Fairview Care Ltd

A Report by the

Deputy Health and Disability Commissioner

(Case 11HDC00512)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2010[1], Mrs A (then aged 95 years) was admitted to a private hospital owned by Fairview Care Ltd (Fairview Care). Mrs A had a history of swallowing difficulties and weight loss, and she required a puréed diet. A month after admission, Mrs A's weight was recorded at 38.6kg.

2. Nursing assessments and a "Care Profile Summary" were completed at the time of Mrs A's admission. However, no initial short-term care plan was completed, and her long-term care plan was not completed until Month9. From Month3 to Month9, Mrs A appeared to be eating and drinking reasonably well and, by Month9, her weight had increased to 39.85kg.

3. In late Month10, it was noted that Mrs A might be dehydrated. Staff were advised to push fluids and to commence a fluid balance chart. In early Month11, the general practitioner (GP) noted that Mrs A was very underweight and recommended that she have a nutritional supplement. Her weight had dropped in Month10 and Month11. Mrs A started on the nutritional supplement Complan, but she continued to lose weight.

4. By Month15, Mrs A weighed 35.55kg. This was a loss of 10.8% over the previous six months. Although staff often observed that Mrs A was reluctant to eat, little was done to investigate or address her ongoing weight loss. On 15 Month15, Mrs A's care plan was updated. It was noted that Mrs A had been refusing to eat and that she appeared to prefer the assistance of particular staff. However, the care plan did not refer to Mrs A's puréed diet, the Complan, the fluid balance chart, or her ongoing weight loss.

5. On 1 Month16, Mrs A had an unwitnessed fall, but did not appear to sustain any injuries. Weight checks on 5 and 12 Month16 indicated that she was continuing to lose weight. Mrs A was due to be seen for her monthly GP review on 13 Month16. However, the GP did not have time to see all of the patients he was scheduled to that day, and Mrs A's review was postponed until the GP's next scheduled visit.

6. Before this could occur, Mrs A's condition deteriorated and, on 14 Month16, she was admitted to a public hospital. She was diagnosed with, and treated for, community acquired pneumonia with secondary aspiration pneumonia and silent aspiration. After a month in hospital, Mrs A was discharged to another private hospital. She died three weeks later.

Findings

7. The Deputy Commissioner found that there were deficiencies in the care provided to Mrs A by Fairview Care, particularly in relation to care planning, weight management and the response to her weight loss, and the assessment and monitoring of her nutrition and hydration.

[1] To maintain privacy, relevant dates are referred to as Month1-Month17.

8. In these circumstances, the Deputy Commissioner found that there was a lack of reasonable care and skill in the services provided to Mrs A by Fairview Care Ltd. Accordingly, Fairview Care Ltd breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[2]

Complaint and investigation

9. The Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs A, by Fairview Care Ltd. The following issue was identified for investigation:

   - *Whether Fairview Care Ltd (trading as Fairview Care) provided Mrs A with an appropriate standard of care between Month2 and Month16.*

10. This report is the opinion of Theo Baker, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

11. The parties directly involved in the investigation were:

Mrs A (dec)	Consumer
Mrs B	Complainant and consumer's daughter
Fairview Care Ltd	Provider

12. Information was reviewed from:

Mrs B	Complainant and consumer's daughter
Fairview Care Ltd	Provider
Ms C	Consumer's friend
A district health board	Provider
A medical centre	General Practice

13. Also mentioned in the report:

Ms D	Clinical Manager, Fairview Care
Mr E	Consumer's son
RN F	Registered Nurse, Fairview Care
RN G	Clinical Manager, Fairview Care
Dr H	General Practitioner
RN I	Registered Nurse, Fairview Care
Ms J	Nurse Assist, Fairview Care
Ms K	General Manager, Fairview Care

[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

14. Independent expert advice was obtained from a registered nurse (RN), Noeline Whitehead (see **Appendix A**).

Information gathered during investigation

Summary of events

Fairview Care

15. Fairview Care Limited (trading as Fairview Care) provides rest home and hospital level care for 47 residents, with a maximum of five rest home residents.

Mrs A, admission for respite care

16. In 2010 (Month1), Mrs A (then aged 95 years) had a two-week period of respite care at Fairview Care.

Admission for long-term care

17. On 7 Month2, Mrs A was readmitted to Fairview Care. During the first two days of her admission, Mrs A was seen by a GP,[3] the Clinical Manager, a physiotherapist, and an activities co-ordinator. Each completed and recorded their assessments. The GP noted the reason for Mrs A's readmission as falls. The nursing assessment completed by the Clinical Manager at that time, RN D, indicated that Mrs A was at medium risk of falls and at high risk of developing pressure areas. The nutrition and hydration assessment stated that she required a puréed diet and that her appetite was "average". The records provided to HDC do not include an initial short-term care plan. A "Care Profile Summary" was completed, but this did not include specific information about Mrs A's care and support needs, to guide staff caring for her. It did record that Mrs A was alert and orientated.

18. Mrs A's vital signs and weight on admission were not documented. They had been recorded at the start of her respite stay one month earlier, at which time Mrs A weighed 37.25kg.

19. On 5 Month3, Fairview Care requested a copy of Mrs A's medical records from the practice that she previously attended. The records, which were received on 15 Month3, showed that Mrs A's weight and weight loss had, from time to time, been cause for concern. In August 2007, Mrs A was reported to have had a two- to three-year history of steady weight loss. At that time, she was given advice on improving her nutritional status, initially with good effect. In late September 2007, Mrs A's GP at the time noted that Mrs A's daughter, Mrs B, was concerned that her mother was having increasing difficulties swallowing. Mrs A was referred for a barium swallow, the results of which indicated cricopharyngeal spasm,[4] mildly impaired oesophageal peristalsis,[5] and gastro-oesophageal reflux with tertiary contractions.[6] Mrs B told

[3] GP services were provided by a medical centre.
[4] Spasms that occur in the cricopharyngeus muscle of the pharynx.
[5] The rippling motion of muscles in the digestive tract.

HDC that the difficulty that her mother had with swallowing often resulted in prolonged coughing fits, which her mother called "the splutters". Mrs B said that the coughing made her mother anxious, and meant that she did not feel comfortable eating in the dining room.

20. Records show that Mrs A's vital signs and weight were checked on 9 Month3 and monthly thereafter, excluding Month7 and Month13. Additional recordings were taken during the first two weeks of Month16. On 9 Month3, Mrs A weighed 38.6kg.

21. On 22 Month3, Mrs A was assessed by the district health board's Needs Assessment and Service Co-ordination (NASC) service as eligible for permanent residential care (hospital level).

22. On 27 Month4, the DHB's Gerontology Nurse Specialist (GNS) assessed Mrs A in response to a referral from the NASC service. The report from the GNS assessment, dated 28 Month4, was apparently copied to the manager of Fairview Care and a doctor at the medical centre, although the report was not included in the records provided to HDC by Fairview Care. In relation to swallowing difficulties, the GNS wrote:

> "[Mrs A] is on puree diet and thin fluid due to some swallowing difficulty. I noted she coughs up after [drinking] water today. She reported that she enjoys puree meal. She denies any swallowing difficulties. No frequent chest infection noted. Due to potential aspiration/choke, she may benefit from eating meal with other [residents] in the [dining] room. If she loses weight, coughs frequently, changes voice after [eating or drinking] then consider [referring] her to community speech language therapist."

23. The GNS also noted in her report that Mrs A had a right hand contracture. Mrs B told HDC that her mother had Dupytrens contractures in both hands, particularly her right hand, and this affected her ability to use that hand, in particular her ability to hold hot drinks.[7]

Month4–Month14

24. Progress notes for the next six months indicate that, for the most part, Mrs A ate and drank well, and that she gained a little weight. By 4 Month9, Mrs A weighed 39.85kg.

25. On 10 Month9, RN F completed Mrs A's long-term care plan. Under "Nutrition and Hydration", it was noted that Mrs A had a good appetite. There was no reference to Mrs A needing a puréed diet.

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[6] Gastro-oesophageal reflux disease (GORD) is a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the oesophagus. Tertiary contractions are non-propulsive contractions, observed with increased frequency in elderly people.

[7] Dupytrens contracture is a slow-developing hand deformity, which occurs when knots of tissue form under the skin. These knots can eventually form a thick cord that can pull one or more fingers into a bent position.

26. In early Month10, Mrs A was having episodes of increased confusion, and she was treated for a urinary tract infection. Blood tests were arranged a fortnight later. Mrs B said that family were informed of this concern.

27. On 29 Month10, GP Dr H noted that Mrs A might be dehydrated. He advised staff to "push fluids and start fluid balance charts for one week". A fluid chart was started that day. Fairview Care provided HDC with fluid charts for Mrs A from 29 Month10 to 13 Month11, with no entries made on 3 and 4 Month11. Further charts were provided for the period 27 Month11 to 12 Month12. Fairview Care's Clinical Manager, RN G, advised that the fluid balance charts showed only the fluids given by staff, and that self-administered fluids were not recorded.[8] RN G acknowledged that this was an area requiring policy and procedure improvement, to ensure more adequate and accurate recording. The charts that were provided indicate that Mrs A's fluid intake fluctuated. The maximum recorded intake during this period was 1460mls (29 Month10), and the minimum recorded intake was 180mls (7 Month11). The charts did not record Mrs A's urinary output. Mrs B told HDC that on occasion, her mother stayed with her and her husband for a few days. Mrs B said that they were never asked to measure, check, or record her mother's fluid intake at these times, or during visits to her mother at Fairview Care.

28. On 4 Month11, Mrs A's weight was recorded as 37.5kg. On 8 Month11, Dr H noted that Mrs A was "very underweight". He considered that Mrs A would probably benefit from a dietary supplement, but that it was "not critical" and public funding would not be available for this. RN G wrote in the progress notes that she had discussed this with Mrs B. RN G wrote that Mrs A's family fully supported Mrs A having a food supplement and would cover any cost. Mrs B said that family were not informed that the doctor considered her mother to be "very underweight".

29. The fluid balance chart indicates that Mrs A started having the nutritional supplement Complan on 10 Month11, although there are no references in the progress notes or on the care plan to confirm this, or to indicate the amount and the frequency with which it was to be given. On 14 Month11, it was noted in the progress notes that Mrs A enjoyed her Complan. As noted above, the fluid balance charts provided to HDC for the period 29 Month10 to 12 Month12 do not include records for each day. Within the records that were provided, there are references to Mrs A having had Complan on three days. Mrs B recalled that occasionally her mother spoke of enjoying a "fruit smoothie drink". Mrs B said that family never saw these, so they concluded that the drinks were an "occasional extra". Mrs B now thinks that these may have been the Complan.

30. On 15 Month11, RN G noted in the "Family Contact Record" that she had spoken with Mrs B again, and that one of the issues they had discussed was the need for Mrs A to wear her dentures every day. Records indicate that Mrs A appeared reasonably well over the next two to three months. No major concerns were identified during her monthly GP reviews between Month12 and Month14.

[8] RN G commenced as Clinical Manager on 6 Month4.

Month15

31. On 8 Month15, Mrs A weighed 35.55kg. She had lost 4.3kg (10.8%) in six months. On 10 Month15, Mrs A was reported to be unwell and not eating or drinking. A urine dipstick test indicated that she might have a urinary tract infection. Later that day, RN I found Mrs A choking on her dinner. RN I noted in the progress notes that she had removed some food from Mrs A's mouth and Mrs A had coughed for about ten minutes, and that she was being monitored by staff.

32. Mrs A had her monthly GP review the following day. Dr H noted that Mrs A was "in good form". She was commenced on antibiotics for a suspected urinary tract infection.

33. On 12 Month15, the progress notes record that Mrs A was "cheerful with no new problems", and that she had been commenced on a "Complan fluid balance chart — to record the complan given".

34. RN G advised HDC that staff had assured her that fluid balance charts were completed in 2011, but she had been unable to find these.[9] In response to my provisional report, Fairview Care provided fluid balance charts for the period from 12 Month15 to 14 Month16. These show that Mrs A's fluid intake was recorded on 20 of 34 days. On 15 of those days, fluid intake included Complan. The maximum recorded fluid intake during this period was 760mls (20 Month15), and the minimum recorded intake was 150mls (15 Month15). Fairview Care noted that these charts also recorded urinary output. While it is correct that on some days, there is reference in the output section of the charts to Mrs A having toiletted or passed urine, there was no output measure.

35. Mrs B told HDC that no fluid balance charts were seen by any of her mother's regular visitors, or commented on by Mrs A or any of her regular caregivers.

36. On 15 Month15, RN F updated Mrs A's care plan. In relation to nutrition and hydration, RN F noted:

> "Prefers to stay in room; needs a lot of time to encourage to eat or even assist — prefers only particular staff; noticed to be refusing to eat lately.
>
> Drinks independently."

The care plan was not updated to include the changes identified during RN F's evaluation, nor did it include the order for Complan, which had been made in Month11, and Complan monitoring. Mrs B told HDC that it was true that her mother preferred to eat in her own room, and that it took her a long time to complete a meal — at least 35 minutes during the latter stages of her stay at Fairview Care. Mrs B said that while her mother had a special affinity with some staff, she often spoke of all staff being kind and friendly.

[9] RN G surmised that the missing fluid charts were either forwarded to the facility Mrs A subsequently moved to, or misfiled. The new facility advised HDC that it received no documentation from Fairview Care.

37. On 17 Month15, Nurse Assist Ms J recorded in the progress notes:

> "[Mrs A] wasn't quite ready when [Ms C][10] came to collect [her] this is no fault of the staff, because [Mrs A] wouldn't allow anyone else to put her teeth in, except myself. I was busy giving out Meds, so she wouldn't eat breakfast until after I had completed my round. Discussed this with [Ms C] & she is well aware of how tricky [Mrs A] can be @ times she was going to inform [Mrs B] …"

38. Mrs B told HDC that it was difficult to place her mother's dentures correctly and without inadvertently hurting her, but some people, including Ms J, were able to do this more successfully than others.

39. On 18 Month15, Ms J noted in the progress notes that it was taking Mrs A a lot longer to eat, even when she was wearing her dentures.

40. On 22 Month15, Ms J wrote in the progress notes:

> "Noted [Mrs A] is not eating, not sure why
> — Has been given the complan as instructed. x2 on my shift.
> — ate pudding but has been leaving the main meal Daily
> — She might be experiencing swallowing difficulties as I've seen her with a plastic bag & tissues & bit & pieces of food amoungst [sic] it, please monitor & observe.
> — Quiet and happy in herself …"

41. On 23 Month15, a urine culture result indicated that Mrs A did not have a symptomatic urinary tract infection. A 10.30pm entry in the progress notes records that Mrs A was demonstrating some "strange behaviour" during dinner, making "some really strange movements with her body and head". Mrs B told HDC that family were not informed of this, but at times her mother's movements indicated general restlessness. Mrs B said that her mother's legs were "always twitching", which she understands to be a symptom of hyperthyroidism.

42. The next morning, it was recorded that Mrs A was cheerful and brighter. That night she was noted to have been quieter than normal.

43. On 29 Month15, Ms J noted in the "Family Contact Record":

> "[Mrs B] phoned regarding her mum, she felt that it has got to the stage where staff need to feed her, but I explained that [Mrs A] refused and wants her independence, we will offer to assist. [Mrs B] realises that her Mum has deteriorated quite a lot. Re: the teeth problem explained that [Mrs A] won't allow many staff to put them in. [Mrs B] is happy with all that we do, but we both agreed that she needs more help of late."

44. On 31 Month15, RN G noted that she had met with Mrs B to discuss Mrs A's care and general condition. RN G noted that Mrs B was to come in the following week to

[10] Ms C was a friend of Mrs A who visited regularly.

sign a multidisciplinary/family meeting form, and that Mrs A's resuscitation status was to be discussed with her son-in-law, Mr B, and her son, Mr E. Mr B and Mr E were referred to as having enduring powers of attorney. RN G noted that the discussion had included "difficulty swallowing and risks", "appetite, nutrition/hydration", and "age-related deterioration + UTI". RN G also noted that Mrs A preferred only certain staff to assist with her care, including putting in her dentures.

45. In response to my provisional report, Mrs B commented that she approached RN G and they talked for a few minutes, but she would not describe this as a "meeting". Mrs B recalled that they briefly discussed the forthcoming meeting, resuscitation status, and that Fairview Care's policy required residents' medications to be discussed every six months.

Month16

46. At 3.20am on 1 Month16, a healthcare assistant found Mrs A on the floor, next to her toilet. There were skin tears to her left elbow and lower left leg, but no evidence that she had hit her head. The skin tears were dressed and Panadol was given. Mrs A's oxygen saturation levels were low, so she was given oxygen for a few hours. Her neurological observations were checked hourly for four hours following the fall. The records show that an incident form was completed, and Mrs B was advised later that morning of Mrs A's fall. Mrs B confirmed that she was informed promptly, and was satisfied with the response and follow-up care.

47. By 5 Month16, Mrs A's weight was 34.9kg. Her blood pressure that day was 108/71 mmHg, pulse 98 beats per minute (bpm), respirations 20 breaths per minute (BPM), temperature 36.9°C, and oxygen saturations 96%.[11]

48. Mrs B told HDC that when she went to visit her mother on 9 Month16, she found her distressed, cold, and without her dentures. The progress notes from that day record only that "[Mrs A] has been her usual self, assisted as required. Not eating well, complan given". Mrs A's vital signs were checked again. Her blood pressure that day was 116/64 mmHg, pulse 84 bpm, respirations 16 BPM, temperature 36.8°C, and oxygen saturations 93%.

49. By 12 Month16, Mrs A weighed 33.5kg (a 2.05kg weight loss in five weeks). Her blood pressure was 106/83 mmHg, pulse 92 bpm, respirations 19 BPM, temperature 36.8°C, and oxygen saturations 93%.

50. That day, Ms J wrote in the progress notes: "Noted when putting [Mrs A's] teeth in a lot of secretion ? in throat or the chest, coughing more than usual this afternoon."

51. Mrs A was scheduled to be seen for her monthly GP review on 13 Month16. Records from Fairview Care show that Dr H saw seven patients that day, including four palliative care patients and two new patients. Mrs A was one of four patients scheduled for a GP review but who were not seen that day. In its response to HDC,

[11] Normal measurements for the average healthy adult are: blood pressure 110–130/70–90 mm/Hg; pulse 60–80 bpm at rest; respirations 12–18 breaths per minute (BPM); temperature 36.3–37.3°C; oxygen saturation 96–99%.

Fairview Care stated that it was under "extreme pressure due to an increased workload during this period", and the doctor was on site for two hours and had to manage his time accordingly. Fairview Care noted that when Mrs A's review was postponed, her observations, as recorded the previous day, were stable. The family was not advised that Mrs A's appointment had been deferred. Mrs B told HDC that had they known that the appointment had been postponed, she and her husband would have taken her mother to their doctor.

52. That same day (13 Month16), Ms J noted that Mrs B had telephoned regarding her concerns about Mrs A, and that Ms C had also commented on the deterioration in Mrs A's condition. RN G also documented that she had spoken to Mrs B, who had requested another care review meeting. RN G noted that she would arrange this and that she would contact Mrs B to confirm a meeting time once she had checked who was Mrs A's primary nurse, so that he or she could also attend. Fairview Care subsequently advised HDC that Mrs A's primary nurse from Month2 to Month16 was RN F. In response to my provisional report, Mrs B said that as no meeting had yet been held, this was not a request for a second meeting. Mrs B said that no care/care review meeting was held at any time during her mother's stay at Fairview Care. Mrs B also noted that family were not previously aware that Fairview Care had a "primary nurse" system, they did not meet RN F, and they were never informed of her involvement in Mrs A's care.

53. At 4pm on 14 Month16, Mrs A's vital signs were recorded as temperature 36.9, pulse 111 bpm, respirations 24 BPM, blood pressure 119/87 mm/Hg, and oxygen saturation 81%. It was noted that Mrs A was very pale. At 5pm, Mrs A started vomiting, and she was noted to be cold, clammy, and short of breath. RN I telephoned Mr E, and then an ambulance was called. Mrs A was transferred to a public hospital, where she was diagnosed with, and treated for, community acquired pneumonia with secondary aspiration pneumonia and silent aspiration. Mrs B said that before Mr E was contacted, she was contacted by Ms C, who had been visiting Mrs A. Ms C told Mrs B that Mrs A was extremely unwell and should be collected immediately.

54. Mrs B states that her mother was also admitted to hospital with serious dehydration. Mrs B recalled that when she arrived at hospital, a doctor informed her that her mother's condition was critical and that she might not survive the night. Fairview Care disagrees that Mrs A was dehydrated on admission to hospital. There is no reference in Mrs A's clinical records from hospital to indicate that dehydration was a symptom on admission.

Public hospital admission

55. Mrs B stated in her letter of complaint that her mother's weight on admission to hospital was 27kgs. The clinical records from hospital show the following:

- On 14 Month16, Mrs A's weight was 33.6kg (original recording not evident in records, but documented in a Speech Language Therapy assessment on 15 Month16 and a Dietetic assessment on 18 Month16).

- On 15 Month16, Mrs A's weight was 32kg (recorded on "Initial Assessment and Risk Screen" and "Malnutrition Screening" forms).
- On 29 Month16, Mrs A's weight was 27kg (recorded on "Initial Assessment and Risk Screen" form).
- On 2 Month17, a dietitian noted: "Weight 32kg (on [rest home] scales), 27kg 29 [Month16] on ward. likely [decrease secondary to] different scales and minimal nutrition prior to [nasogastric] feed."
- On 4 Month17, Mrs A's weight was 29.3kg (recorded on "Weight Chart").
- On 10 Month17, Mrs A's weight was 30.4kg (recorded on "Weight Chart").

56. During her admission, it was determined that Mrs A's swallow was irreversibly impaired, and that nasogastric feeding was needed to minimise the risk of further aspiration. This was commenced on 24 Month16.

57. On 12 Month17, Mrs A was discharged to a private hospital. She died three weeks later.

Written complaint

58. On 18 Month16, Mrs B wrote to Fairview Care's General Manager, Ms K, outlining her concerns about the care that had been provided to her mother. Mrs B noted her requests for a care review meeting and for her mother's care plan to be reviewed. At that stage, Mrs B was anticipating that Mrs A would return to Fairview Care.

59. In her complaint to HDC, Mrs B stated that she did not receive a response to her letter.

60. On 20 Month16, Ms K wrote in the "Family Contact Record" that she had left a message on Mrs B's phone. The following day Ms K noted that she had left a further message but received no response to either message. Ms K advised HDC that the purpose of her calls was to arrange a meeting with Mrs B.

61. Fairview Care has provided HDC with copies of its telephone records, confirming that calls were made to Mrs B's number on 20 and 21 Month16. Mrs B advised HDC that she did not receive any messages on her answerphone, and that she could not explain records suggesting messages had been left. Mrs B considers that the messages should have been followed up with an email or letter.

62. On 26 Month16, Mr E emailed Ms K to confirm that Mrs A was no longer a resident at Fairview Care, and that her room had been vacated on 23 Month16. Ms K states that this email led her to believe that Mrs A's family did not want any further contact and, accordingly, she did not attempt to contact them again.

Aqueous cream

63. Mrs B also raised a concern that aqueous cream that had been prescribed for another resident was found in her mother's room. RN G confirmed that no cream had been prescribed for Mrs A but staff had confirmed that they did use aqueous cream to

moisturise Mrs A's legs. RN G agreed that it is inappropriate for one resident's cream to be used on another resident, and said that if that was happening previously, it is not now.

Advance directive

64. In Month1, when Mrs A was admitted to Fairview Care for respite care, an "Advanced Directive" document was signed by Mr E. This confirmed that in the event of serious illness, advanced illness or cardiac arrest, Mrs A should be given active treatment and resuscitation. In a section entitled "ADVOCATE/FAMILY MEMBER", it states that the signatory had not been appointed as Enduring Power of Attorney (EPOA) and so did not have the authority to make decisions regarding these matters, but "as the resident is unable to express their wishes, your decisions will be given serious consideration should any of the situations arise". There is no evidence to indicate that Mrs A lacked the capacity to make or communicate decisions regarding her personal care and welfare. Mrs B said that family agree this was so.

Additional information from Fairview Care

65. In its response to this complaint, Fairview Care submitted that Mrs A was a very independent woman who, in the later months of her admission, increasingly expressed a desire not to eat. Fairview Care stated that staff provided assistance with meals and drinks but there were times when this assistance was refused. Staff also found food hidden in tissues.

66. In response to preliminary advice from my independent nursing expert, Noelene Whitehead, Fairview Care disagreed that Mrs A's weight was not adequately monitored or taken to be a serious matter. Fairview Care noted that Mrs A was put on a puréed diet on admission and that she gained weight over the first six months of her stay at Fairview Care. It noted the use of a nutritional supplement and fluid balance charts once Mrs A began to lose weight. Fairview Care submitted that it became increasingly difficult for staff to monitor and assist Mrs A with meals as she frequently refused to eat, and that "staff did all they could to assist [Mrs A] with weight gain".

67. Ms K advised HDC that she and Mrs A developed a strong bond from the time of Mrs A's arrival. Ms K noted that in the last four months of Mrs A's stay at Fairview Care, she became more reclusive and would sometimes not engage in conversation. Ms K noted Mrs A's apparent refusal to eat. Ms K stated:

> "Given that this is most residents' final home you become aware of [residents'] lives drawing to a close and I personally felt this was so in [Mrs A's] case. There is a frequent conflict of interest with the resident often choosing what they wish to do and having the mental capacity to do so. This may, however, be at odds with the wishes of the family."

Care plans

68. Fairview Care's **Resident Admission Policy** (current at the time) required that, on admission, new residents and their families be orientated to the facility, a nursing

assessment be completed together with the resident/relative/agent, and an initial short-term care plan be developed. The policy further stated:

> "Following 1–2 weeks of observation and feedback from staff a more definite care plan is developed ... All care plans are reviewed every six months or more often if resident's circumstances or condition changes."

69. Fairview Care advised HDC that responsibility for assessing, developing, implementing, and evaluating the individualised plan of care of each resident lay with that resident's primary nurse.

70. RN G advised HDC that updating care plans was "one of the nurses' weaknesses here at Fairview, and one of the areas which I have been getting up to standard since commencing employment with Fairview". Fairview Care acknowledged that Mrs A's care plan was not always kept up to date, with items in the progress notes not transferred to the care plan. However, Fairview Care submitted that this in no way compromised the care provided to Mrs A.

Weight Loss Management Policy

71. Fairview care's **Weight Loss Management Policy** (current at the time) stated: "A well-accepted definition of clinically important weight loss is 5% over a period of 6–12 months."

72. Under "Procedure", the policy stated:

> "The first priority in managing weight loss is to systematically identify and treat the underlying causes.
>
> The following steps should be taken as strategies:
>
> A. Assess dietary intake or screen for malnutrition.
> i. Use the Bapen 'MUST' Tool[12]
> ii. Check records i.e. weight chart to establish pattern …"

73. The policy states that a probable or definite cause for the weight loss should be identified. It then specifies a range of treatments to be considered, including measures such as optimising energy intake with high energy and protein foods, ensuring adequate oral health, providing nutritional supplements between meals, and other nutritional support such as involving a dietitian or nutritionist.

74. The policy stated that if no reversal or weight gain occurs, other options should be considered in consultation with the medical team, resident, family/whānau, and EPOA.

[12] The BAPEN (British Association of Parenteral and Enteral Nutrition) "MUST" (Malnutrition Universal Screening Tool) is a screening tool that helps identify adults who are malnourished, at risk of malnutrition, or obese. No BAPEN tool was completed for Mrs A.

75. The policy required interventions to be reviewed on a monthly basis, until weight gain was evident and the targeted outcome was achieved.

Advance directive

76. Fairview Care's **Healthcare Advanced Directives Policy** (current at the time) states:

> "The Patients' Right to Decide
>
> All adult individuals in health care facilities such as rest homes hospitals, hospices and home health agencies, have certain rights under the law.
>
> …
>
> Advance directives only come into consideration once patients lose their mental capacity, are unconscious or otherwise unable to communicate …"

77. Fairview Care's **Resuscitation Protocol and Policy** (current at the time) begins:

> "Who should sign a resuscitation form where a person is not competent?
>
> Only a competent consumer can.
>
> Where a person is not competent, no person — not their legal representative nor their GP — can make an advance choice about resuscitation.
>
> …"

78. Fairview Care has acknowledged that it was in breach of Fairview Care's policies to have the advance directive signed by a family member rather than by Mrs A herself. Fairview Care stated that the Clinical Manager at the time was "not up to speed with proper processes and procedures".

Changes made by Fairview Care

79. Fairview Care advised HDC that in light of this complaint it has updated its policies, including:

- assisting a resident to eat;
- the nutritional policy, which covers nutrition and hydration, and weight loss;
- the resuscitation protocol and policy, which covers advance directives;
- management of falls;
- accidents and incidents; and
- adverse event/exception reporting.

80. Fairview Care also advised that it has conducted training sessions for its staff on:

- care plans and care planning;
- advance directives and the need to have them signed by the resident if the resident has mental capacity to do so; and

- communication with residents' families — what they are expected to communicate to a family, including changes to a resident's health status.

81. Other changes implemented by Fairview Care include:

- a requirement for staff to complete progress notes during the last hour of each shift; and
- increased contractual hours for in-house GP visits by the medical centre from two to two and a half hours per visit.

82. In response to my provisional report, Fairview Care advised that it has also improved its policies around care plans, improved its staff training in relation to care plans, and improved the audit and monitoring of care plans by the Clinical Manager.

HealthCERT audit

83. Fairview Care was audited by HealthCERT on 18 and 19 July 2011. It was noted in the audit report that there were eight required improvements including ensuring care plans clearly reflect the needs assessed and that care evaluations describe the degree of achievement. HDC was subsequently advised that Fairview Care met all corrective actions within the required timeframe.

84. Fairview Care was also the subject of a surveillance audit in January 2013, which noted that areas identified for improvement in the previous audit were now fully attained. Fairview Care provided HDC with the results of the surveillance audit in relation to care plans.

Responses to provisional report

85. Relevant information from the responses to my provisional report has been incorporated above. The following comments are also noted.

Fairview Care

86. Fairview Care stated that while it accepts that its documentation is open to criticism, staff were alert to, and seriously concerned about, Mrs A's weight loss. Fairview Care stated that staff instigated a number of measures to address Mrs A's weight loss, including: assisting her with feeding and changing staff around to ensure that her preferred staff were on hand whenever possible; making up Complan for her; feeding her a puréed diet; and assisting her with putting her dentures in. Fairview Care stated further that the 3.2% increase in Mrs A's weight between Month3 and Month9 was a direct result of staff taking the matter seriously.

87. With regard to its policy on involving a dietitian or nutritionist, Fairview Care advised that generally the nurses at Fairview Care would discuss such involvement with the GP in the first instance. Fairview Care said that, with the benefit of hindsight, as the

GP was not in a position to see Mrs A in Month15, it may have been beneficial on this occasion to seek such involvement without GP input.[13]

88. Fairview Care stated that it did seem to be the case that Mrs A refused to eat, as staff sometimes found food that she had hidden. Fairview Care said that again, it accepts that its documentation is open to criticism, but on occasion the staff with whom Mrs A had a particularly good relationship discussed her eating habits with her.

Mrs B

89. Mrs B said that she disagrees that staff offered her mother assistance with eating meals. Mrs B said that at no time did they witness staff feeding her mother or assisting her to eat. Mrs B said that her mother ate well following her move to another private hospital, where it was routine for an RN to feed residents with high risk problems. Mrs B said that as a result, her mother did not feel as though she was a nuisance even though staff were busy.

90. Mrs B said that she believes that staff looking after her mother cared about her weight but lacked the training, support, and time to deal with her mother's possible dehydration and her weight loss.

91. Mrs B said that she saw no evidence that her mother hid food or spat out food, but she was of the "waste not want not" generation, so if she did not finish something, such as a scone, she would sometimes wrap it in a serviette to eat later.

Other relevant standards

92. New Zealand Standard Health and Disability Services (Core) Standards (NZS 8134.1:2008) include:

> "3.5 Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery. …
>
> 3.8 Consumers' service delivery plans are evaluated in a comprehensive and timely manner. …
>
> 3.13 A consumer's individual food, fluids and nutritional needs are met where this is a component of service delivery."

93. The Aged-Related Residential Care Services Agreement includes the following requirements:

> "D16.3 Care Planning
>
> You must ensure that:

[13] Mrs A was in fact reviewed by the GP on 11 Month15.

a. Each Subsidised Resident has a Care Plan and that all staff follow the Care Plan;

…

c. Each Care Plan is developed, documented, and evaluated by a Registered Nurse within 3 weeks of the Subsidised Resident's admission;

d. Each Subsidised Resident's Care Plan is reviewed by a Registered Nurse and amended where necessary to ensure it remains relevant to address the Subsidised Resident's current identified needs and health status;

…

i. That a Registered Nurse is responsible for ensuring the plan reflects the Subsidised Resident's assessed physical, psychosocial, spiritual and cultural abilities, deficits, and needs;

j. Each Care Plan focuses on each Subsidised Resident and states actual or potential problems/deficits, and sets goals for rectifying these and details required interventions;

k. Short-term needs together with planned interventions are documented either by amending the Care Plan or as a separate short-term Care Plan attached to the Care Plan;

l. Care Plans are available to all Care Staff and that they use these Care Plans to guide the care delivery provided according to the relevant staff member's level of responsibility.

D16.4 Evaluation

a. You must ensure that each Subsidised Resident's Care Plan is evaluated, reviewed and amended either when clinically indicated by a change in the Subsidised Resident's condition or at least every six months, whichever is the earlier.

…"

Opinion: Breach — Fairview Care Ltd

Introduction

94. In Month2, Mrs A was admitted to Fairview Care for long-term hospital level care. Mrs A was alert and orientated, and independently mobile. However, at 95 years old, she was becoming increasingly frail. A month after admission, Mrs A's weight was 38.6kg.

95. Fairview Care and its staff owed a duty of care to Mrs A. This duty of care included ensuring that its policies and procedures were consistent with relevant standards, and that staff complied with those policies and procedures.[14] Without staff compliance,

[14] See Opinion 11HDC00471 (25 June 2013), available at www.hdc.org.nz.

policies are of little value, and compliance requires effective oversight and monitoring of staff by the organisation. This Office has made similar statements on a number of occasions,[15] and further:

> "The inaction and failure of multiple staff to adhere to policies and procedures points towards an environment that does not sufficiently support and assist staff to do what is required of them. [The rest home] as an organisation must bear overall responsibility for this."[16]

96. The New Zealand Health and Disability Sector Standards (see above) require that rest homes ensure that the operation of their services is managed in an efficient and effective manner, which ensures the provision of timely, appropriate, and safe services to consumers.

97. In my view, there were deficiencies in the care provided to Mrs A by Fairview Care, particularly in relation to care planning, weight management and the response to her weight loss, and the assessment and monitoring of her nutrition and hydration. For the reasons set out below, I find that Fairview Care failed to provide services with reasonable care and skill and, accordingly, Fairview Care breached Right 4(1) of the Code.

Care planning

98. Effective care planning is fundamental to the provision of good residential care. It is a means by which a resident's physical, mental, social, and emotional well-being is evaluated and acted upon. A documented care plan enables multiple staff to ensure the provision of care consistent with a resident's needs. It ensures that as a resident's needs change over time, care provision is appropriately modified. In settings where care is provided by both registered and non-registered staff, a comprehensive assessment, planning, implementation, and evaluation process is essential. This is the responsibility of registered healthcare providers. It is the proper documentation of this process that ensures continuity of care.

99. Fairview Care's Resident Admission Policy required an initial short-term care plan to be completed on admission, and a more detailed care plan to be completed within one to two weeks of admission. Mrs A was assessed on admission by the clinical manager, but there is no evidence from the records provided to HDC that an initial short-term care plan was completed. A "Care Profile Summary" was completed, but this did not include specific information about Mrs A's care and support needs, to guide staff caring for her. Moreover, Mrs A's long-term care plan was not completed until 10 Month9, more than seven months after her admission. This was not acceptable. The fact that Mrs A was without a long-term care plan for such an extended period suggests that Fairview Care did not have an effective system in place to monitor the completion of care plans.

[15] Opinion 09HDC01974 (21 June 2012), Opinion 07HDC16959 (20 May 2008) and Opinion 10HDC00308 (29 June 2012).
[16] Opinion 09HDC01783 (28 March 2011) p 23.

100. The initial nursing assessment recorded that Mrs A had an average appetite and that she required a puréed diet. Her weight one month after admission was 38.6kgs. Neither the "Care Profile Summary" (completed in Month2) nor the long-term care plan (completed in Month9) referred to the need for a puréed diet, Mrs A's low body weight, or whether her low weight required further investigation or intervention.

101. In Month15, Mrs A's care plan was updated. The evaluation refers to Mrs A needing a lot of encouragement or assistance with eating, and to her refusing to eat. It also stated that Mrs A was drinking independently. There are no references in the updated care plan to Mrs A needing a puréed diet and Complan (including the frequency and amount), the fluid balance chart that was apparently re-commenced on 12 Month15, or the fact that Mrs A had lost weight every month for the previous six months. The recording of the interventions was therefore incomplete, and there is no evidence that the interventions were evaluated.

102. It appears that progress notes, rather than the care plan, were used to document changes in Mrs A's care.

103. Fairview Care advised that responsibility for care planning lay with the primary nurse assigned to each resident, and that Mrs A's primary nurse was RN F. I will comment later on RN F's responsibilities in relation to Mrs A's care planning. However, I note RN G's submission that updating care plans was an area of weakness amongst the nurses at Fairview Care. Moreover, while RN F may have been the assigned nurse, records show that multiple other staff — including several other registered nurses and enrolled nurses — were involved in the provision of care to Mrs A. The fact that these staff continued to provide care to Mrs A without reference to an initial or long-term care plan leads me to believe this was an organisational failing rather than suboptimal care on the part of just one nurse.

104. In addition, with respect to care planning, Fairview Care did not meet the requirements of Standards 3.5 and 3.8 of the New Zealand Standard Health and Disability Services (Core) Standards (NZS 8134.1:2008), or of the Age Related Residential Care Services Agreement.

Weight management

105. Mrs A's medical records were received by Fairview Care six weeks after her admission. These show that concerns had been raised regarding Mrs A's weight, weight loss, and swallowing prior to her admission to Fairview Care. I consider that these factors should have prompted staff to take action at that time in accordance with Fairview Care's Weight Loss Management Policy.

106. Mrs A's weight was not checked on admission in Month2, but the following month, she weighed 38.6kg. Over the next six months, her weight increased by 3.2%, to 39.85kg. However, by Month12, Mrs A weighed 37.4kg, a loss of 6.1% in just three months. Fairview Care's own policy identified weight loss of 5% over a period of 6–12 months as clinically important.

107. By Month15, Mrs A weighed 35.55kg, a loss of 10.8% over the previous six months. Unintentional and unexplained weight loss of this magnitude is concerning for any resident; it should have prompted further investigation or consideration for a resident with a starting weight as low as Mrs A had. I have noted Fairview Care's submissions on this matter, in response to my provisional report (see paragraph 86). I remain of the view that there is little evidence that staff recognised the significance of Mrs A's continuing weight loss between Month10 and Month16.

108. I accept that Mrs A had become increasingly reluctant to eat but I am concerned that the reasons for this were not adequately investigated. Ms K considers that Mrs A's reluctance to eat may have been a decision on her part that needs to be seen in the context of her nearing the end of her life. While I accept that older people do sometimes refuse food as they near death, it is not acceptable simply to allow a resident to refuse food without further evaluation. In its response to my provisional report, Fairview Care stated that staff were alert to and seriously concerned about Mrs A's weight loss, and "on occasion" the staff with whom she had particularly good relationships discussed her eating habits with her. I remain of the view that neither Mrs A's reluctance to eat, nor her continued weight loss over six months, were discussed with her in a focused or meaningful way. There are indications in the notes that difficulties with swallowing or with her dentures may have been affecting her ability to eat, but the possibility of seeking input from a dietitian, nutritionist, or speech language therapist, with a view to alleviating any such difficulties, does not appear to have been considered or offered to Mrs A.

109. In addition, there is no evidence that Mrs A's continuing weight loss was brought to the attention of Dr H at any time after his advice in Month11 that Mrs A would benefit from a dietary supplement.

110. The following components of Fairview Care's Weight Loss Management Policy were also not adhered to:

- The policy stipulated that the BAPEN MUST tool and a weight chart should be used to assess dietary intake and screen for malnutrition. No BAPEN MUST tool was completed for Mrs A.

- The policy required Mrs A to be weighed at least monthly. There are no records regarding Mrs A's weight for Month7 or Month13.

- The policy required interventions to be reviewed on a monthly basis until weight gain was evident and the targeted outcome was achieved. Fairview Care has identified the interventions in Mrs A's case as the provision of a puréed diet, Complan, and staff assistance and encouragement with eating. There is no evidence that the effectiveness of these interventions was reviewed at any time.

111. I note also Ms Whitehead's advice that Fairview Care's policy for the management of weight loss was unclear about the importance of involving a dietitian and, where there were swallowing difficulties, a speech language therapist.

112. It is not for me to comment on whether input from a dietitian, nutritionist, or speech language therapist while Mrs A was still at Fairview Care would have altered the outcome for Mrs A. However, I believe it was remiss of staff at Fairview Care not to at least have considered these options and discussed them in the first instance with Mrs A.

113. I agree with Ms Whitehead's advice:

> "Nowhere in the progress notes or the care evaluation is there evidence that the registered nurses adequately addressed [first], Mrs A being very underweight and secondly, the weight loss from [Month10] and ongoing until her discharge. It is my view that the registered nurses did not record adequately follow up and follow through when her weight began to reduce in [Month10], and especially in [Month15 to Month16]."

114. Furthermore, the care provided was not in accordance with Standard 3.13 of the New Zealand Standard Health and Disability Services (Core) Standards (NZS 8134.1:2008).

Fluid charts

115. On 29 Month10, Dr H was concerned that Mrs A was dehydrated. He asked staff to "push fluids" and to complete a fluid balance chart for one week.

116. A fluid chart was commenced, with staff recording only fluid intake. The chart was completed for five days, and then two days were missed. It appears that a decision was made to continue recording Mrs A's intake after the first week, but Fairview Care was unable to provide charts for 14–26 Month11 and from 12 Month12–11 Month15. RN G initially advised HDC that charts had been completed in 2011, but these could not be located. Fairview Care subsequently provided fluid balance charts for 12 Month15–14 Month16. The progress notes refer to a "Complan fluid balance chart" being started on 12 Month15. There is no information in the notes to explain the rationale for this decision. The 2011 fluid balance charts provided show Mrs A's fluid intake for 20 of the 34 days prior to her admission to hospital, with Complan recorded on 15 of those days. The maximum daily fluid intake recorded during this period was 760mls.

117. Fluid intake recordings were incomplete during the first week that they were made (29 Month10–4 Month11), and during the month prior to Mrs A's admission to hospital. There is no information in the clinical records regarding the decision to continue recording Mrs A's fluid intake after the first week. There is no reference in the care plan to fluid charts. Given the incomplete records and documentation, it is difficult to establish whether the fluctuating intake evident in the charts that are available reflects Mrs A's intake or inconsistent recording. There is no evidence that the charts that were completed were evaluated. In addition, there was no system in place to ensure self-administered fluids were recorded. Accordingly, the charts that were completed were of limited value.

Conclusion

118. Fairview Care acknowledged that Mrs A's care plan was not always kept up to date but submitted that this in no way compromised the care provided to her. I do not accept this. In my view, an accurate, relevant, and up-to-date care plan may well have assisted staff to identify and respond to issues of concern, including Mrs A's weight loss and fluid intake.

119. I have carefully considered the extent to which the shortcomings in Mrs A's care occurred as a result of poor care by individual staff, as opposed to organisational and systems deficiencies. Fairview Care had policies in place for care planning and weight loss management but, in my view, it did not have a staff culture and adequate systems to ensure staff adhered to those policies. In addition, its system for the monitoring and recording of fluids was not consistently followed, and was, in itself, flawed in that it did not provide for the recording of self-administered fluids. In these circumstances, I find that Fairview Care Ltd failed to provide services to Mrs A with reasonable care and skill, and so breached Right 4(1) of the Code.

Other matters — Fairview Care Ltd

Advance directive — adverse comment

120. An advance directive can be completed only by a competent consumer, and comes into effect only if that consumer loses competence.[17] Accordingly, Mr E should not have been asked in Month1 to sign an advance directive on his mother's behalf. In addition, the documentation completed at this time referred to Mrs A being unable to express her wishes, when in fact there is no evidence that Mrs A lacked competence or the ability to communicate her decisions. A person is presumed to be competent in the absence of evidence to the contrary.

121. A similarly erroneous note was recorded in Month15, when RN G wrote that Mrs A's resuscitation status was to be discussed with Mrs A's son and son-in-law, as her EPOAs. Aside from the fact that a person can appoint only one EPOA in relation to care and welfare,[18] the reason for not discussing this matter with Mrs A herself is not apparent. There was still no evidence to indicate that Mrs A's EPOA had been activated (that is, that Mrs A had been medically assessed as having lost competence), or that it needed to be activated.

122. Fairview Care has acknowledged that Mr E should not have been asked to sign an advance directive. Although I have found no evidence to suggest that this documentation influenced the provision of care to Mrs A, this is not acceptable. The frequency with which I see evidence of staff in residential care facilities failing to understand the requirements associated with both advance directives and enduring

[17] Clause 4 of the Code states: "'Advance directive' means a written or oral directive — (a) by which a consumer makes a choice about a possible future health care procedure; and (b) that is intended to be effective only when he or she is not competent."
[18] Section 98(2) of the Protection of Personal and Property Rights Act 1988.

powers of attorney is concerning. Residential care facilities need to ensure that their staff fully understand these requirements and act accordingly.[19]

123. I note that Fairview Care subsequently provided its staff with refresher training, to ensure that all staff are aware that an advance directive needs to be signed by a competent resident.

Aqueous cream — adverse comment

124. Mrs A's family found aqueous cream prescribed for another resident in Mrs A's room. RN G confirmed that no aqueous cream had been prescribed for Mrs A but staff acknowledged that they did use aqueous cream to moisturise Mrs A's legs.

125. Creams such as this are often available on standing order and over the counter. However, containers of cream should be patient specific and not used on multiple residents. Fairview Care acknowledged that it was inappropriate for cream prescribed for another resident to be used on Mrs A.

Documentation — adverse comment

126. I accept Ms Whitehead's advice that in general, the day-to-day documentation is of a reasonable standard. However, as outlined above, there are significant gaps in documentation in the care plan and fluid charts.

127. In addition, there were occasional days for which there is no entry in the progress notes. I do not consider this appropriate for residents requiring hospital level care, and particularly for a resident whose condition is deteriorating.

128. As this Office has previously stated, "… records are an essential tool for patient management, for communicating with doctors and health professionals, and for ensuring continuity of care".[20]

Response to deterioration in Month16 — adverse comment

129. The records confirm that Mrs A's vital signs were checked monthly (excluding Month7 and Month13), with additional recordings taken during the first two weeks of Month16.

130. On 1 Month16, Mrs A had an unwitnessed fall. There were no apparent injuries, although her oxygen saturations were low and she was given oxygen. On 5 Month16, Mrs A's blood pressure was slightly low. On 9 and 12 Month16, her blood pressure and oxygen saturations were lower than normal for her. Her weight on 12 Month16 indicated a 1.5kg loss over the previous week.

131. My nursing expert, Ms Whitehead, considers that, as Mrs A required oxygen following the fall on 1 Month16, the GP should have been informed. Ms Whitehead also considers that there were signs the following week that Mrs A's condition was deteriorating — in particular, her blood pressure, oxygen saturations, continued

[19] This matter has been highlighted in previous HDC investigations, including 08HDC20957.
[20] Opinion 06HDC12164 (29 February 2008) p 18.

weight loss, and reports of a chesty cough. In these circumstances, Ms Whitehead considers that the GP should have been contacted, and Mrs A's vital signs monitored more closely until she was seen by the GP.

132. Fairview Care has explained the circumstances leading to Mrs A's scheduled GP review on 13 Month16 being postponed. In short, the GP did not have sufficient time to see all of the residents he was scheduled to review. The reviews of Mrs A and three other residents were deferred to the next scheduled visit, by which time Mrs A had been admitted to hospital.

133. It is certainly unfortunate, given the deterioration in Mrs A's condition the following day, that Mrs A was not seen by the GP on 13 Month16 as intended. Fairview Care needed to have in place a strategy for dealing with periods of high demand so that residents were able to be clinically assessed in a timely manner. It was only when Mrs A deteriorated on 14 Month16 that action was taken.

134. I note that Fairview Care subsequently increased its routine GP cover, and that it has arrangements in place to ensure access to medical input outside of these hours when required.

Communication with Mrs A's family — other comment

135. Following Mrs A's admission to hospital, Mrs B wrote to Ms K, outlining her and her brother's concerns regarding their mother's recent care. Ms K states that she left voicemail messages on 20 and 21 Month16, asking Mrs B to contact her to discuss these concerns. Telephone records confirm that calls were made to Mrs B's cell phone number, but Mrs B does not recall receiving any messages. Ms K states that when she subsequently received Mr E's email advising that Mrs A would not be returning to Fairview Care, she concluded that Mrs A's family did not want any further contact. Accordingly, Ms K did not attempt to contact them again.

136. Providers are required to have a complaints procedure, as set out in Right 10(6) of the Code.[21] The specific obligations of providers when dealing with complaints are set out in Rights 10(7)[22] and 10(8) of the Code.[23] In my view, Ms K was unwise to assume

[21] Right 10(6) states: "Every provider, unless an employee of a provider, must have a complaints procedure that ensures that —

a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and

b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of — i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and ii. The Health and Disability Commissioner; and

c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and

d) The consumer receives all information held by the provider that is or may be relevant to the complaint."

[22] Right 10(7) states: "Within 10 working days of giving written acknowledgement of a complaint, the provider must, —

a) Decide whether the provider —

i. Accepts that the complaint is justified; or ii. Does not accept that the complaint is justified; or

that the email from Mr E indicated that Mrs A's family wanted no further contact. Fairview Care should have followed up in writing, offering Mrs A's family the opportunity to discuss their concerns and any outstanding issues.

Adverse comment — RN F

137. On 7 Month2, Mrs A was admitted to Fairview Care as a permanent resident. Initial assessments and a "Care Profile Summary" were completed. Fairview Care's Resident Admission Policy at that time required an initial short-term care plan to be developed on admission and a more definite care plan to be completed following one to two weeks of observation and staff feedback. The policy required care plans to be reviewed every six months or more often if the resident's circumstances or condition changed. Fairview Care advised that responsibility for a resident's care plan lay with that resident's primary nurse, and that from Month2 to Month15, Mrs A's primary nurse was RN F.

138. RN F completed Mrs A's long-term care plan on 10 Month9, more than seven months after Mrs A's admission.

139. The care plan stated that Mrs A had a good appetite. It did not refer to Mrs A needing a puréed diet, her low body weight, or whether her low weight required further assessment.

140. In Month15, RN F updated Mrs A's care plan. The evaluation refers to Mrs A needing a lot of encouragement or assistance with eating, and to her refusing to eat. It also stated that Mrs A was drinking independently. There are no references in the updated care plan to Mrs A needing a puréed diet and Complan, the Complan fluid chart, or the fact that Mrs A had lost weight every month for the previous six months. The recording of the interventions was therefore incomplete, and there is no evidence that the interventions were evaluated.

141. RN F did not complete Mrs A's long-term care plan within the expected time frame. The care plan did not include relevant information with regard to Mrs A's nutrition and weight management, and interventions were not evaluated. As I have outlined above, I am concerned that the shortcomings in Mrs A's care planning were indicative

b) If it decides that more time is needed to investigate the complaint, — i. Determine how much additional time is needed; and ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it."

[23] Right 10(8) states: "As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of —
a) The reasons for the decision; and
b) Any actions the provider proposes to take; and
c) Any appeal procedure the provider has in place."

of an organisational problem. However, in my view, RN F should reflect on the adequacy with which she fulfilled her responsibilities as Mrs A's primary nurse.

Recommendations

142. The changes made by Fairview Care since and/or in response to these events, as outlined in paragraphs 79–82 of this report, are noted. In my provisional report, I recommended that Fairview Care:

- Apologise to Mrs A's family for its breaches of the Code.
- Undertake an audit of all care plans and report the results to HDC.
- Advise HDC of the systems in place to monitor and audit care planning on an ongoing basis.
- Advise HDC of the procedures in place to ensure accurate monitoring of fluid intake for those residents who require this, and provide a copy of the relevant policy.
- Undertake an audit of compliance with the updated nutritional policy and report the results to HDC.
- Review its advance directives policies to ensure compliance with legal requirements, and provide HDC with a copy of the relevant policies.
- Undertake an audit of residents' files to ensure that any advance directives comply with legal requirements, and report the results to HDC.

143. Fairview Care has complied with these recommendations. RN F also provided a written apology for forwarding to Mrs A's family.

Follow-up action

144. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Fairview Care Ltd, will be sent to the district health board, the Ministry of Health (HealthCert), and the Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent nursing advice to the Commissioner

Preliminary advice was obtained from Noeline Whitehead. Ms Whitehead reviewed her advice following the commencement of an investigation. Her amended report is as follows:

"**Professional Expert Advice 11/00512 Independent Advisor's Report**

Section 1

Request for further advice

I, Noeline Whitehead, have been asked to provide a further opinion to the Commissioner on case number 11/00512. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

Qualifications and experience

My qualifications are:

New Zealand Registered Nurse holding a current practicing certificate, Post Graduate Diploma in Health Science, Master of Nursing (1st Class Honours) and a Doctorate from University of Auckland.

I have thirty-three years in senior nursing positions:

- Nurse manager and general manager for a group of long term care hospitals and a rest home in Auckland
- Clinical Nurse Director for Health of Older People at Counties Manukau District Health Board (full time) 2005 to 2007 and currently for Age Related Residential Care (part time)
- In 2011, I commenced on staff at the University of Auckland two days a week and have set up and am teaching clinical leadership in residential care (post graduate paper)
- I have a consulting business that provides consultancy services and education to the Age Related Residential Care Sector
- I was appointed Temporary Manager on two occasions by District Health Boards under the Age Related Residential Care service provider agreement
- I was a team leader surveyor and lead auditor for ten years for Quality Health New Zealand

My areas of expertise are standards of practice, quality of care, advanced clinical nursing practice, research and evidence based practice related to Age Related Residential Care and Health of Older People.

Instructions from the Commissioner

In the light of the additional response and information from Fairview Care are there any changes in my advice to the Commissioner.

The original request was to provide preliminary expert advice to enable the Commissioner to determine whether, from the information available, there were concerns about the standard of care provided by Fairview Care to [Mrs A]. Advice includes:

1. Whether staff [at] Fairview Care appropriately assessed and monitored [Mrs A's] nutrition and hydration;
2. Whether [Mrs A's] weight was monitored appropriately and in accordance with Fairview Care's weight management policy;
3. Comment on care planning and implementation;
4. Comment on communication;
5. Comment on documentation; and
6. Comment on any other relevant issues.

Section 2

The standards that apply to this complaint

1. NZS 8134:2008. Health and Disability Services Standards. (Standards New Zealand, 2008)
2. Age-related residential-care services agreement 2011. (District Health Boards New Zealand, 2011)

NZS 8134:2008 Standards that the facility must comply with

1. Standard 1.8 requires consumers receive services of an appropriate standard
2. Standard 1.9 requires service providers are to communicate effectively with consumers and provide an environment conducive to effective communication.
3. Standard 3.4 requires that resident's needs, support requirements and preferences are gathered and recorded in a timely manner.
4. Standard 3.5 requires that the resident's service delivery plans are consumer focused, integrated, and promote continuity of service delivery.
5. Standard 3.6 requires that provision of services is consistent with, and contribute to meeting the resident's assessed needs and desired outcomes.
6. Standard 3.8 requires that individual service plans are evaluated in a comprehensive and timely manner detailing the degree of achievement/ response to interventions/care and changes are made when the response is less than expected.
7. Standard 3.13 requires that a resident's individual food, fluids and nutritional needs are met.

Contractual obligation of the facility

8. ARRC Service provider agreements (New Zealand District Health Boards, 2007 and 2008) require that on admission an assessment is completed that covers the physical, psycho-social and cultural aspects and that this information is used to develop an initial care plan and a comprehensive care plan.
9. ARRC service provider agreement D16.3 and D16.4 (District Health Boards New Zealand, 2008) requires ongoing review and evaluation when there is a significant change in the resident's clinical condition and at least six monthly.

The competencies for registered nurses

Apply to this complaint

Competencies for registered nurses Wellington Nursing Council of New Zealand (Nursing Council of New Zealand, 2007).

Guidelines relevant to this complaint

Ministry of Health. (2010). *Food and Nutrition Guidelines for Healthy Older People: A background paper.* (Ministry of Health, 2010)

Although this paper is old, it is the best source of information for this healthcare setting:

Burger, S., Kayser-Jones, J., & Bell, J. (2000). *Malnutrition and Dehydration in Nursing Homes: Key Issues In Prevention and Treatment.* (Burger, Kayser-Jones, & Bell, 2000)

Recommendations

Weight loss management

All newly admitted residents should undergo a nutritional assessment and this is updated regularly when health or behaviour status alters. Residents are weighed regularly at least monthly and more frequently if suffering from low body weight. Residents with weight loss of 5% in one month or 10% in 6 months to be referred to a dietician and where swallowing issues are evident, a speech language therapist, and be investigated unless the resident has been diagnosed with an end of life illness or does not wish to have further investigations (also consider advance care plan). In some instances, the GP considers further investigation/treatment is futile.

Standard for fluid intake for older people

30mls of water per kilogram of body weight e.g. 50kgs x 30 = 1500mls

A simple standard for older women is 1680mls of oral fluids in addition to food per day (Ministry of Health, 2010)

Definitions

Weight loss

Unintentional significant weight loss is defined as 5% in 30 days (or 10% in 180 days).

Dehydration

Dehydration can be defined as a rapid weight loss of greater than three percent of body weight and can result from increased fluid losses due to illness, the effects of medications or decreased fluid intake or physiological changes. Dehydration may result in life threatening electrolyte imbalances (Burger et al., 2000).

List of abbreviations

Age related residential care	ARRC
General practitioner	GP
Registered nurse	RN
Kilograms	kg

Section 3 — Preliminary advice

The nature of the complaint

This is a complaint regarding the care of [Mrs A] her admission as a permanent resident on 7 [Month2] to her discharge to [hospital] 14 [Month16]. This complaint relates to the care of [Mrs A]. I, Noeline Whitehead have been asked to advise on whether the nursing care provided to [Mrs A] was consistent with expected standards, in particular:

1. Whether staff [at] Fairview Care appropriately assessed and monitored [Mrs A's] nutrition and hydration;
2. Whether [Mrs A's] weight was monitored appropriately and in accordance with Fairview Care's weight management policy;
3. Comment on care planning and implementation;
4. Comment on communication;
5. Comment on documentation; and
6. Comment on any other relevant issues.

The preliminary advice provided was based on the documented evidence provided at the time of the original request. Further evidence and comments … have been received from the facility and have been reviewed and considered.

Primary sources of information

- Copy of the complaint
- Clinical records from Fairview Care
- Response from Fairview Care
- Additional information from [Mrs B], [Ms C], and [Mr E]
- Clinical records from [the public hospital]
- The General Practitioner notes from [the medical centre]

- The General Practitioner notes from [previous] Medical Centre
- The response to the preliminary report by Fairview

Clinical background

[Mrs A] was admitted from the community. [Mrs A] had not been admitted to a public hospital in recent years (daughter). In the facility response to the preliminary report, Fairview have provided evidence that they obtained the clinical record from [Mrs A's] previous GP. There is no history or a complete problem list in Fairview Care documentation or the General Practitioner's (GP) notes provided. There is a short diagnosis list on the top of the nursing care plan. Therefore, I have summarised the clinical background from the General Practitioner notes from [previous] Medical Centre.

1. Haemorrhoids — internal
2. Diverticulosis
3. Hypothyroidism
4. Chronic bronchitis
5. Impaired renal function
6. Hypertension
7. Vitamin B_{12} deficiency (2006)
8. Severe head injury 1968
9. In 2003, her body weight was 46–49kgs, in 2004 43kgs, in 2007 37–48kgs, in 2008 37.5kg, very underweight
10. Concern about weight loss and appetite by family in 2007
11. Low energy from weight loss
12. Swallowing difficulties related to spasm of the cricopharyngeus muscle, mildly impaired oesophageal peristalsis, Gastro-oesophageal reflux with tertiary contractions.
13. Keratoacanthoma
14. Surgery for cataracts 2004 and [Month8]
15. In addition the physiotherapist identified dizzy spells and a recent history of falls

Short-term problem list

The infection surveillance record indicates that [Mrs A] suffered urinary tract infections in [Month10], and [Month14], eye infections in [Month3] and [Month4]. The care profile provides an additional entry of dental procedures. An incident form was provided for a fall on 1 [Month16] Observations taken hourly for four hours. There was no incident form provided for the choking incident on 10th [Month15] that was recorded in the progress notes. There were entries in the progress notes regarding skin tears, skin wounds, eye infections, and periods of confusion.

Advance directive

There is a documented advance directive signed by the son requesting active treatment and resuscitation. It states in the section titled 'advocate/family member' that the resident was unable to express her wishes. There is no evidence provided

to support this and in fact [Mrs A] appeared to express her wishes about care in the documentation provided.

Medications

- Levothyroxine 50mcg daily
- Paracetamol 1000 mg PRN to four times a day
- Zopiclone 7.5 mg Tabs ½ Nocte PRN

There is evidence that the medications were reviewed regularly by the GP. There is evidence of monthly examinations by the GP except in [Month16].

Admission Assessments

At the time of admission the physiotherapist, GP, Registered Nurse (RN), and activities person completed and recorded their assessments. [Mrs A] was medium risk for falls and as high risk for pressure injuries. The nutrition and hydration assessment stated she needed a purée diet and had an average appetite. She had some of her own teeth, but most were gone. There was no mention of dentures, or of her ability to swallow or of her hydration. The assessment did not indicate that [Mrs A] was very underweight. Her weight was recorded. There is no evidence that the assessment was updated at any time during her stay.

Care plan

The care plan dated 10 [Month9] lists the medical diagnosis as [Cricopharyngeal spasm], mildly impaired oesophageal peristasis, Gastro-oesophageal reflux with tertiary contractions. The problem/needs states that [Mrs A] had a good appetite and was to be offered a well balanced diet. It did not state it was to be a purée diet or that Complan was to be given. There was no indication of how frequently [Mrs A] was to be weighed what to do if ideal weight was not reached, or current weight levels were not maintained.

Evaluation of care

The evaluation dated 15 [Month15] indicated that [Mrs A] was 'refusing to eat lately and needed lots of assistance'. It does not appear that the nursing interventions were updated to reflect the changes identified during the evaluation.

Vital signs

Vital signs were recorded on the day of admission:

- Temperature 36.3ºC
- Pulse 98
- Blood pressure 117/80
- Oxygen saturation 96%

Vital signs were recorded monthly.

In [Month16], this increased to four entries between 5 [Month16] to 14 [Month16]. Blood pressure varied between 106/83 in [Month16] and 151/100 in

[Month8]. Oxygen saturation varied from 93% and above to 99% (it was 81% on 14 [Month16]). Temperature ranged from 35.3 to 37.5°C, it was (36.9°C on 14 [Month16]). Pulse ranged from 85 to 99 beat per minute, (it was 111 beats per minute on 14 [Month16]). Respirations ranged from 17 to 24 breaths per minute (it was 24 breaths per minute on 14 [Month16]).

Weight loss

[Mrs A] suffered from long term swallowing difficulties resulting in being very underweight. It is not clear as to what extent these problems had been investigated prior to admission to the facility. At the time of admission, [Mrs A] was 37.25 kgs. Between [Month1] and [Month9], [Mrs A] had a weight gain of 14.27 percent of her admission body weight. [Mrs A] had lost weight between [Month9] and [Month10] (0.95 kgs, 2.4% of her body weight). From [Month11], [Mrs A] continued to lose weight (1.95 kgs between [Month11] and [Month15] (5.2 percent of her body weight). In [Month14], her weight was less than it had been at the time of admission. By [Month15], [Mrs A] had lost 10.8% of her body weight since [Month9] (6 months). Weights were recorded as follows:

[Month1]: 37.25 kg (similar to her weight recorded in 2008)

[Month2]: nil

[Month3]: 38.6kgs

[Month4]: 39.20kgs

[Month5]: 38 kgs

[Month6]: 38.75kg

[Month7]: nil

[Month8]: 39.15 kg

[Month9]: 39.85kg

[Month10] 38.9 kg — Family raised concerns about [Mrs A's] weight

[Month11]: 37.5 kg. The GP recorded that [Mrs A] is very underweight and would benefit from a supplement. Blood tests were ordered. Staff recorded that they [have] spoken with the family who agreed to fund the supplement.

[Month12]: 37.4 kg

[Month13]: nil

[Month14]: 36.10 kg

[Month15]: 35.55 kg

[Month16]: 34.9 kg on 5th, 33.5 kg on 12th, 33.6 kg on 14th

Diagnostic tests indicate that [Mrs A] had a history borderline Total Protein and a low Albumin.

Fluid intake

Some fluid balance charts have been provided for [Month10] to 12 [Month12] (pages 00018–00023. This was following the GP suggesting [Mrs A] may have been dehydrated. The charts indicate intake was inconsistent (some days less than 1000mls and at other times over 1000mls).

Summary of progress

[Mrs A] was admitted to Fairview Care in [Month1] for respite care and as a permanent resident on 7th [Month2]. [Mrs A] appeared to settle into life at Fairview Care well. It is recorded that she was independent and appeared happy.

On 6th [Month10], [Mrs A] was seen by the GP as an acute visit. [Mrs A] was unusually confused. Treatment was commenced for a urinary tract infection. She was seen by the GP again on 8 [Month10]. A delirium screen was recorded as being done by the GP. On 28 [Month10], [Mrs A's] family raised concerns about her being chesty. She was seen by the GP who did not find any cause for concern in relation to her respiratory system but suggested she may be dehydrated. Blood test indicated that CRP was evaluated (58). The GP, after consideration, made a decision against undertaking extensive investigations. The GP ordered a fluid balance chart for one week and suggested a dietary supplement would be of benefit as she was very underweight. [Mrs A] was recorded as improving, and eating and drinking well. However, 8 [Month11], daughter was concerned that [Mrs A's] condition had deteriorated. There is evidence of communication between the staff and family.

From this time forward staff recorded that [Mrs A] was confused at times and her appetite and fluid intake was variable. She was also needing more assistance with walking. In the main, however, her condition appeared to be stable but she was losing weight.

On 9th [Month15], staff queried infection wound on [Mrs A's] lower left leg. On 10th [Month15], [Mrs A] was reported as being unwell. A dipstick of her urine indicated that she possibly had a urinary tract infection. Staff noted that she was not eating and drinking enough. She was found choking on her tea at 5.45pm. She was in respiratory distress. During the night, she was recorded as having a temperature of 37.8°C and by morning, it was 35.9°C. Paracetamol was given. She was seen by the GP on 11th [Month15], who commenced treatment for a urinary tract infection. Staff record that [Mrs A] was less confused and irritable on the 12th [Month15]. She was afebrile on 12th [Month15]. Staff recorded that [Mrs A] was cheerful with no new problems. A Complan/fluid chart was commenced. Copies of this have not been provided as part of the complaint. Complan requirements were recorded in the progress notes. The care plan was evaluated on the 15th [Month15] with the nursing interventions being updated but the changes did not include the order for Complan or a purée diet. On 22nd [Month15], the care staff recorded that [Mrs A] was not eating and that she may be experiencing swallowing difficulties. On 23rd [Month 15], the urine culture result indicated that [Mrs A] did not have a symptomatic urinary tract infection. At 2230 hours staff

recorded that [Mrs A] was deteriorating and had 'some strange behaviour' (strange movements of her head). Next morning she was bright but by the afternoon, she was quiet.

On 1st [Month16], a staff member found [Mrs A] on the floor in the toilet. She had sustained skin tears to her arm and leg. No other injuries were noted. She was given oxygen because of her low oxygen saturation and vital signs were checked for four hours. On 5th [Month16], [Mrs A's] weight was recorded as 34.9kgs (4kg loss in 6 months). Other vital signs were similar to her baseline recording. However, her blood pressure was low 108/71. On 6th [Month16], staff recorded that [Mrs A] was needing lots of help and was very frail. Vital signs were recorded on 9th [Month16], and again were similar to baseline recordings and blood pressure had improved to 116/64. On 12th [Month16], it was recorded that [Mrs A] was chesty and coughing more than usual. Vital signs were recorded. Weight was down to 33.5kgs, down 1.6 kgs since 5th [Month16]. Oxygen saturation was 93% and blood pressure was low, 106/83. [Mrs A] was scheduled to see the GP on 13th [Month16], but was not seen due to the number of residents that needed to be seen on that day. The family spoke to the staff about their concerns. On 14th [Month16], at 4pm, staff recorded that [Mrs A] was pale, at 5 pm vomited, was cold, clammy, and short of breath. Her vital signs were recorded as temperature 36.9, pulse 111, respirations 24, and oxygen saturation 81%. Family were contacted and a decision was made to transfer [Mrs A] to [hospital] where she was diagnosed to have community-acquired pneumonia secondary to aspiration and silent aspiration.

Section 4 — Findings

Findings

Monitoring of [Mrs A's] nutrition and hydration

The assessment recorded that [Mrs A] had an average appetite and was to have a purée diet. Her weight was recorded at the time of admission.[24] The care plan did not reflect that [Mrs A] was to be on a purée diet and there is no indication in the clinical record that she was. The care plan did not indicate that she had a very low body weight.

[Mrs A] was likely to be suffering swallowing difficulties related to Circopharyneus muscle spasm, mildly impaired oesophageal peristalsis, Gastro-oesophageal reflux with tertiary contractions. She was therefore high risk for aspiration and weight loss. She needed to have a diet that she could manage to swallow, with enough calories and protein and other nutrients to maintain her health and wellbeing. She was assessed as suffering from fatigue at the time of admission, which may indicate that she was suffering protein/energy malnutrition. The diagnostic tests tend to support this.

[24] Mrs A's weight was recorded when she was admitted for respite care. It was next recorded on 9 Month3, a month after she was admitted for long-term care.

The staff monitored [Mrs A's] weight monthly and more frequently in [Month16]. Fairview Care was successful in achieving a weight gain from the time of admission until [Month9]. However, when [Mrs A] became unwell in [Month10], she began to have weight loss. She was also possibly dehydrated at this time. This would have contributed to the weight loss. [Mrs A] suffered significant weight loss (10.8% of body weight) over the six months from [Month9] to [Month15]. The GP suggested a nutritional supplement and a fluid balance chart. It is apparent from the progress notes that this was actioned by the nursing staff. However, the care plan was not updated to reflect these new interventions. Nor is there documented evidence that the nurses properly evaluated the effectiveness of these interventions.

[Mrs A] continued to lose weight. Staff gave supplements and provided assistance with meals. However, [Mrs A] wished to maintain her independence so this was challenging for staff. When the weight loss started again in [Month10], there was no referral to a dietician or speech language therapist or to specialist services. It is acknowledged that some of the weight loss [Mrs A] suffered in the last month may have been a result of dehydration.

In view of her very low body weight, her special dietary needs, and seating needs at meal times to prevent aspiration, it is my view she should have been referred to a dietician and speech language therapist or to the specialist services at [the hospital], especially in view of the requirement for active treatment on the advance directive. There is no indication that this option was offered to [Mrs A].

Nowhere in the progress notes or the care evaluation is there evidence that the registered nurses adequately addressed [Mrs A] being very underweight and secondly, the weight loss from [Month10] and ongoing until her discharge. It is my view that the registered nurses did not record adequate follow up and follow through when her weight began to reduce in [Month10], and especially in [Month15] to [Month16].

Therefore, I am of the opinion that the standards NZS 8134:2008 3.5, 3.8 and 3.13 were not met.

Weight monitored appropriately and in accordance with Fairview Care's weight management policy

[Mrs A's] weight was recorded monthly. I note that there was no weight recorded in [Month7] and [Month13]. The policy states weight was to be recorded monthly or as frequently as daily. In relation to following Fairview Care's weight loss policy there was no evidence provided that the BAPEN 'MUST' tool was completed, weight loss was not documented by nursing staff as a concern in the assessment or care plan.

There did not appear to be a non-pharmacological approach of enhancing food taken. In addition, the procedure is unclear about the importance of involving a dietician, and where there are swallowing difficulties a speech language therapist which the BAPEN flowchart does. I note this has been addressed in a revised

policy. I note that [Mrs A's] weight dropped further when in [the hospital] and she was commenced on Nasogastric feeding after a review by the speech language therapist. This highlights the importance of speech language therapist input in this case. In my view, the policies and procedures in place at Fairview Care were not followed in the case of [Mrs A]. Nor do they support a multidisciplinary approach to weight loss management. It is possible that the weight loss was irreversible due to an unknown cause.

Care planning and implementation
As already presented above, the care plan for [Mrs A] did not reflect assessed needs in relation to nutrition. Nor was it updated to reflect changing nutritional and hydration needs. It is my view that the care plan did not provide adequate direction to care staff. In my view care planning and implementation did not meet the requirements of NZS 8134:2008 — 3.5.

Communication
Communications with the family were recorded. However, it appears that in most instances the communications were family initiated. It appears that the family did not know the name of the primary nurse. The family were advised of the fall on 1st [Month16]. There is no evidence that staff contacted the family on 12th [Month16] when [Mrs A] was obviously very unwell, nor did they advise the family that she had not been seen by the GP on 13th [Month16]. It is my view that staff did communicate with the family and provide evidence of this; however, the communication was mostly initiated by the family and was accommodated by the staff, including requesting care reviews. There was a lack of facility initiated communication with the family between the 12th and until the evening of 14th [Month16]. Some evidence of phone calls made has been provided. In my view the NZS 8134:2008 — 1.9 was not fully met.

Documentation
In general, the day-to-day documentation is of a reasonable standard. However, there appear to be gaps with recording care given such as actual food intake and the effectiveness of interventions. The fluid balance charts did not appear to be completed consistently. The dietary requirements were not well documented in the care plan. Care plans were not updated at the time care needs changed in all cases. There does not appear to have been a comprehensive medical problem list or a short-term problem list. All have been covered in the finding above.

Any other issues
I am concerned that there is an advance directive signed by a family member rather than [Mrs A]. It is my understanding only the person himself or herself can make an advance directive. Therefore, it is advisable that Fairview Care seek expert advice to ensure that they are meeting the requirements of the legislation.

After the choking episode on 10th [Month15], [Mrs A] was examined by the GP the following day but was not seen again. There is evidence in the progress notes that [Mrs A] was becoming increasingly unwell, especially in the week before her acute admission to [hospital]. She had a fall on the 1st [Month16] and her vital

signs were abnormal for her. Her vital signs recorded on the 12th [Month16] indicated that her blood pressure and oxygen saturation were low, and she was continuing to have rapid weight loss (a sign of dehydration). It is my opinion that the lack of follow up of these vital signs may have contributed to [Mrs A] becoming so acutely unwell by 14th [Month16]. It is my opinion that the GP should have been notified of the fall (1 [Month16]) as [Mrs A] has low oxygen saturations that required oxygen to be given. In addition, the low blood pressure on the 5 [Month16] possibly indicated that she was dehydrated. While her blood pressure improved on the 12 [Month16], [Mrs A] was, in my opinion, unwell with a cough, reported as chesty, oxygen saturation of 93%. Staff should have contacted the GP and had her vital signs closely monitored by the registered nurses until the GP saw her. If the vital signs deteriorated further, the GP should have been called immediately. After being alerted by a visitor that [Mrs A] was unwell the vital signs recorded on 14 [Month16] indicated that [Mrs A] was very unwell and were indicative of a pneumonia which was the diagnosis made by [the hospital].

Additionally, it is my opinion that Fairview Care failed to meet its contractual obligations in the ARRC service provider agreement D16.3 and D16.4 (District Health Boards New Zealand, 2008) that required ongoing review and evaluation when there is a significant change in the resident's clinical condition.

Systems failures

There appears to have been some systems failures. The fact that the GP did not have enough time allocated to see all residents during the medical round resulted in [Mrs A] not being seen in a timely manner. I note that more GP time has been allowed for since this complaint. The facility [has] experienced difficulty in maintaining current care plans. The documentation of the advance directive did not meet legal requirements.

Conclusions

[Mrs A] suffered weight loss and possible dehydration while in the care of Fairview Care. As stated above the care of [Mrs A] failed to reach the expected standards. The seriousness of these failings is stated below:

1. Effectively assessing and monitoring nutrition and hydration — mild to moderate;
2. Adherence to policy — mild to moderate;
3. Communication — mild;
4. Care planning — moderate;
5. Documentation — mild to moderate;
6. Advance directive — unable to state as policy was not reviewed; and
7. Ongoing review and evaluation of [Mrs A's] health status from 1st to 14th [Month16] including not being seen by the GP — moderate.

Reference list

Burger, S., Kayser-Jones, J., & Bell, J. (2000). *Malnutrition and Dehydration in Nursing Homes: Key Issues In Prevention and Treatment* National Citizens' Collation for Nursing Home Reform.

District Health Boards New Zealand. (2011). *Age-related residential-care services agreement*. Wellington District Health Boards New Zealand.

Ministry of Health. (2010). *Food and Nutrition Guidelines for Healthy Older People: A background paper.* Wellington: Ministry of Health.

New Zealand District Health Boards. (2007 and 2008). *Age related residential care service provider agreement.*

Nursing Council of New Zealand. (2007). *Competencies for registered nurses* Wellington Nursing Council of New Zealand.

Standards New Zealand. (2008). *NZS 8134:2008. Health and disability services standards*. Retrieved. from http://moh.govt.nz/moh.nsf/pagesmh/8656/$File/81343-2008-nzs-readonly.pdf.

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