Waitemata District Health Board

A Report by the

Health and Disability Commissioner

(Case 13HDC00732)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. Mr A, aged 89 years, had a history of Type 2 diabetes (treated with insulin), ischaemic heart disease, hypertension, dyslipidaemia,[1] psoriasis,[2] and transurethral resection of the prostate. Previously he had had a triple bypass.

2. In 2012, Mr A fell while out walking. He was taken to a public hospital by ambulance.

3. Mr A was found to have a hip fracture and was reviewed by the medical and orthopaedic teams. Due to his poor clinical condition, the plan was to address his medical issues prior to operating on his hip.

4. Throughout Mr A's 15-day stay[3] at the public hospital, he spent time in four different wards. He complained of hip pain frequently, and was vomiting. The pain team reviewed Mr A several times throughout his stay and made recommendations. A range of oral and intravenous medications was given to alleviate his pain, minimise his confusion and reduce his vomiting. However, often he refused oral medications, and sometimes the intravenous line did not work properly.

5. Mr A also frequently refused food and drink while at the public hospital. He was given fluids intravenously and subcutaneously. Speech language therapists reviewed him but were unable to assess him because of his drowsiness and inability to follow instructions. A referral to a dietitian was made on Day 14.

6. Mr A had become confused since his fall, and was very restless during his time at the public hospital. He was given a low bed, and partway through his stay was transferred to a low stimulus area. A suprapubic catheter was inserted in an attempt to reduce his restlessness. At times Mr A had an observer in attendance. Laboratory tests indicated a possible urinary tract infection, which was treated with antibiotics. A CT scan of his head did not show anything of concern.

7. On Day 8, a decision was made to proceed to hip surgery. Following some confusion between staff and Mr A's family as to what time he would have the surgery, Mr A went into theatre on the afternoon of Day 9. The surgery was uneventful.

8. Mr A's family said that they called the public hospital early on Day 15 and were told that Mr A was resting. At 8am a nurse found Mr A cold and unresponsive, and, soon afterwards, he died.

Findings

9. Mr A's assessment and management were suboptimal with regard to his pain, oral care, nutrition and fluids. Overall, Waitemata DHB failed to provide services to Mr A

[1] Dyslipidaemia is an abnormal amount of lipids (such as cholesterol and/or fat) in the blood. Prolonged elevation of insulin levels can lead to dyslipidaemia.
[2] Psoriasis is a chronic, relapsing/remitting, immune-mediated systemic disease characterised by skin lesions including red, scaly patches, papules, and plaques, which usually itch.
[3] Relevant dates are referred to as Days 1-15 to protect privacy.

with reasonable care and skill and, accordingly, breached Right 4(1)[4] of the Code of Health and Disability Services Consumers' Rights (the Code).

Complaint and investigation

10. The Commissioner received a complaint from Mrs B regarding the care provided to her father, Mr A, by Waitemata District Health Board.

11. The following issue was identified for investigation:

- *The appropriateness of the care provided to Mr A by Waitemata District Health Board in 2012.*

12. An investigation was commenced on 2 July 2014. The parties referred to in the report are:

Mr A	Consumer
Mrs B	Complainant, consumer's daughter
Waitemata District Health Board	Provider
RN C	Registered nurse
RN D	Registered nurse
Dr E	Registrar
Dr F	Registrar
RN G	Registered nurse
RN H	Registered nurse
Ms I	Speech language therapist
RN J	Registered nurse
RN K	Registered nurse
Dr L	Orthopaedic consultant
Dr M	Anaesthetist
Dr N	Orthopaedic consultant
Dr O	Registered nurse
RN P	Registered nurse
RN Q	Registered nurse
RN R	Registered nurse
Dr S	House surgeon
Dr T	Registered nurse
Ms U	Physiotherapist
Ms V	Speech language therapist
Ms W	Dietician
RN X	Registered nurse
RN Y	Registered nurse

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

13. Independent expert advice was obtained from consultant physician Professor Tim Wilkinson (**Appendix A**) and registered nurse Ms Dawn Carey (**Appendix B**).

Information gathered during investigation

Background

14. Mr A was 89 years old at the time of these events. He was living at home with his daughter, and was able to mobilise with the aid of a walking stick.

15. Mr A had a history of Type 2 diabetes (treated with insulin), ischaemic heart disease, hypertension, dyslipidaemia, psoriasis, and transurethral resection of the prostate. Previously he had had a triple bypass.

Fall

16. Mr A went for walks regularly. On Day 1, members of the public found Mr A lying on the footpath and called an ambulance. The paramedic's report states that, on the ambulance's arrival at 1.27pm, Mr A was conscious but confused. His skin was cool and dry, and he had cold peripheries and blue lips. The report states that Mr A was vague as to how he had collapsed, and noted that he could "weigh[t] bear on own — shuffling steps".

17. The observations recorded by the paramedic at 1.35pm were that Mr A's respirations were 16 breaths per minute,[5] pulse 74 beats per minute,[6] blood pressure 140/60mmHg,[7] temperature 35.2°C,[8] and his oxygen saturations were 70%. Mr A was transferred by ambulance to Waitemata DHB and arrived there at 1.54pm.

18. On assessment in the emergency department at 2.30pm, Mr A's oxygen saturations had improved to 77% on room air, and his temperature was 35.7°C. Mr A was hypothermic and initially unable to have blood tests or X-rays because of his shivering. Later that day, an X-ray of Mr A's hip and pelvis was performed, and the report states that "no bony injury was seen".

19. RN C completed a written handover form, which noted that Mr A needed a pain team review, was for a CT scan, and that the urology nurse was to catheterise him.

20. Mr A's records contain an "initial assessment and risk screen" form, which states that it is to be completed within 24 hours of admission; however, the form is blank. The records also contain blank assessments and care plans.

[5] Normal adult respiration rate is 12–20 breaths per minute.
[6] Normal adult pulse is 60–100 beats per minute.
[7] Normal adult blood pressure is below 140/90mmHg.
[8] A normal body temperature is an oral temperature of 36.5–37.5°C.

Day 2–Day 9

Medical Ward

21. On Day 2 at 6.28pm, Mr A was admitted to a medical ward, where he remained until Day 6. That day, a CT scan showed that he had a hip fracture resulting in a shortened left leg. A skin integrity assessment (Waterlow) was undertaken, resulting in a score of 10 (over 10 is at risk of pressure injury), but Waitemata DHB stated that the score was not correct, as he would have been at higher risk than that assessed. No further assessment of Mr A's pressure risk was undertaken during his admission.

22. Mr A was reviewed by the medical and orthopaedic teams and, due to his poor clinical condition, the initial plan was to address his medical issues, including a likely myocardial infarction (heart attack) and heart failure. Once Mr A was stable from a medical point of view, he was to have an operation on his hip.

23. On Day 2, Mr A was prescribed PRN (as required) OxyNorm,[9] tramadol,[10] ondansetron,[11] and cyclizine[12] in addition to his regular medications, which included simvastatin,[13] omeprazole,[14] spironolactone,[15] aspirin, clopidogrel,[16] paracetamol and codeine.

Pain

24. There are numerous instances recorded in the clinical notes of Mr A complaining of hip pain. Mr A's family told HDC that they had never witnessed him in such pain previously. They said that, between his arrival at the public hospital on Day 1 and surgery on Day 9 (see below), he was given only oral painkillers, which he was unable to take because of his inability to swallow.

25. On Day 3, the clinical notes record that a house officer reviewed Mr A and advised that he could have OxyNorm subcutaneously despite his increasing sensitivity to opiates.

26. On Day 4, RN D noted that Mr A would not open his mouth to take his oral medications. That day a family meeting was held, during which medical registrar Dr E discussed Mr A's prognosis. Dr E told the family that Mr A had become more delirious, which could be a result of a UTI[17] or the opiates. Dr E said that he had changed Mr A from opiates to intravenous fentanyl,[18] and prescribed lorazepam[19] and

[9] A semisynthetic opioid. It is an analgesic generally indicated for relief of moderate to severe pain.
[10] An opioid pain medication that is used to treat moderate to moderately severe pain.
[11] Ondansetron is used to prevent nausea and vomiting.
[12] Cyclizine is an antihistamine drug used to treat nausea, vomiting and dizziness.
[13] Simvastatin is a cholesterol-lowering medication.
[14] Omeprazole is used to treat gastro-oesophageal reflux disease.
[15] Spironolactone treats fluid retention in patients with congestive heart failure, cirrhosis, or kidney problems.
[16] Clopidogrel is used to prevent myocardial infarction (heart attack) and stroke in people who are at high risk of these events, including those with a history of myocardial infarction and other forms of acute coronary syndrome, stroke, and those with peripheral artery disease.
[17] Urinary tract infection.
[18] Fentanyl is a potent, synthetic opioid analgesic with a rapid onset and short duration of action. It is used to treat breakthrough pain and is commonly used in pre-procedures as a pain reliever as well as an

haloperidol[20] "to settle him down", and said that a decision about whether Mr A would have surgery on his hip would be made the following day. Dr E recorded that he had told the family that Mr A might deteriorate.

27. Waitemata DHB stated that the opiates initially used for pain management, intravenous tramadol and OxyNorm, were stopped because of concern that they may have been contributing to Mr A's delirium.

28. The family were present at a ward round on Day 5, during which Mr A was noted to be confused. The family are recorded as having expressed the view that they "wanted [Mr A to be] comfortable".

29. Waitemata DHB advised that on Day 6, following a review by the pain team, a trial of a single dose of femoral nerve block[21] was undertaken, but a femoral catheter[22] was deemed not to be suitable for Mr A because he was too restless. Thereafter, a fentanyl, haloperidol, and metoclopramide[23] infusion was started.

30. At 3.50pm on Day 6, registrar Dr F recorded that Mr A was still having pain despite the nerve block, so his fentanyl was increased to 450mcg/24 hours subcutaneously. Dr F noted in the records that, in his view, Mr A had been stabilised medically "as best we can".

31. Waitemata DHB stated:

> "[A] range of oral and intravenous medication was used thereafter, adjusted to minimise [Mr A's] confusion and delirium. The pain team reviewed him regularly and on call medical staff were called to assess and prescribe medication. As [Mr A] was not taking oral medications, other options were considered including per rectum and intravenous analgesia."

32. The clinical notes reflect the consideration of these options.

Confusion/delirium

33. From Day 2, Mr A was noted to be confused. His family advised staff that Mr A's confusion was new, and that he was normally alert and orientated. They said that when he had had surgery previously, opioid medication had made him very confused.

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anaesthetic in combination with a benzodiazepine. Fentanyl is approximately 80–100 times more potent than morphine and roughly 15–20 times more potent than heroin.

[19] Lorazepam is used for the management of anxiety disorders, the short-term relief of symptoms of anxiety, or anxiety associated with depression, and is used in combination with other medications to prevent nausea and vomiting.

[20] Haloperidol is an antipsychotic medication used in the treatment of delirium.

[21] A femoral nerve block results in anaesthesia of the anterior and medial thigh down to the knee (the knee included), as well as a variable strip of skin on the medial leg and foot.

[22] A type of central venous catheter that is inserted into the femoral vein in the thigh.

[23] Metoclopramide is a medication commonly used to treat nausea and vomiting.

34. On Day 2, the medical ward's nursing assessment records: "[C]onfused, ? secondary to UTI. History of confusion with Morphine. Hypersensitive to opioids." On Day 4, Mr A was reportedly "extremely restless, rolling from side to side" and trying to get out of bed. A constant observer shared with another patient was arranged to ensure that Mr A was watched at all times.

35. Waitemata DHB advised that the Urology Nurse Specialist and doctor inserted a suprapubic catheter to reduce Mr A's restlessness, as he was not able to stand, and a bladder scan showed that there was residual urine in his bladder.[24]

36. The clinical record indicates that efforts were made to identify the possible cause of Mr A's delirium.[25] On Day 3, the laboratory results from testing of a urine sample showed "mixed gram positive and gram negative bacteria". Waitemata DHB stated that those results in the context of a catheter urine sample may have indicated an infection, which may have been contributing to the delirium. The DHB stated that originally Mr A was treated with the IV antibiotic cefuroxime, which was later changed to another antibiotic, trimethoprim, after identification of antibiotic-resistant bacteria.

37. On Day 4, Mr A had a CT scan of his head to determine the cause of his delirium. The report states: "Impression: no intracranial haemorrhage."

38. Waitemata DHB stated that a further possible contributing cause of Mr A's delirium was hypernatraemia,[26] which may have been caused by a combination of dehydration, raised blood glucose and, at one stage, by the nature of the replacement fluids that he was administered.

39. On Day 4, it is noted that Mr A was restless, yelling, trying to pull out his lines, and trying to get out of bed. At 3pm RN D recorded that Mr A was to be transferred to a low bed against the wall with a mattress beside it, because of concerns that he might fall out of bed. The record states: "[H]owever he is moving around so much may continue to roll off." A constant observer remained in place.

40. On Day 6, RN D noted that Mr A's delirium care plan was for him to have a "low bed, frequent observations". His shoulder was red and swollen, and it was recommended that an air mattress be ordered. Mr A remained agitated, and was moaning, calling out and taking off his bedclothes. He was reviewed by the orthopaedic registrar and pain team, and it was decided that Mr A would be transferred to another ward, which has a low stimulus area, and provides care for people experiencing delirium.

41. From Day 6 to Day 8 there are multiple instances recorded in the clinical notes that Mr A was confused, delirious, restless and moaning.

[24] The clinical notes show that the suprapubic catheter was inserted on Day 2.
[25] The clinical records refer variously to "confusion" and "delirium".
[26] Elevated sodium level in the blood.

Food and fluids

42. On Day 3, RN D recorded that Mr A was "unable to tolerate oral meds" and was eating and drinking "very little", not swallowing, and holding medications in his mouth. She noted: "[M]onitor urine output." Dr E recorded that subcutaneous fluids could be given as charted if Mr A's oral intake was less than 800ml per day.

43. Mr A's family told HDC that they noticed that his mouth was very dry and the inside of his lips were sticking to his teeth. Mr A's family also said that they found that Mr A's drip had disconnected, and this had soaked his bed.

44. On Day 3, Mr A was referred to the speech and language therapist (SLT) for a swallowing assessment. While waiting for the assessment, the nurses completed a dysphagia[27] screen and, as Mr A's swallow with water was strong, they decided to offer him a puréed diet. On Day 4, RN G recorded that Mr A was refusing to eat or drink. On Day 5, RN H also noted that he had refused all oral intake.

45. At 9am on Day 5, SLT Ms I reviewed Mr A. Ms I noted that Mr A was tolerating a puréed diet and receiving subcutaneous fluids. However, he was not able to be assessed at that time as he was drowsy, confused, and unable to follow the instructions required for the assessment. Ms I requested that the nurses re-refer Mr A when he was accepting oral intake and if he continued to show signs of dysphagia.

46. At 10am on Day 5, Dr F recorded that Mr A had not had anything to eat or drink for the last few days. Dr F noted that Mr A was dehydrated, and IV fluids were prescribed.

47. That afternoon, RN H noted that Mr A had refused "all oral intake, including medications". At 2.30pm RN H noted that, given Mr A's restlessness, subcutaneous fluids would be more appropriate than IV fluids, and she paged the medical team to review Mr A. At 4.45pm on Day 6, RN D noted that intravenous fluids were "just charted by team [house officer]" and were to commence at that time.

48. On Day 6 at 10.30pm, RN J noted: "[Mr A] refused to eat or drink and oral meds … insulin not given." RN J noted that Mr A required oral cares because his tongue was very dry; however, no care plan was prepared for his mouth hygiene.

49. Overnight on Day 6/Day 7 it was noted that staff had attempted to give Mr A sips of water but he was not cooperative. Mr A had a low-grade fever with a temperature of 37.5°C. The nursing plan included "? SLT or Dietitian input", and again staff queried whether he needed an air mattress. The registered nurse recorded: "[E]ncourage oral fluid intake + oral cares."

50. There are repeated references in the clinical notes to Mr A having difficulty swallowing and refusing all oral intake, including medication. However, there is no nursing assessment, care planning or evaluation of Mr A's nutritional status, and the fluid balance charts are incomplete.

[27] Dysphagia is difficulty with swallowing.

Transfer to another medical ward

51. At 6pm on Day 6, Mr A was transferred to another ward, where he remained until Day 9. RN D noted that she had taken Mr A to the new ward and verbally handed over to RN J.

52. On Day 7, Mr A was reviewed by Dr F, who noted that Mr A was not able to communicate and had been like that for the past few days. Mr A was agitated and restless. His sodium level was very high at 159mEq/L.[28] Dr F noted that Mr A's urine output had not been documented, and requested hourly urine output records. Dr F noted that he had discussed Mr A's deterioration with his family, who were "aware of [his] poor prognosis", and that the aim was "to achieve better pain control".

53. On Day 7 at 10.40pm, RN K noted that Mr A's urine output should be recorded hourly, and that the aim was for a urine output of not less than 30ml per hour. Dextrose saline was charted, but normal saline was given overnight. Mr A's sodium level rose to 167mEq/L.

54. On Day 8 at 7.50am, Mr A was reviewed by the orthopaedic team. The record states: "Clinically deteriorating. Hypernatraemia. Presently not an anaesthetic candidate." At 11.45am Dr F recorded that he had discussed Mr A's condition with his daughters, and they had indicated concern that Mr A should have better symptomatic control. Dr F discussed this concern with the pain team.

55. That afternoon, orthopaedic consultant Dr L noted: "[Agreed] best to proceed with surgery tomorrow. [Discussed with] family who understand risks & will be present for consent tomorrow am." Mr A was to be nil by mouth from midnight.

56. Dr F noted that Mr A "seemed to be improved as per family" and was more alert and making more sense. It was decided to proceed to hip surgery. Mr A's family were advised of the risks of the surgery.

Surgery, Day 9

57. Mr A's family told HDC that on Day 9 they arrived at the hospital at 7.30am and were advised that Mr A would go to theatre as soon as possible. At 8.10am Mr A was reviewed by the anaesthetic fellow, Dr M, who noted that he had explained to Mr A's daughter the "high risk for the anaesthetic and surgery", and also "the risk of further heart attacks, heart failure, and even death in the perioperative period". The "consent to treatment" anaesthesia form was signed by Mr A's daughter, and the consent to the surgery was signed by Mrs B. There is no record of any assessment of Mr A's competence to consent on his own behalf.

58. Mr A's family stated that by midday they had heard nothing, and Mr A was asking for a drink, but they were told that he was not able to have any oral fluids as he was going to theatre. They stated:

[28] The normal range for blood sodium levels is 135–145mEq/L.

> "[W]e were advised after a call to Theatre Staff that [Mr A] was not on the operating list for that day and nobody knew where the consent forms to treatment had been filed. Family members then made it very obvious that we were not happy with the situation and at [2.30pm] we had a call from [orthopaedic consultant] [Dr N] who spoke to [Mrs B] ([Mr A's] [second] daughter) advising that he had reshuffled the theatre schedule so that [Mr A] could go to theatre, we advised what we had been told in relation to post op care and said we wanted something done before the end of the day. He said this was 'good news' for [Mr A] but that he now had to tell somebody else they could not have their operation."

59. Waitemata DHB stated:

> "[W]e apologise for the confused messages about the time for when [Mr A] would be operated. He was on a medical ward and it is not clear whether the staff knew what time he was on the operating list, except that he needed to be nil by mouth from midnight. On the acute theatre list the surgeons try to get as many patients through the operating room and it is not always clear at what time or whether the patients will be done. This can be upsetting for patients and families."

60. Mr A was taken to the theatre ward to be prepared for the surgery at approximately 3.30pm. He was accompanied by Mrs B, who stated that the nurse filling in the admission forms asked her when her father had last eaten, and was advised that he had not eaten since his admission on Day 1. Mrs B stated that the nurse was convinced that Mr A had food in his mouth, but when the nurse swabbed his mouth she found a large piece of dead skin, which was removed from his mouth. Mrs B said that the nurse advised her that when Mr A returned to the ward following surgery she should insist that oral care was to be given every two hours, as his oral condition was not acceptable. However, there is no record of this requirement in the clinical records. Waitemata DHB stated that caring for Mr A's mouth was difficult, as he refused to open his mouth at times.

Orthopaedic ward (postoperatively)

61. The surgery, undertaken by Dr N, was uneventful. Postoperatively Mr A was transferred to the orthopaedic ward, where he remained for three days. He remained confused and had an observer in attendance. He continued to refuse food and oral fluids.

62. On the morning of Day 10, Dr O recorded that Mr A was not eating or drinking much, and that his IV fluids had been given as charted. The notes record: "[Daughter] helping to feed the patient." Dr O noted that Mr A had refused his oral medications, and that his blood pressure, oral intake and fluids should be monitored.

63. Mr A's blood sugar levels as recorded in the BG (blood glucose) monitoring record from Day 7–Day 15 ranged from 8.3–24.2mmol/L.[29] Waitemata DHB told HDC:

[29] A normal blood sugar level is considered to be 4–7mmol/L before meals for people with Type 2 diabetes.

> "It is always a delicate balance restarting insulin in circumstances of infection, post operative, with possible myocardial infarction and heart failure all on a background of poor diabetic control. Ideally the blood sugars should have been lower with an increase in long acting insulin therapy."

64. Mr A's family thought that Mr A may have had diabetic ketoacidosis.[30] Waitemata DHB stated that this was highly unlikely, as Mr A had Type 2 diabetes, and his blood sugars were not high enough.

65. That evening, Mr A was reviewed by the pain team and, at 10.30pm, by an orthopaedic registrar, who noted that Mr A was stable from an orthopaedic point of view but required medical follow-up.

66. On Day 11, Mr A was reviewed again by the pain team, and it was noted that he was more settled, but restless at times, and that it was difficult to assess his pain because of his confusion. His IV fentanyl and haloperidol were continued.

67. During the morning (time not recorded), Dr O noted that Mr A had refused oral medications but had been given "IV Panadol". It is recorded that Mr A seemed stable and settled and had had a few spoonfuls of porridge and sips of water. His sodium level was 158mEq/L.

68. Dr O noted that she had asked the medical team on-call house surgeon (OCHS) to chart fluids, and the OCHS had responded that Mr A would be reviewed the following day. That evening, RN P noted that the IV line was "tissued and leaking", and that the OCHS had been paged. Mr A had not tolerated food, and drank only 75ml of fluid on that shift. It is recorded that the OCHS was paged to chart fluids but had not replied. The night shift nurse, RN Q, also noted that Mr A needed a new IV line.

69. At 8.15am on Day 12, the pain team recorded that Mr A was sleepy and settled and that the sedation/analgesia via a pump should be stopped, and noted: "[P]lease give regular oral paracetamol prn meds available." At 1.20pm RN R noted that Mr A had been given his medications as charted, but had vomited after the medications were given. The house surgeon was contacted and, at 2.13pm, Dr S reviewed Mr A and noted that he was awake, able to communicate, and had no pain. His delirium was improving, and his agitation was reducing. The plan was to administer fentanyl subcutaneously, and "PR (per rectum) paracetamol". His fluid output and input were to be monitored. Mr A was reviewed by the physiotherapist, but was drowsy and unable to do the exercises.

Third medical ward

70. On Day 12 at 3.45pm, Mr A was transferred to a third medical ward for ongoing medical care. RN R provided verbal handover to Dr T. The notes state that on Day 13 Mrs B requested that an SLT consultation be arranged because she had concerns about Mr A's swallowing.

[30] A serious diabetic complication where the body produces excess blood acids.

71. At 12.30pm on Day 13, Mr A was reviewed by a physiotherapist, Ms U, who recorded: "[V]omiting ++ (dark brown [no] solids)." Mr A's daughters stated that "the Physiotherapist came to see [Mr A] but he was too weak to do the exercises and when he was sat up to do exercises he vomited coffee grain like fluid as witnessed by [us]". Mr A's family said that the vomiting continued over the next few days.

72. At 1.15pm Mr A was reviewed by SLT Ms V, who noted in the nursing notes the ongoing concerns with swallowing. Ms V recorded a plan that Mr A was for non-oral nutrition, and that a dietitian's opinion was needed. The plan was for a further SLT review in one to two days' time. Ms V noted that Mr A would need to be fully alert for more than 15 minutes, be able to sit upright, able to take oral intake without vomiting, and not refusing to eat or drink, for the assessment to take place.

73. On Day 14 at 4pm, Mr A was seen by a dietitian for the first time since his admission on Day 1. Dietitian Ms W noted that Mr A was at high risk of malnutrition because he had had 13 days of poor/minimal oral intake and vomiting. She noted:

> "[T]his patient is not meeting their nutritional requirements orally. Consideration should be made by the medical team as to whether nutrition support using enteral feeding[31] is a medically appropriate treatment for this [patient]. Please contact the [dietitian] should the decision be made to enteral feed."

74. Mr A remained confused and was calling out. He had been given NILSTAT[32] for his mouth, but it was leaking out, his mouth was sore, and he was unable to swallow.

75. Waitemata DHB told HDC that Mr A continued to have a constant observer in attendance. However, Mr A's family said that he shared a room with another patient, and the observers sat in a position where they were not able to observe Mr A. Waitemata DHB provided HDC with "Watch Handover" sheets for Mr A, on which the watcher has completed hourly observations. On Day 15, the watcher noted that two patients were sharing the watch. The Waitemata DHB "Special Care Assistants [Watch Management]" policy requires the assistant to "observe" patients at risk of harming themself or others. If patients are under one-to-one observation, the watcher must be "within arms length and immediate supervision".

76. RN X stated that at 10pm on Day 14, Mr A vomited black fluid. She told HDC:

> "I power paged the on-call medical officer to advise him that [Mr A] had vomited again. As [Mr A] had not triggered the Early Warning Score[33] this was not an emergency call and I handed over to the night nurse that I had notified the doctor."

77. RN X recorded these events in the clinical notes.

[31] Enteral feeding is feeding via a tube.
[32] NILSTAT is used to treat oral thrush. This is an infection in the mouth caused by the fungus Candida, and is marked by sore, creamy-yellow, raised patches in the mouth.
[33] An early warning score (MEWS) is a guide used by hospital nursing and medical staff to quickly determine the degree of illness of a patient.

78. Dr T stated that at 11.45pm RN X handed over to her that she (RN X) had paged the on-call house surgeon. Dr T stated that she expected that the house surgeon would either come to the ward or call. When he called, she told him that Mr A was asleep and comfortable.

79. Dr T spoke with the house surgeon again at 2am, as she needed to administer an additional dose of insulin because Mr A's capillary glucose was 24.2 and, at that time, he had not vomited again and appeared stable. Dr T recorded that she had administered 4 units NovoRapid as charted.

80. Waitemata DHB stated that it has no record of the pages that were sent to the house surgeon (such as a page log or telephone log), but advised that a doctor attended Mr A at 10.45pm and at 2am on Day 14, in response to calls made by the nurses, and prescribed insulin on both occasions. The insulin prescription is documented in Mr A's diabetes insulin prescription chart, which records a prescription on Day 14 for 3 units of NovoRapid, which was administered at 10.50pm, and on Day 15 for 4 units of NovoRapid, which was administered at 2.10am.

81. Waitemata DHB stated that the calls to the house surgeon were not emergency calls, and that Mr A had not triggered the Early Warning Score. The DHB stated: "Having attended and prescribed insulin and later being informed by the nursing staff that [Mr A] was comfortable and asleep, and his observations remained stable, we consider that the calls to the house officer were appropriately responded to."

82. Dr T stated that she checked Mr A again at 6am, prior to finalising her night duty report and handing over to the morning nurse, RN Y. At 6.35am on Day 15, Dr T recorded that Mr A had slept well overnight, and that there was a constant observer in attendance.

Deterioration

83. At approximately 8am, RN Y went to Mr A's room to record his observations. She found him cold and pale with laboured breathing. Mr A did not respond to pain stimulus, and his blood sugar was very high, at 17.29mmol/L. Mr A then vomited black liquid and began Cheyne-Stokes breathing.[34]

84. RN Y commenced oxygen by way of mask at 6 litres, and the charge nurse contacted Mr A's family. RN Y called the house surgeon and, by the time she returned to Mr A's room, he had stopped breathing.

85. Mr A's cause of death was recorded as urosepsis[35] with underlying myocardial infarction and left neck of femur fracture.

[34] Toward the end of life, respiration often takes on an abnormal pattern called Cheyne-Stokes respiration, which ranges from very shallow breaths to alternating periods of apnoea and deep, rapid breathing.
[35] Urosepsis occurs when an infection starts in the urinary tract and spreads into the bloodstream.

86. Mr A's family stated that they were upset that they had been advised at 6am and 8am that Mr A was comfortable and resting. They were distressed that by the time they arrived at the hospital their father had already died, and noted that they could have been with him before his death if they had been advised about his condition earlier. Waitemata DHB noted that the morning staff may have passed on the message that Mr A had had a restful night, as that is what is documented.

Further information from Waitemata DHB

87. Waitemata DHB advised that it regrets that Mr A's family were not able to be present at the time of his death. It stated that the DHB does not provide grief counselling, but social work and chaplaincy services are available. The DHB apologised that the family did not experience adequate support.

88. Waitemata DHB stated that it has a programme of work focussed on end-of-life/bereavement care, which aims to assist staff to communicate with families so that they feel more supported at the time of the death of their loved one.

89. Waitemata DHB stated that it would like to extend sincere condolences to Mr A's family for their loss, and acknowledged that it must have been a difficult and distressing time for the family. The DHB stated:

> "We apologise that elements of [Mr A's] care fell short of their and our expectations. We have work underway with the nursing staff on the medical wards to review care planning, care of patients who are deteriorating and reinforcement of basic nursing care, especially in relation to hydration and nutrition, pressure assessment and referral for allied health e.g. dietitian. We are also working on processes to minimise the transfer of patients at risk to multiple wards and to identify these patients early to ensure care management is coordinated and families are communicated with in a proactive way. We will continue to focus on making improvements in our systems, processes and practices to prevent recurrence of the shortcomings experienced by [Mr A]."

90. Waitemata DHB acknowledged that Mr A should have received regular nutritional assessments throughout his admission. It told HDC that the Malnutrition Universal Screening Tool is in the clinical record, but it had not been completed. The DHB further acknowledged that a food diary was not started, and that fluid balance charts were not completed consistently.

91. After Day 2, there is no further pressure injury risk assessment. The DHB acknowledged that Mr A's pressure care could have been better, stating: "We would have expected that more regular skin integrity assessment was done and more specific documentation of the wounds/injuries were made." The DHB has participated in a Regional Pressure Injury Prevention Programme, and audits are undertaken by the nursing staff monthly to ensure that risk assessment is completed in a timely manner and appropriate interventions are implemented.

92. Further specific initiatives undertaken by the DHB following this case include:

- a focus on patient experience, including hourly checks of patients, and a daily visit by the charge nurse manager;
- a programme focused on improving the essentials of care;
- a review of nursing documentation, including an audit of the completion of essential assessments. Nursing documentation is now kept at the bedside so that medical and allied health staff have immediate access to the documentation to inform their care planning;
- an interdisciplinary improvement group has been working on implementing improvements relating to nutrition and hydration;
- a focus on the quality of transfer of care documentation, including ward transfer;
- a focus on patient observation, including the education of healthcare assistants;
- a clinical nurse specialist focused on diabetes management visits each ward daily and has input into nursing staff education and updates;
- the general manager for Surgical and Ambulatory Services has worked with the surgical team to monitor patients scheduled for acute theatre procedures. Key staff have been delegated to review the people booked, at least twice a day, to identify patients who have had surgery delayed. They are then to communicate in a timely way if the procedure is delayed, so that the patient/family can be given information and the patient's needs for food/hydration are monitored and provided for;
- an electronic theatre whiteboard and report is under development to further enhance the management of the acute theatre list;
- an early recovery after surgery (ERAS) programme is underway to ensure that all patients who present with an acute fractured neck of femur are managed according to ERAS principles. A nurse-led early mobilisation tool has been implemented; and
- all medical and surgical ward charge nurses carry out a daily review of patients who have special needs requiring allied health referral. The "smart page" system has been introduced to provide safeguards to improve management of calls to an on-call doctor.

Opinion: Waitemata District Health Board

93. Mr A was 89 years old at the time of these events, and had a number of co-morbidities. However, he was still able to walk with the aid of a walking stick, and was in the habit of going for regular walks. On Day 1, he was found lying on the footpath and was transported by ambulance to the public hospital, where he was an inpatient from Day 1 to Day 15.

94. During his stay, Mr A was a patient on four different wards. He had the right to receive care of an appropriate standard during that stay. He had some complex issues, particularly in relation to pain and delirium, which may have had a number of causes. For this reason, the management of those issues required critical thinking on the part of the health team. In my view, there were several areas of Mr A's care where critical thinking was lacking, in particular, the evaluation of his pain, and the management of his oral care, fluids and nutrition. In addition, my expert nursing advisor, Ms Dawn Carey, advised that, in her opinion, the four wards operated as "information silos". I am also concerned that within Mr A's clinical notes there are blank assessments, and inadequate or blank care plans, and clinical requests have been made but not actioned.

95. I consider that failures by Waitemata DHB at an organisational level contributed to these deficiencies. A DHB is responsible for ensuring that it has robust systems in place to provide an appropriate standard of care to its patients. While multiple staff recognised issues with Mr A's health on a day-to-day basis, aspects of the issues identified were not managed adequately, and therefore the care provided by Waitemata DHB was suboptimal.

Standard of Care — Breach

Pain monitoring and evaluation

96. There are numerous instances recorded in the clinical notes of Mr A complaining of hip pain. Mr A's family told HDC that, between his admission on Day 1 and his surgery on Day 9, he was given only oral pain killers, which he was unable to take because of his inability to swallow.

97. However, the clinical records support Waitemata DHB's advice that following a review by the pain service a trial of a single dose of femoral nerve block was undertaken on the ward, but a femoral catheter was deemed not to be suitable for Mr A because he was too restless. A fentanyl, haloperidol and metoclopramide infusion was started. A range of oral and intravenous medication was used thereafter, adjusted to minimise his delirium. The pain team reviewed Mr A regularly, and on-call medical staff were called to assess and prescribe medication. As Mr A was not taking oral medications, other options were considered, including per rectum and intravenous analgesia.

98. My independent expert consultant physician, Professor Tim Wilkinson, advised that the management of Mr A's pain would have been difficult. There was a risk that increasing Mr A's analgesia would worsen his delirium, but not increasing the analgesia would mean his pain was not controlled. Although an operation on his hip would have helped to ease his pain, that would have been unsafe while he was medically unstable. Professor Wilkinson advised that the strategies adopted to manage Mr A's pain were reasonable, and the fact that they were not successful was not due to a lack of care on the part of the health care team.

99. However, Ms Carey advised that, in her view, the nursing staff did not evaluate sufficiently whether the prescribed/administered analgesia was effective at managing Mr A's pain. She noted that there was no completed pain care plan and, in her

opinion, an objective pain assessment tool should have been used when assessing pain and evaluating the effectiveness of administered analgesia. She advised that tools such as the PAINAD Scale[36] or Abbey Scale[37] would have been suitable to use when Mr A was experiencing delirium. Ms Carey noted: "[Mr A] was presenting with symptoms such as restlessness that may have been due to pain or not. Part of determining possible causes of symptoms requires an objective evaluation of the patient response to administered interventions."

100. Ms Carey also noted that there were occasions when Mr A did not receive paracetamol therapy despite it being prescribed for regular administration. She stated: "There is a general absence of documentation in either the clinical nursing notes or on [Mr A's] medication chart to explain incidences of non administration."

101. Although I accept that Mr A was reviewed regularly by the pain team, and on-call medical staff were called to assess him and prescribe medication, in my view the nursing care in relation to the care planning, monitoring and evaluation of the effectiveness of Mr A's pain management was suboptimal throughout his admission.

Nutrition

102. Mr A had difficulty swallowing, and would hold food and medication in his mouth. On Day 3, the nursing staff referred him to the SLT for a swallowing assessment. However, I am concerned that a dietitian referral did not occur until Day 13, when the physiotherapist made the referral. By this time, Mr A had been in hospital for 13 days without adequate oral intake.

103. Professor Wilkinson noted that, although an assessment of Mr A's swallowing was undertaken, a review of his nutritional intake was delayed until Day 14, and, as a consequence, there was no adequate consideration of his nutritional intake. Professor Wilkinson advised that failing to actively consider the issues relating to Mr A's poor oral intake and dehydration, and not attending to his nutritional state, was a moderate departure from accepted standards of care.

104. Ms Carey was also critical of the delay in recognising that Mr A required nutritional specialist involvement. She noted that there was a lack of nutritional intervention or management by the nursing staff.

105. Ms Carey advised that a validated nutrition assessment tool, the Malnutrition Universal Screening Tool, was included in Mr A's clinical notes, but it was not completed, despite the form stating to "complete within 72 hours of hospital admission". Ms Carey advised that based on her calculation of Mr A's malnutrition by way of the universal screening tool score, a dietitian referral should have been made earlier.

[36] Warden, V, Hurley, A & Volicer, L, "Development and Psychometric Evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale". *Journal of American Medical Directors Association*. 4(1): 9–15 (USA:AMDA, 2003).
[37] Abbey Scale: www.dementiacareaustralia.com/docs/Abbey_Pain_Scale.pdf.

106. Waitemata DHB acknowledged that Mr A should have received regular nutritional assessments throughout his admission, that the Malnutrition Universal Screening Tool was not completed, and no food diary was started.

107. Nursing staff regularly documented throughout his admission that Mr A had little or no nutritional intake, but did not document further actions such as quantifying his intake, increasing his calorific intake, or escalating their concerns. Ms Carey advised:

> "[I]n my opinion, it is simply not sufficient to continually report a 'problem' without attempting to clinically manage it. Whilst I acknowledge that commencing enteral feeding would have been quite difficult due to [Mr A's] delirium, there is sparse evidence that it was considered in an appropriate timeframe or that there was an actual plan to prevent unintentional weight loss."

108. In my view, an assessment of Mr A's nutritional status, with appropriate care planning and evaluation of his response to the strategies adopted, should have been undertaken and recorded much earlier than Day 13.

Fluid therapy

109. Mr A was prescribed and administered intravenous and subcutaneous fluid therapy. However, the fluid balance records throughout his admission are incomplete despite intake/output monitoring being requested, fluids being administered, delirium being a recognised problem, and Mr A being clinically dehydrated.

110. The maintenance of fluid balance records was particularly important for Mr A, both because of his clinical condition, and because he was transferred on four occasions to different wards. I consider that it was essential that appropriate fluid balance assessments were undertaken and recorded to assess the effectiveness of his fluid replacement treatment.

Oral care

111. Mr A was vomiting intermittently and had difficulties with swallowing throughout his admission. Mrs B stated that prior to Mr A's surgery, the nurse advised her that when Mr A returned to the ward following surgery she should insist that oral care be given every two hours, as his oral condition was "not acceptable". However, this advice is not recorded in the clinical notes.

112. Ms Carey advised that Mr A required regular mouth hygiene for comfort, and to prevent complications. She noted that there are regular nursing entries reporting that Mr A received mouth care, but the entries lack commentary on the condition of his mouth, and no oral care plan was completed.

113. In my view, the planning and evaluation of the oral care provided to Mr A by the nurses caring for him was unsatisfactory.

Conclusion

114. I accept that since these events Waitemata DHB has put in place a number of new initiatives, which may minimise the risk of the shortcomings identified in this case

being repeated. However, I consider that Mr A's assessment and management were suboptimal with regard to his pain, oral care, nutrition and fluids. Overall, I find that Waitemata DHB failed to provide services to Mr A with reasonable care and skill, and, accordingly, breached Right 4(1) of the Code.

Consent to surgery — Other comment

115. On Day 9 at 8.10am, Mr A was reviewed by the anaesthetic fellow, Dr M, who noted that he had explained to Mr A's daughter the high risk that the anaesthetic and surgery posed for Mr A. Dr M also explained the risk of further heart attacks, heart failure, and even death in the perioperative period.

116. The "consent to treatment" anaesthesia form was signed by Mr A's daughter, and the consent to the surgery was signed by Mrs B. There is no record of any assessment having been conducted of Mr A's competence to consent on his own behalf.

117. I accept that Mr A was confused and suffering from delirium, and that there were reasonable grounds to question his competence to consent to the surgery. However, even when consumers themselves are not competent, their family members do not have the right to consent on the consumer's behalf. Right 7(4) of the Code provides that where a consumer is not competent to give informed consent, and there is no one entitled to give consent on the consumer's behalf (such as an activated enduring power of attorney), providers may nonetheless provide services where it is in the best interests of the consumer and reasonable steps have been taken to ascertain the views of the consumer. Right 7(4)(c) provides further that if the consumer's views cannot be ascertained, providers are required to take into account the views of other suitable persons who are interested in the welfare of the consumer and available to advise the provider.

118. There is no evidence that either of Mr A's daughters were his legal representative. In my view, if the DHB considered that Mr A was not competent to consent to the surgery himself, and the surgery was in his best interests, his family should have been consulted. However, the assessment of his competence should have been recorded, and the decision to proceed with surgery pursuant to Right 7(4) should have been documented by the responsible clinician. In these circumstances, Mr A's daughters had no legal right to consent to surgery on Mr A's behalf.

Recommendations

119. I recommend that Waitemata DHB provide a written apology to Mr A's family. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A's family.

120. I recommend that Waitemata DHB provide evidence to HDC of having completed the following recommendations, within three months of the date of this report:

a) Training of staff on the importance of monitoring of pain, oral cares, nutrition and hydration.
b) An audit of the documentation practices in the wards where Mr A was cared for.
c) An evaluation of the changes made to the scheduling of times for patients' operations and the communication with patients regarding expected operation times.
d) Report on the findings from the audit of pressure risk assessments.
e) Report on the changes made by the group implementing improvements relating to nutrition and hydration.
f) Report on the outcome of the audit of nursing practice.
g) Consider undertaking a project to identify and respond to signs of deterioration in adult patients.

Follow-up action

121. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Waitemata DHB, will be sent to DHB Shared Services and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Independent expert advice to the Commissioner

The following expert advice was obtained from consultant physician Professor Tim Wilkinson:

"I have been asked to provide an opinion to the Commissioner on [Mr A] (dec)/[the public hospital], ref C13HDC00732. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

My qualifications are: Bachelor of Medicine and Bachelor of Surgery from the University of Otago, Fellowship of the Royal Australasian College of Physicians, Fellowship of the Royal College of Physicians (London), Master of Clinical Education from the University of New South Wales, Doctor of Philosophy from the University of Otago and Doctor of Medicine from the University of Otago. I have worked as a Consultant Physician in Geriatric Medicine at The Princess Margaret Hospital in Christchurch, New Zealand, since 1994 and I am also a Professor in Medicine at the University of Otago, Christchurch. In my clinical work I deal with common problems faced by older people, particularly those that threaten their independence. I see older people in their homes, in Outpatient Clinics and in Inpatient Wards.

The instructions from the Commissioner are as follows:

'The purpose of this advice is to enable the Commissioner's Office to determine whether, from the information available, there are concerns about the care provided by Waitemata DHB which may require further action. This file is still at the assessment stage, and we are interested in whether you consider the care provided to [Mr A] was appropriate. In addition to your general comments on the standard of care [Mr A] received, please address the following issues:

1. The management of [Mr A's] pain
2. The decision to proceed to hip surgery
3. The management of [Mr A's] poor oral intake and dehydration
4. That there is no record on file that the on-call house surgeon responded to a page on the night of [Day 14] and reviewed [Mr A]
5. Whether Waitemata DHB have responded appropriately to issue 4.'

I have available to me copies of

1. Letters of complaint
2. Clinical records
3. Response letters from Waitemata DHB, dated 9 August 2013 and 20 December 2103

I agree with your summary of the situation, and will not repeat it here. The only general comment to make is to agree with the opinions of Waitemata DHB regarding the possibility, raised by [Mr A's] relatives, of diabetic ketoacidosis as a

contributing factor to his illness. In my opinion, I agree that this seems a highly unlikely contributing factor.

1. **The management of [Mr A's] pain**

The situation that [Mr A] experienced is not uncommon and is difficult. Essentially, there is a risk that increasing analgesics would worsen his delirium, yet not increasing analgesics would worsen his pain. An operation would help in easing his pain and ultimately his delirium, but this was judged unsafe while he was medically unstable. I note that the health care team engaged the help of the pain management service and that local anaesthesia was tried. In my opinion, these were all reasonable steps and in line with current practice. It is also my opinion that the health care team were placed with a very difficult balance to achieve. There is evidence that they recognised this difficult balance and took steps to relieve [Mr A's] suffering. That an ideal outcome was not achieved was not, in my view, due to lack of care on the part of the health care team.

2. The decision to proceed to hip surgery

This decision, in my opinion, also creates a dilemma. Ideally, surgery should occur as soon as possible after the fracture as this not only helps the pain, but also helps a person regain general health and strength as they are then able to mobilise and resume many of their usual activities. On the other hand, surgery on an unwell person carries risks. These competing factors need to be weighed up and the timing of an operation determined that represents the optimal balance of risk versus benefit. In my opinion, there is evidence that the health care team were aware of these factors and attempted to achieve this optimal balance. In my opinion, the decision on the timing of the operation seemed reasonable. Having said this, and as acknowledged by Waitemata DHB, the process could be more streamlined in providing more certainty around the actual timing of the operation and, in particular, around the timing of any food/fluid restrictions (see section 3, below). Overall, it is my opinion that there was not a significant departure from expected standards of care.

3. The management of [Mr A's] poor oral intake and dehydration

[Mr A's] other health problems and a series of delays resulted in some time before [Mr A] had an operation to manage his fractured hip. His delirium and other health problems also resulted in [Mr A] sometimes refusing the food and fluids that were offered. Although an assessment of his swallowing was undertaken, a review of his nutritional intake was delayed, and this delay is acknowledged by Waitemata DHB to be unsatisfactory. Thus, while there were several mitigating factors, the end result was [Mr A] did not receive adequate consideration of his nutritional intake. It is also important to emphasise that while sick, [Mr A] may well have a reduced appetite and a reduced capacity to eat. Furthermore, providing food by other means, such as nasogastric feeding, in my opinion, also carries some risk. This means that even if more timely nutritional assessments had been undertaken, it is my opinion that this may not necessarily have resulted in a substantial change to his nutritional state. Indeed, forcing food on a person in such a state, in my opinion carries the risk of causing harm. Nevertheless, it is also my

opinion that not actively considering these issues and not attending to his nutritional state does represent a moderate departure from expected standards of care. The response from Waitemata DHB recognises and agrees with this. The response however, in my opinion does not make it clear what practices will change in the future as a result of this incident. In other words, what steps have they taken to prevent this happening again?

4. That there is no record on file that the on-call house surgeon responded to a page on the night of [Day 14] and reviewed [Mr A]

The clinical notes show that the on-call house surgeon was paged at 2200 hours on [Day 14]. The nursing record notes this again at 0635 hours on [Day 15] but there is no record to suggest that either the house surgeon attended, or that he/she was called again. Although it is recorded in the clinical notes that a page was sent, we have no other verification as the letter from the Waitemata DHB indicates it has no separate record of this. In my opinion, non-response to a call should prompt further action, such as a repeat page and, failing that, an incident report. Furthermore, in my opinion, such a non-response to a call for a doctor from a nurse within a major hospital represents a severe departure from expected standards.

5. Whether Waitemata DHB have responded appropriately to issue 4

The new interactive pager system would appear to be an improvement. This would at least provide a record that the doctor had been notified. However, the response from Waitemata DHB does not state what might happen should the doctor, who has been called, fail to respond. Other work priorities, more urgent patients, or simply human error could be plausible explanations for a non-response. However, the point that seems to be missing from the Waitemata DHB letter is what action will be taken should there be no response. In my opinion it would be reasonable to expect the person, who sent the original page, to follow this up with a further one. Failing this, it should prompt further enquiry, such as through an incident report.

Professor Tim Wilkinson
MBChB, MClinEd, PhD, MD, FRACP, FRCP

Further advice in light of further information received

Instead of 'Furthermore, in my opinion, such a non-response to a call for a doctor from a nurse within a major hospital represents a severe departure from expected standards.'

I would say

'Furthermore, in my opinion, lack of documentation in the clinical notes of a response to a call for a doctor from a nurse within a major hospital represents a moderate departure from expected standards.'"

Appendix B — Independent expert advice to the Commissioner

The following expert advice was obtained from nursing advisor Dawn Carey:

"1. Thank you for the request that I provide clinical nursing advice in relation to the complaint from the family of [Mr A] about the care provided to their father whilst he was an in-patient at [the public hospital] ([the public hospital]). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I have reviewed the documentation on file: complaints from [Mr A's family]; responses from Waitemata District Health Board (WDHB) including [Mr A's] clinical notes.

3. I have been asked to review the nursing care provided to [Mr A] at [the public hospital] from [Day 1–Day 15]. I have been asked to specifically address the following issues:
   - Diabetes management
   - Pain management
   - Oral Care
   - Nutrition/fluids
   - Staff presence
   - Catheterisation and UTI management

4. I have read the responses from WDHB, which are in keeping with the contemporaneous clinical documentation. For the purpose of brevity I have not repeated the content of the WDHB responses.

5. Review of clinical records and comments

Diabetes management: There is good evidence that [Mr A's] blood glucose levels were appropriately monitored during his inpatient stay, and that he was administered insulin as prescribed. In my opinion, the provided nursing care was in accordance with expected standards.

Pain management: I note that while the nursing staff recognised pain as a significant problem for [Mr A] there was a general lack of evaluation of whether the prescribed/administered analgesia was effective at managing his pain. I have also not found a completed relevant care plan. In my opinion, an objective pain assessment tool should always be used when assessing pain and evaluating the effectiveness of administered analgesia. Tools such as the PAINAD Scale[1] or Abbey Scale[2] would have been suitable to use whilst [Mr A] was experiencing

[1] Warden, V., Hurley, A. & Volicer, L., Development and Psychometric Evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *Journal of American Medical Directors Association*. 4(1): 9–15 (USA:AMDA, 2003).
[2] Abbey Scale: www.dementiacareaustralia.com/docs/Abbey_Pain_Scale.pdf

delirium. [Mr A] was presenting with symptoms such as restlessness that may have been due to pain or not. Part of determining possible causes of symptoms requires an objective evaluation of the patient response to administered interventions.

I am also critical that there were occasions when [Mr A] did not receive paracetamol therapy despite it being prescribed for regular administration and per rectum. I also note that regular administration of paracetamol is also requested in [Mr A's] clinical notes. There is a general absence of documentation in either the clinical nursing notes or on [Mr A's] medication chart to explain incidences of non administration.

In my opinion, the provided nursing care in relation to assessment and management of [Mr A's] pain departed from expected standards.

Oral Care: Patients who are vomiting and have swallow concerns require regular mouth hygiene for comfort and to prevent complications. Whilst there are regular nursing entries reporting that [Mr A] received mouth care they are generally without any commentary that relates to the condition of his mouth. I have also not found a completed care plan. Whilst I note that ward nursing staff included mouth hygiene as a delegated task on the watch handover sheet, there is no evidence that this was ever done. Registered nurses retain accountability and responsibility for care that they delegate to non registered health workers.

In my opinion, the provided nursing care in relation to oral care departed from expected standards.

Nutrition/fluids: A validated nutrition assessment tool, the Malnutrition Universal Screening Tool (MUST), is used within WDHB and available within [Mr A's] clinical notes. Printed on this form is the guideline, *complete within 72 hours of hospital admission*. An objective assessment of a patient's nutritional status and needs is especially important in the elderly populace, as some macro and micro nutrient requirements increase with age[3]. Also, impaired nutritional intake is a risk factor associated with pressure ulcer formation and impaired healing processes. Based on my calculation of [Mr A's] MUST score, a dietitian referral would have been a required action. Whilst a dietitian referral was made during his inpatient stay, this did not occur until [Day 13] and was actioned by the treating physiotherapist. I am critical of the delay in recognising that [Mr A] required nutritional specialist involvement.

I note that nursing staff documented regularly that [Mr A] had little or nil nutritional intake. However, this reportage is in isolation of further actions such as quantifying intake, increasing calorific intake or escalating concerns. In my opinion, it is simply not sufficient to continually report a 'problem' without attempting to clinically manage it. Whilst I acknowledge that commencing enteral

[3] Ministry of Health (MoH), *Food and nutrition guidelines for healthy older people: A background paper* (Wellington: MoH, 2010).

feeding would have been quite difficult due to [Mr A's] delirium, there is sparse evidence that it was considered in an appropriate time frame or that there was an actual plan to prevent unintentional weight loss. I consider that a nursing assessment of [Mr A's] nutritional status, with appropriate care planning and monitoring, and a nursing evaluation of his response to specified interventions should have been done. I consider such steps to be required to meet the expected standard of nursing competencies[4], relevant nutritional standards[5] and guidelines[6].

Whilst [Mr A] was prescribed and administered intravenous or subcutaneous fluid therapy, the submitted fluid balance records (FBR) are incomplete. This is despite intake/output monitoring being requested, fluids being administered, delirium being a recognised problem and [Mr A] becoming clinically dehydrated.

In relation to nutrition and fluid assessment, management, and monitoring; I am critical of the nursing care provided to [Mr A].

Staff presence: I note that the need for a 'watch' for [Mr A] was appropriately recognised, and actioned by the nursing staff. In my opinion, the watch handover sheet (WHS) is well designed and supports RN responsibilities when directing and delegating care to a non-registered health worker[7]. Whilst I agree that there is a written entry on a WHS that does not relate to [Mr A], this appears to be a single isolated incident. In my opinion, the provided care meets expected standards.

Catheterisation and UTI management: I am of the opinion, that the provided care in relation to need for catheterisation, involvement of Urology team, clinical documentation, and management of a urinary tract infection (UTI) — excluding fluid therapy, which I have addressed separately — meet the expected standards of care.

6. Comments

I note that over the course of his two week stay at [the public hospital], [Mr A] was a patient on [4 different wards]. [Mr A] had some complex issues — restlessness that may have been a feature of pain or infection or both; delirium that may have been a feature of pain, infection, opiate administration, dehydration etc. In my opinion, management of such issues takes a degree of time and critical thinking on the part of the health team. Whilst I do not condone the suboptimal aspects of nursing care that were provided to [Mr A], I can see the circumstances that facilitated it. I consider that the four wards operated as information silos. I base this criticism on the evidence within [Mr A's] clinical notes — blank assessments, inadequate or blank care plans, on his air mattress not accompanying him, on clinical requests being underlined but ignored, on the lack of nutritional

[4] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012).
[5] Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).
[6] Ministry of Health (MoH), *Food and nutrition guidelines for healthy older people: A background paper* (Wellington: MoH, 2010).
[7] Nursing Council of New Zealand (NCNZ), *Guideline: Direction and delegation* (Wellington: NCNZ, 2008).

intervention or management by the nursing staff. Whilst there may have been good rationales behind each of [Mr A's] ward transfers I consider that the quality of nursing assessment and management of his problems were compromised by the lack of patient-centered transfer documentation. I would recommend that the WDHB consider developing/promoting ward transfer documentation, which supports the safe transfer of patient care.

7. Clinical advice

Registered nurses are accountable for ensuring that all health services that they provide are consistent with their education and assessed competence, meet legislative requirements and are supported by appropriate standards[8]. In my opinion, the nursing care provided to [Mr A] at [the public hospital] departed from expected standards. These departures relate to

- Pain management — mild–moderate departure from the expected standards of nursing care
- Oral Care — mild departure from the expected standards of nursing care
- Nutrition/fluids — moderate departure from the expected standards of nursing care

Dawn Carey (RN PG Dip)
Nursing Advisor
Health and Disability Commissioner
Auckland.

1. Thank you for the request that I provide additional clinical advice in relation to the complaint from family of [Mr A]. I have been asked to review the additional response from Waitemata District Health Board (WDHB) and consider whether any changes to my preliminary advice are necessary. I have also been asked to comment on the changes WDHB have implemented in response to this complaint. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
2. I have reviewed the following documentation: additional response and supporting documentation from WDHB dated 29 August 2014; my preliminary advice dated 29 April 2014.
3. Following a review of the additional response from WDHB I have not seen cause to amend my preliminary advice. I remain of the opinion that the nursing care provided to [Mr A] at [the public hospital] departed from expected standards and that the departures relate to:

[8] Nursing Council of New Zealand (NCNZ), *Code of conduct* (Wellington: NCNZ, 2012). Standards New Zealand (NZS), *8132:2008 Health and disability (general) services standards* (Wellington: NZS, 2008).

- Pain management — mild–moderate departure from the expected standards of nursing care
- Oral Care — mild departure from the expected standards of nursing care
- Nutrition/fluids — moderate departure from the expected standards of nursing care

4. I acknowledge that in response to this complaint WDHB have completed a significant amount of work which relates to the issues identified. The reported quality improvement initiatives are broad in scope and clinically focussed. There is evidence of appropriate education, policies and leadership supporting them. In my opinion the work completed by WDHB in response to this complaint demonstrates a significant commitment to improving patient care.

Dawn Carey (RN PG Dip)
Nursing Advisor"