home management, Mr B noted that the August and September 2004 weights had been recorded. Mr B claimed that the rest home has subsequently amended the weight recording documentation. The rest home categorically denies that there had been any

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amendment to either the weight book or weight chart to show that Mr A had been weighed every month.

I am left with some misgivings about the information that the rest home has provided, in light of the information recorded contemporaneously by Ms F and Ms L. I believe that both Ms L and Ms F would have taken care in recording their assessment of Mr A's weight when performing their assessments of Mr A, as they were confronted with a patient with a history of significant weight loss. However, their contemporaneous records of Mr A's weight differ markedly from the rest home's records (see Appendix 2). The rest home company submitted that as Ms L and Ms F recorded a weight for February, one had been taken, but not recorded on any clinical record identified. I do not accept the rest home company's argument, in particular since the rest home company has previously stated that Mr A was not weighed in February or March.

Application for 2CalHN
Dr Turnbull commented on the process whereby Pharmac approves funding for nutritional supplements:

> "Although GPs and dietitians for frail or ill people may think nutritional supplements appropriate, the method of obtaining funding for these through Pharmac is cumbersome and slow. The application has to be made by a specialist physician, who in this case and in many others, will take the word of the GP/dietitian on faith and make the appropriate application. Minor technicalities, as in this case, may block the application."

As Ms F stated that the New Zealand Dietetic Association is currently working with Pharmac to enable dietitians to make the applications, I intend to send a copy of my final report to Pharmac to assist its deliberations.

Summary

In summary, I cite the following comments of my dietitian advisor and Mr A's son:

Mrs Wallace:

> "I am appalled that [Mr A] fell victim to such poor care, where staff presided over increasing malnutrition and starvation which contributed significantly to his death."

Mr B:

> "[The rest home's] contention [that Mr A's weight had been closely monitored] is tantamount to pilots flying their aircraft into the ground whilst 'closely monitoring' their instruments and disregarding other visual warning signs of peril."

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Recommendations

I recommend that Dr D review her practice, particularly in relation to regular reviews of residents of rest homes.

I recommend that Ms E review her practice in light of this case, in particular her monitoring of care planning at the rest home.

I recommend that the rest home:

- introduce regular training for nursing staff at the rest home on nutritional management;
- arrange an independent audit of the measurement of residents' weights;
- arrange an independent audit of compliance with fluid charts;
- arrange an independent audit of compliance with nutritional assessment of residents (both on admission and ongoing);
- arrange an independent audit of completion of care planning documents, and provide copies of these audits to the Ministry of Health and the DHB;
- arrange an independent audit of compliance with all aspects of the quality improvement action plan of November 2003.

Follow-up actions

- The rest home will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A copy of this report will be sent to the Medical Council, the Nursing Council, and the Dietitians Board.

- A copy of this report, identifying only the rest home, will be sent to the District Health Board, Healthcare Providers NZ, and the Director-General of Health.

- A copy of this report, with details identifying the parties removed, will be sent to Pharmac, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, at the conclusion of the Director of Proceedings' process.

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Addendum

The Director of Proceedings decided to issue proceedings before the Human Rights Review Tribunal. The proceedings were discontinued on the basis of a confidential settlement agreement.

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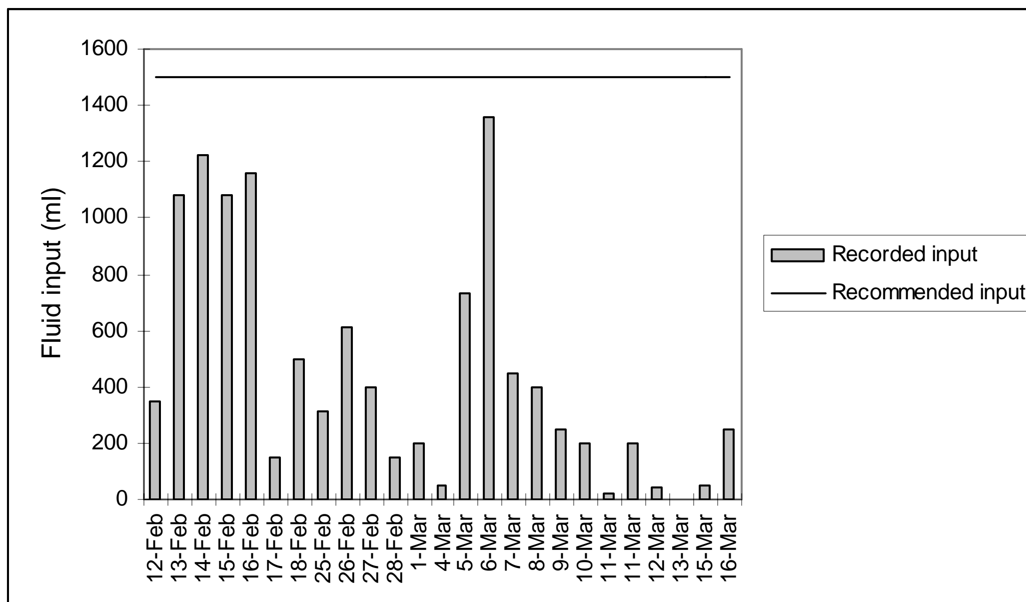
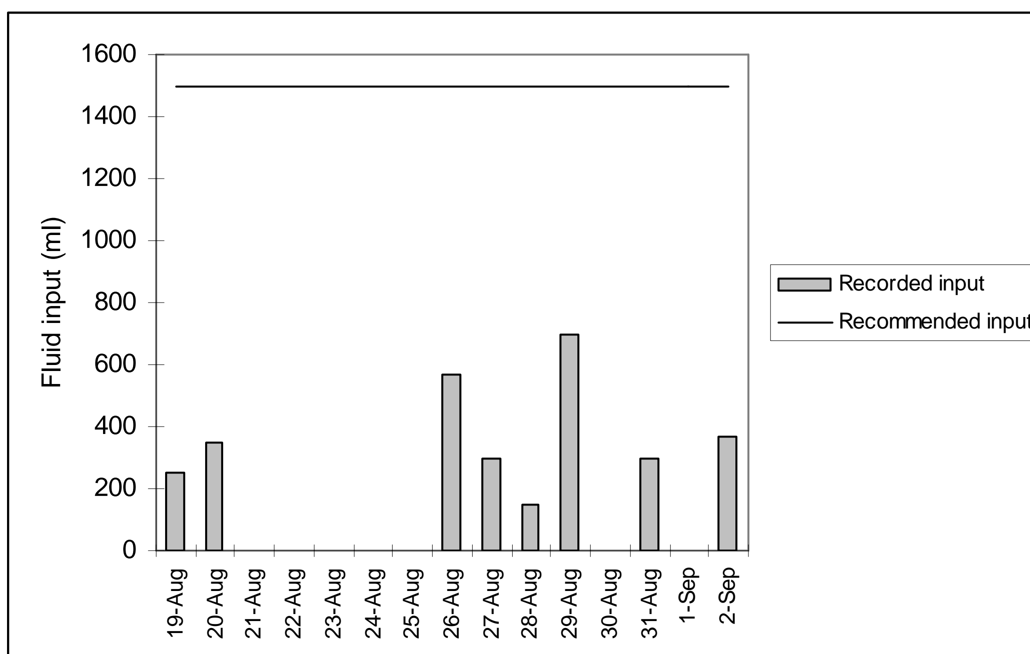
Appendix 1
Mr A's fluid intake as recorded on the fluid balance charts. The recommended fluid intake of 1500ml per day is the figure advised by Dr Tessa Turnbull, and is stated on Mr A's care plan as his planned fluid intake for a 24-hour period.

1.a. 12 February to 16 March 2004:



1.b. 19 August to 2 September 2004:



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Appendix 2

Mr A's weight from December 2003 to November 2004, as recorded by the rest home, Ms F ('Dietitian') and Ms L ('DHB audit'):