Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 21HDC02752)

Introduction

1. On 5 November 2021 this Office received a complaint from Mrs A about the care provided to her late mother, Mrs B (in her eighties at time of events), while she was a resident at a Presbyterian Support Southland care home between July and September 2021.

2. The following issue was identified for investigation:

   - *Whether Presbyterian Support Southland provided Mrs B with an appropriate standard of care between July 2021 to September 2021 (inclusive).*

3. This report is the opinion of Carolyn Cooper, Aged Care Commissioner.

Names have been removed (except Presbyterian Support Southland, Health NZ Southern, Southland Hospital and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Background

4. Mrs B had multiple long-term health conditions, including essential thrombocythaemia,[1] an extended left hemicolectomy[2] following a diagnosis of colorectal cancer,[3] type 2 diabetes,[4] hypertension,[5] hypercholesterolemia,[6] possible mini strokes (TIAs), a right total hip replacement in 2013, and bilateral lower limb swelling since late 2013 (not responsive to diuretics[7]). Mrs B lived in an independent cottage within the care home complex and received support with her personal and hygiene needs and support with her household tasks once a week.

5. On 26 June 2021, Mrs B slipped out of bed and landed on the right-hand side of her body and hit her head but did not lose consciousness. She experienced upper mid-back pain following her fall. She was unable to get up, so she called an ambulance and was taken to Southland Hospital (Health New Zealand|Te Whatu Ora (Health NZ) Southern). The admitting medical team documented that she had pulmonary oedema[8] and had sustained a compression fracture in her back (T11). The assessment notes indicate that Mrs B had pitting oedema[9] up to her waist and sacral oedema. Mrs B told hospital staff that she had been experiencing increasing shortness of breath when she exerted herself for at least the past month, and she had struggled to walk to the rest home for dinner (which previously she could do with 'ease'), and she had noticed that her legs had become more swollen.

6. While in hospital, Mrs B had a clinical needs assessment to determine the level of support she required moving forward. The clinical needs assessor determined that to meet Mrs B's safety and wellbeing needs, she required hospital-level care. The clinical needs assessor noted that Mrs B's primary need for hospital-level support 'relate[d] to heart failure with long standing lower leg bilateral oedema,[10] shortness of breath at rest, compression fractures, reduced mobility and recent fall'. This plan was discussed with Mrs B's EPOA,[11] her daughter Mrs A. Mrs B accepted placement into hospital-level care at the care home.

Admission to hospital-level wing

7. Mrs B was discharged from Health NZ Southern on 15 July 2021. Mrs B's 'resident transfer/discharge form' from Health NZ Southern to the care home noted that Mrs B had been 'fluid over loaded and short of breath' for a couple of months, her leg was swollen,

[1] A rare blood cancer.
[2] Surgery to remove part of the large intestine.
[3] Cancer in the colon.
[4] A condition that can lead to high levels of sugar in the blood.
[5] High blood pressure.
[6] High cholesterol.
[7] Medicines to help reduce fluid build-up in the body.
[8] An abnormal build-up of fluid in the lungs.
[9] Excess fluid build-up in the body, which causes swelling; when pressure is applied to the swollen area, a 'pit' or indentation remains.
[10] A build-up of fluid in the body, which causes the affected tissue to become swollen.
[11] Enduring Power of Attorney (a legal document that outlines who can take care of someone's personal or financial decisions if the person is unable to do so).

and she had had a fall prior to admission. It was also noted that Mrs B was to drink only 1.5 litres of a fluid a day and needed to be weighed daily, and that on 15 July 2021 she weighed 68.8kg. The form recorded that Mrs B required assistance with mobility by one person and required a walking frame. Although it was documented on the form that Mrs B had had a fall, it was not noted that she was at risk of further falls. Mrs B's transfer form noted that she was not on oxygen.

8. Mrs B returned to the care home at 3.00pm on 15 July 2021 and was admitted to the hospital-level wing. The admitting documentation noted that she was on 'ongoing oxygen' at 2 litres/minute, but that this had not been written in Mrs B's discharge summary. The admitting notes record that Mrs B weighed 68.8kg on admission and required daily weighs and a fluid restriction of 1.5 litres. Mrs B kept her own GP and did not use the contracted GP service provide by the care home.

9. In response to the provisional opinion, Health NZ Southern told HDC:

> '[W]hen [Mrs B] was discharged from Southland Hospital, she was no longer receiving oxygen therapy and her diagnosis was congestive heart failure. Congestive cardiac failure is not an indication for community oxygen therapy services as per the Ministry of Health Service Specifications … so oxygen therapy was not able to be prescribed on discharge. We acknowledge that this was not explicitly detailed in the discharge summary …'

Oxygen therapy

Medication Management Policy

10. At the time of events, the care home had a Medication Management Policy (issued December 2003, reviewed June 2021), the purpose of which was '[t]o ensure medications are managed and administered safely and in line with legislation, standards and guidelines'. The policy provided the following:

- It is the responsibility of the registered nurses to ensure that all medications 'are administ[er]ed safely and in line with policy'.
- Section 19 of the policy provides guidance regarding oxygen therapy, including:
  - how to administer oxygen, documentation expectations (such as checking the resident's oxygen saturation);
  - how the oxygen tubing is managed (such as to prevent causing a trip hazard); and
  - the safe storage of oxygen cylinders (in that they must be secured at all times in an 'upright position … with a chain or bar preventing them from falling over').

11. However, the policy contains no information on how to educate residents and/or their family regarding the safe use of oxygen, both within and away from the care home.

12. Mrs B's discharge form from the hospital selected 'no' regarding whether she was using oxygen. This oversight caused a delay in prescribing Mrs B oxygen therapy on her return to

the care home (although the care home did have an oxygen concentrator available, and Mrs B was able to use this while awaiting a formal prescription). Notes in Mrs B's electronic medication record (MediMap) indicate that she was prescribed continuous flow oxygen at 2 litres/minute on 13 August 2021, but it is unclear whether she had an interim paper-based prescription in place.

13. An initial care plan developed on 16 July 2021 noted that Mrs B was on 'continuous delivery of oxygen' and to '[a]dminister oxygen as per medical officers' directive'. However, the plan did not specify how many litres of oxygen she had been prescribed and did not note personalised clinical information such as Mrs B's baseline oxygen saturation and signs that could signal staff to escalate her care. The progress notes show that continuous flow oxygen was administered to Mrs B via nasal prongs, but only one entry in the electronic record, dated 13 August 2021, notes the administration of prescribed oxygen therapy while Mrs B was a resident.

14. In a family meeting, Mrs A requested portable oxygen so that she could take Mrs B to a café. The care home stated that portable oxygen was available in Mrs B's room on 28 July 2021, and it instructed a registered nurse to organise the oxygen cylinder to be chained to the wall in the wardrobe and to educate Mrs A on how to use the oxygen safely. The care home said that it appears that the nurse did not follow these instructions, and maintenance records show that Mrs A did not receive any education on using the portable oxygen. The care home apologised for not complying with oxygen safety requirements.

15. In response to the provisional opinion, Mrs A told HDC that the portable oxygen was requested so that Mrs B could also attend appointments at Southland Hospital. Mrs A also maintained that she was trained in the use of portable oxygen and stated: 'I videoed it with permission of the staff member as I thought I could use the video to refer back to again in the future …' Mrs A noted: 'Mum had been on [oxygen] in hospital and I understood that [the care home] had advised that [oxygen] would be required.' Mrs A also told HDC:

> 'The permanent [oxygen] in the room was found multiple times to have the tubing squashed by furniture or pulled out past the tubing limit [and] [m]ultiple times mum [was] found by family with [the oxygen] prong out, and [I would] have to remind staff to correctly replace the nose prong after going to the toilet.'

Oral intake and weight recording

Nutrition and Hydration Policy

16. At the time of events, the care home had a Nutrition and Hydration Policy (issued June 2006, reviewed March 2021), the purpose of which was '[t]o achieve and maintain optimum nutritional status [for the resident and] an acceptable minimum body weight'. The policy also notes the consequences of dehydration in the elderly, such as an increased risk of acute kidney injury, increased risk of falls, pressure ulcers, impaired cognition, and fatigue, to name a few. Of note, the policy contains no guidance on how to manage older persons who require a fluid restriction and a fluid balance chart (FBC).

17. Mrs B's initial care plan at the care home includes to '[m]onitor and report on food/fluid intake/output for [Mrs B]'. However, this appears to be a generic entry, as no further instructions were incorporated from Mrs B's resident transfer/ discharge form regarding her fluid restriction of 1.5 litres/day or that she required an FBC to be maintained. Regarding the need for daily weighs, Mrs B's initial care plan notes this as a requirement in relation to her fluid overload.

18. In response to the provisional opinion, Mrs A told HDC: '1.5 [litres] per day fluid restriction … was no way adhered to … The fluid charts were not maintained, no running balance …' Regarding daily weighs, Mrs A stated: 'Daily weight charts were not done as directed multiple times. It was hit and miss if they monitored her weight.'

Fluid balance analysis

19. The care home provided HDC with only four FBCs, but another 29 charts were supplied by the complainant.

20. A table summarising how Mrs B's FBCs were completed is included as Appendix A. The table includes information about whether a running balance was used, whether one FBC was used per 24-hour period, and whether the fluid restriction amount was noted on the FBC.

21. As reflected in the table:

- Out of the 33 FBCs reviewed, 27 did not have a running balance:
  - out of the six records that had a running balance, one was completed and calculated correctly, two had an incorrect calculation, and three were incomplete.
- Out of the 33 FBCs reviewed, nine did not have the fluid restriction amount noted.
- Out of the 33 FBCs reviewed, five had recorded multiple days on the same sheet.

22. Another table, summarising when Mrs B's progress notes recorded her fluid intake, or that she was on an FBC, and/or her fluid restriction, is included as Appendix B.

23. As reflected in the table, from 15 July 2021 to 19 September 2021, 87 entries in Mrs B's progress notes refer to her fluid intake. The following is noted:

- Out of 87 entries, 48 entries document that Mrs B was on a fluid restriction and/or FBC.
- Out of 87 entries, 39 entries documented Mrs B's intake:
  - as fluid in millilitres taken for the shift;
  - as intake but no measurement in the notes; or
  - as described as 'good intake', 'drinking well' or 'fine'.
- Out of these 37 entries, none included the context that Mrs B was on a fluid restriction and FBC.

24. On 30 July 2021, it is documented that Mrs B's fluid restriction was increased by 500ml, to 2 litres a day. Mrs B's family expressed concerns that a senior staff member suggested taking her off the fluid balance chart. In an email between senior staff members in the care home dated 5 August 2021, a staff member documented: 'My suggestion that maybe we don't worry about the fluid balance as that she is now on 2000ml intake and this would be a lot.'

25. In response to the provisional opinion, Mrs A stated that in a meeting with staff, it was suggested that 'we take mum off the fluid restriction'. Mrs A told the staff members that this was 'inappropriate' and was a discussion for her mum, herself, and the GP. Mrs A stated that it felt as if they were encouraging her mum '[to] drink herself to death', and that Mrs B said that she was 'happy on the restriction'. Mrs A said that this discussion caused her 'huge distress'.

Weight management

26. Mrs B required daily weighing while she was on a fluid restriction.

27. Progress notes from the care home document that from 8 August 2021 to 20 September 2021 Mrs B was to be weighed every second day.

28. A table summarising when Mrs B was weighed is included as Appendix C. The table includes information about whether the time of weighing was recorded, and whether the type of scales was noted.

29. The table noted that out of a potential 43 weight entries from 15 July 2021 to 20 September 2021, Mrs B was weighed only 18 times.

Management of compression stockings

30. Mrs B was required to wear medical compression stockings on her legs. They were to be placed on her in the morning, removed in the evening, and washed overnight and hung to dry. Mrs B's family had experience placing these on her and were willing to show staff if required, but the family state that they were told multiple times that the staff were trained in placing compression stockings on residents. Nevertheless, Mrs B's family stated that her stockings were not placed on her legs correctly, and sometimes when they visited in the morning they found the stockings inside out, at different heights on each leg, or not on her legs. A photograph provided to HDC showed the stockings placed incorrectly, with one stocking below Mrs B's knee on one leg, and the other above her knee.

31. Mrs B's family created reminder notices for staff regarding the compression stockings and included a photograph of Mrs B wearing the stockings placed correctly.

32. Mrs B's admission care plan summary report contained no guidance for staff regarding the application, positioning, and removal of compression stockings, and no specific care plan was developed to manage Mrs B's compression stockings.

Management of pain and prescribed medications

Medication Management Policy

33. As noted at paragraph 10, at the time of events, the care home had a Medication Management Policy '[t]o ensure medications are managed and administered safely and in line with legislation, standards and guidelines'. The policy notes that PRN (as required) medication will be administered to the resident if it is 'clinically indicated' as assessed by the registered nurse. If PRN medication is given, then the effect on the resident is to be recorded, and whether it achieved the desired outcome (such as relieving pain).

Pain — Assessment and Management Policy

34. At the time of events, the care home had a Pain — Assessment and Management Policy (issued December 2003, reviewed March 2019), the purpose of which was to guide staff to 'effectively assess, address and relieve pain for all residents'.

35. Mrs B's progress notes show that she was assessed by her GP on 23 July 2021 and 3 September 2021, but it is unclear whether a consultation or medication review occurred outside these two visits.

36. The care home told HDC that Mrs B was prescribed morphine for pain and distress, shortness of breath, and anxiety. On 8 September 2021 progress notes record that Mrs B was concerned about the potential addictive component of morphine and declined to take it.

37. On 13 September 2021, Mrs B and her daughter, Mrs A, met with a hospice nurse to discuss Mrs B's refusal of pain relief. Following the meeting it was documented that Mrs B 'agreed with this and promised not to refuse' the morphine. Anti-nausea medication was also prescribed in response to Mrs A's concern that the morphine caused Mrs B to be nauseated, and Mrs B's Medi-map contained instructions that anti-nausea medication was to be administered with her morphine. The care home told HDC that 'a strict and clear directive [was] given to the Nurses to administer Morphine … regardless of the absence of pain'.

38. A table summarising when Mrs B was given her morphine and anti-nausea medication is included as Appendix D. The table includes information about whether the rationale for giving the medication was recorded, whether the effect of the medication was noted, and whether this was recorded in Medi-map.

39. As reflected in the table, from 18 July 2021 to 20 September 2021, 16 entries in Mrs B's Medi-map refer to the administration of her pain relief and anti-nausea medication. The following is noted:

- All entries recorded a rationale for why the medication was given to Mrs B.
- All entries were recorded in Mrs B's Medi-map.
- Out of the 16 entries, 11 did not note the effect of the medication.

Personal hygiene, care, safety needs, and privacy issues

40. The care home told HDC that prior to Mrs B's admission into hospital-level care, Mrs A viewed the only available room and was told that it required new carpet, basin, and wallpaper, and that the care home would not be able to secure tradespeople prior to Mrs B's admission. The care home stated that Mrs A 'accepted the room with this knowledge'.

41. In response to the provisional opinion, Mrs A told HDC that she did accept the room, 'BUT it was to be cleaned and tidied. Cleaned and tidied never happened' (Mrs A's emphasis).

42. Mrs A told HDC that she did check the room approximately 2.5 weeks prior to Mrs B occupying it. She said that it was 'old, dirty, and in need of work'. She noted that the wallpaper was peeling off and, in some places, missing, the vanity had bulges due to water damage, and there were marks on the carpet and splatters up the walls and on the ceiling. Mrs A provided HDC with photographs that showed the condition of Mrs B's room. She said that she was 'assured by the nurse' who showed her the room that these issues would be fixed before Mrs B occupied the room, but the issues were not fixed.

43. Mrs A told HDC that upon discharge from the hospital on 15 July 2021, Mrs B received a wheelchair from the care home that was not adequate, as it did not have footplates. The care home responded that a transit wheelchair with footplates was organised for Mrs B ready for the taxi to collect at 11.00am, but another resident used this wheelchair, and when the taxi came to collect it after 11.00am staff could not locate it, and no one came into reception to ask which was the correct chair.

44. Mrs B's family told HDC that Mrs B was not attended to promptly when she needed to use the toilet, and sometimes she was incontinent because of the long wait time. The family said that sometimes they had to chase down staff or wait for over an hour for assistance.

45. A statement from a staff member noted that Mrs B's call bell was 'always in reach' but often Mrs B would be 'calling out for help instead of using her call bell'. This staff member also noted that they did an hourly check on Mrs B and instructed care staff to check on her every time they walked past her room.

46. In response to the provisional opinion, Mrs A told HDC:

> 'Mum's call bell was not always in reach and as for the hourly check it didn't happen. When I sit with mum waiting for over 1 hour to get assistance to toilet, no one has done a[n] hourly check.'

47. Mrs A had provided the care home with a one-page document that summarised Mrs B's care plan and had placed this on the bathroom door. Mrs A provided HDC with photographs of extra local documents, signage, and care instructions that staff had placed on Mrs B's walls, doors, mirrors, and table.

48. The care home told HDC that it had experienced a high turnover of registered nursing staff and that this 'impact[ed] on the level of service that [could] be provided'.

Nursing assessment and care planning

49. Section D16.2a of the Age-Related Care (ARRC) services agreement states that providers of aged-care services must ensure that 'each Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 21 days'.

50. Although an initial care plan was developed for Mrs B between 16 and 21 July 2021, there is no evidence that nursing assessments were completed to inform the interim plan of care (such as a falls risk assessment given that Mrs B had fallen out of bed and could not get herself off the floor).

51. There is also no evidence that short-term care plans were developed for Mrs B (such as a care plan regarding her fluid restriction).

52. In addition, although there is evidence of family meetings and communication with Mrs B's EPOA, Mrs A, there is no evidence that a long-term care plan was developed.

53. In response to the provisional opinion, Mrs A told HDC that '[t]o achieve any care plan for my mum, they would or should have include[d] myself and maybe other family members'.

Assessment and management of deteriorating condition and escalation of care

54. A Clinical Order Articulating Scope of Treatment (COAST) form is an individualised plan for end-of-life care that considers both the resident's preferences and clinical judgement based on medical evaluation.

55. Mrs B was admitted to the care home for hospital-level care with a COAST in place dated 15 July 2021. The instructions noted that Mrs B was not for resuscitation, and that she was to have 'comfort-focused treatment', to have any pain relieved with medication, and for her not to be transferred to hospital unless her needs were unable to be met in the care home.

56. Medical notes on 23 July 2021 document that Mrs B was '[s]leepy but wakes when spoken to' and that she was near the end of her life. It is documented that Mrs B's COAST was activated by a doctor and that Mrs B was to be provided with comfort cares.

57. An advance care plan is a document created with input from the resident, their family or nominated representatives, and the clinical team. The advance care plan outlines how the resident wants to be cared for in the future, and it can have a palliative[12] focus.

58. 'Te Ara Whakapiri: Principles and guidance for the last days of life' outlines the 'essential components and considerations required to promote quality care at the end of life for all

[12] Palliative care is specialised medical care that focuses on providing relief from pain and other symptoms of serious illness. The three main forms of palliative care are symptom management, emotional support, and spiritual care.

adults in New Zealand'. This document could have been used to guide the development of an advance care plan for Mrs B, but there is no evidence that this was done.

59. On 24 August 2021, the nurse on duty for the afternoon shift documented that she checked Mrs B at the start of her shift, and Mrs B was sleeping in her reclining chair. When the nurse went to administer Mrs B's dinner-time medications at 4pm, she found Mrs B to be very tired with a flushed face. The nurse checked Mrs B's vital observations (temperature 36.5°C, pulse rate 82 beats per minute, respiratory rate 18 breaths per minute, blood pressure 111/80mmHg, and oxygen saturation 93% on 2 litres of oxygen), which appeared to be within her normal limits; however, Mrs B's blood glucose level was very high at 30.1mmol/L.[13] Although it was documented that Mrs B's blood glucose had 'always been on the higher end' and ranged from 11mmol/L to 21.6mmol/L pre meals, 30.1mmol/L was a significantly high blood glucose level.

60. Mrs B was given her usual oral diabetes medication. At 5pm the nurse received a call from the Facility Manager that Mrs B's MSU (midstream urine test) showed ESBL.[14] The Facility Manager instructed the nurse to contact Health NZ Southern to have an antibiotic charted for Mrs B, but the nurse was unsuccessful.

61. The nurse attempted to contact Mrs B's GP, but it was outside the medical practice's working hours. Mrs B's blood glucose level was checked again at 5.30pm and it was still high but had reduced to 23.1mmol/L. The nurse noted that Mrs B was 'becoming very confused and was speaking inappropriately' and saying that she felt sick.

62. The nurse contacted the Urgent Doctors for an antibiotic prescription via email, and at 7pm received a reply to transfer Mrs B to hospital due to her high blood glucose level and her co-morbidities. The nurse contacted Mrs A regarding the plan to transfer Mrs B to hospital, as Mrs B's COAST indicated that she should receive comfort cares only. Mrs A spoke with Mrs B and discussed the plan to transfer her to hospital, and Mrs A agreed to the transfer. An ambulance arrived at the care home at 7.50pm and Mrs B arrived at Southland Hospital at 8.15pm.

63. Mrs B was transferred back to the care home the following day. There is no evidence that nursing assessments were undertaken to inform a short-term care plan to manage Mrs B's UTI, or that education was provided to staff regarding infection control and management, given that Mrs B had ESBL.

Communication with Mrs B and her family

64. Section D3.1(h) of the ARRC services agreement states that service providers must 'acknowledge, value and encourage the involvement of families/whānau in the provision of care'.

[13] Normal blood glucose levels range between 3.9mmol/L and 5.6mmol/L.

[14] ESBL (extended spectrum beta-lactamase) is an enzyme found in some strains of bacteria. ESBL-producing bacteria cannot be killed by many antibiotics, which makes it harder to treat.

65. Ngā Parewa Health and Disability services standards promote the safe provision of services for people and whānau in New Zealand. There is an expectation that service providers ensure that residents and their family are 'empowered to make decisions about their own care and support in order to achieve their goals'.

66. There is evidence of correspondence between Mrs A (as Mrs B's EPOA and daughter) and the care home via text messages, phone calls, emails, and family meetings.

67. There is also evidence of communication between allied clinical teams, such as physiotherapists, hospice, and nurse specialists, but there is no evidence that these discussions were integrated into a more personalised plan for Mrs B.

68. There is limited evidence that an initial meeting was held between the care home, Mrs B, and her family to assess Mrs B's needs and determine her goals for care. It is unclear whether the goals listed in Mrs B's care plan were reviewed by the care home together with Mrs B and her family.

Further information

Mrs A

Mrs A has raised concerns about the care and treatment of her mother while she was in the care home. Mrs A moved her mother to a different hospital-level-care facility on 20 September 2021, and Mrs B passed away a few weeks later in the presence of her family.

Continuous improvements made by care home

69. The care home told HDC that although it believes that some of the care instructions discussed in the complaint were placed in Mrs B's room by Mrs B's family, it accepts that it is best for any guidance information to be placed out of public view (such as inside a wardrobe door).

70. The care home stated that a 'large number of [its registered nurses] are internationally trained with little experience in care planning', and therefore it has set up care planning training. The care home said that it has reintroduced a primary nurse model to allow the nursing staff 'to plan and co-ordinate resident care' and achieve 'person centred care planning'. In view of nursing shortages, the care home employed a nurse in the role as an interRAI and Care Planning lead, which has 'allowed consistency in care planning'.

71. Regarding discharge of a resident from hospital, the care home stated that it created a handover sheet that includes a space to document equipment needed, and the Clinical Manager undertakes the telephone handover from the discharging hospital and completes the initial documentation to 'ensure adequate information is obtained before arrival [at the facility]'.

72. The care home said that all registered nurses/enrolled nurses have been provided with a copy of the Frailty Guidelines 2023.

73. The care home accepted that good practice would have been to develop a specific care plan to manage compression stockings. The care home said that its induction programme now includes how to manage compression stockings.

Responses to provisional opinion

Mrs A

74. Mrs A was given the opportunity to respond to the 'information gathered' section of the provisional opinion and her comments have been incorporated into this report where relevant.

75. Mrs A told HDC:

> 'We as a family accepted mum's death. It was a terrible time for us, but we also knew she needed to leave us. We struggle and cannot accept the way she was cared for … Mum deserved so much better. Everyone does …
>
> My mum was a living, vulnerable human, that for the first time required major help in her life. I know mum was nothing to them but she was our beloved mum.'

Presbyterian Support Southland

76. Presbyterian Support Southland was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. It submitted that the provisional report did not reflect accurately that communication with Mrs A was challenging and at times confrontational, and that Mrs A's comments regarding some issues 'are distorted and very one sided'.

77. Presbyterian Support Southland also submitted that while it 'accept[s] the clinical findings [in] this report … [t]here is also very little support in the report to reflect the staffing crisis [the] sector faced during this time'.

Health NZ Southern

78. Health NZ Southern was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. Health NZ Southern's comments have been incorporated into this report where relevant.

Opinion: Presbyterian Support Southland — breach

79. I acknowledge the distress that these events caused Mrs B's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Presbyterian Support Southland was appropriate, I considered in-house nursing advice from RN Jane Ferreira (see Appendix E).

Oxygen therapy

80. Mrs B was diagnosed with pulmonary oedema due to congestive heart failure and placed on oxygen therapy to help ease her shortness of breath.

81. RN Ferreira advised that Mrs B's initial care plan provided generic interventions regarding oxygen management that aligned with policy guidelines but did not include information such as Mrs B's baseline vital observations, including her oxygen saturation, which 'may indicate resident distress or supportive actions to assist staff to deliver clinically appropriate care'. I agree that in order for staff to know when to escalate Mrs B's care, they would first have to know her baseline observations for comparison with her current presentation. I am critical that Mrs B did not have a personalised care plan to guide staff in the management of her required oxygen therapy.

82. RN Ferreira identified that Mrs B's oxygen was not prescribed by Health NZ Southern, where she had been commenced on oxygen therapy while she was an inpatient prior to her return to the care home. The hospital discharge form indicated that Mrs B was not on oxygen, although she had been on this therapy in hospital, and therefore, when she returned to the care home there was a delay in prescribing her oxygen. Mrs B had decided to retain her own GP instead of using the care home's contracted GP, which also may have contributed to the delay in prescribing oxygen therapy.

83. I consider that the care home was not responsible for the delay in prescribing Mrs B's oxygen therapy when she returned to the care home. Rather, I consider that Health NZ Southern should have been more explicit in the discharge paperwork that Mrs B was not for community oxygen therapy, as when she arrived at the care home there was confusion as to whether she was still on oxygen therapy.

84. RN Ferreira noted that although Mrs B's progress notes record that she was on oxygen, there is only one record within her electronic medication record that shows that she was administered the prescribed oxygen therapy. RN Ferreira advised that the nursing staff should have sought clarity from the GP regarding Mrs B's required amount of continuous oxygen therapy and should have received guidance on how to record this in her electronic medication record. As outlined in the Medication Management Policy, registered nurses are required to ensure that all medications 'are administrated safely and in line with policy'.

85. RN Ferreira noted that the care home 'acknowledged and apologised for noncompliance with oxygen safety; however, there appears to be a need for wider improvement regarding medication safety and the application of organizational policies to staff practice'.

86. RN Ferreira advised that the management of Mrs B's oxygen therapy was a significant departure from accepted practice. I agree. Oxygen therapy was an essential part of Mrs B's therapy for shortness of breath caused by her pulmonary oedema. It was important to maintain her comfort with adequate oxygen management.

Oral intake and weight recording

87. Mrs B presented to Health NZ Southern on 26 June 2021 with shortness of breath, and the admitting team considered that she was in fluid overload, with pitting oedema up to her waist. She was diagnosed with pulmonary oedema due to congestive heart failure and placed on a fluid restriction of 1.5 litres/day to help decrease the oedema in her lungs and

legs, to help her to breathe more freely. She was also prescribed daily weighs to ensure that she was losing water weight.

88. RN Ferreira identified that while Mrs B's initial care plan mentioned the requirement for daily weighs, it did not provide guidance regarding managing a resident on a fluid-restricted diet, or rationale for why accurate monitoring of her fluid intake was needed. I am critical that this important clinical information was not included within the care plan to help inform staff on how to manage a resident who required daily weighs and a fluid restriction.

89. At the time of events, the care home had a Nutrition and Hydration Policy in place, the purpose of which was '[t]o achieve and maintain optimum nutritional status [for the resident and] an acceptable minimum body weight'. The policy noted the consequences of dehydration in the elderly. However, RN Ferreira advised that the policy contained no guidance on how to manage older persons who require a fluid restriction and FBC. This is of concern, first because maintaining an accurate FBC was essential in managing Mrs B's fluid overload and alleviating her shortness of breath, and secondly, because management of a resident on a fluid restriction and FBC is uncommon in aged-care residential facilities, and therefore, guidance for staff was important.

90. FBCs are used to determine whether there is a deficit or an excess of fluid within a person's body. When used in conjunction with a fluid restriction, it is important to ensure that the FBC is complete and accurate. The FBC documents a person's fluid input and output within a 24-hour period and therefore, only one FBC should be used per 24-hour period. A running balance is important to ensure that any staff member, across any shift (morning, afternoon, or night), can see how much fluid a person has had, and whether they are close to their restriction. It is helpful to write the restriction amount (eg, 1.5L/day) on the FBC to remind staff when they are calculating the running total.

91. The care home provided HDC with only four FBCs. Mrs A and her family were very concerned about the correct monitoring of Mrs B's fluid intake and supplied HDC with photographs of additional copies of Mrs B's FBCs, which provided a much larger sample for analysis. I am concerned that the four FBCs provided by the care home did not allow HDC to see the whole clinical picture.

92. I am critical that of the 33 FBCs reviewed, 27 did not have a running balance, and that out of the six records that did have a running balance, only one had been completed and calculated correctly. This shows a significant knowledge deficit of the staff at the care home regarding how to manage a resident with a fluid restriction on an FBC. As Mrs B was on a fluid restriction, it was essential that an accurate FBC was maintained to inform staff across different shifts (in a 24-hour period) of how much fluid Mrs B had left in her restriction, so that the restriction was not exceeded. Potentially this could have worsened her pulmonary oedema and affected her breathing.

93. Daily weighs were used in conjunction with fluid restriction to ensure that fluid in Mrs B's body was decreasing. To enable accurate weights, the person should be measured around the same time every day, and the scales used (sitting scales, standing scales, bed scales)

should be documented to maintain the accuracy of recordings. It is preferable to use the same type of scale when recording a person's weight.

94. Mrs B's documented weights were analysed to determine whether she was weighed daily, and whether the time and the type of scales was recorded. The analysis from 15 July 2021 to 20 September 2021 (the date on which Mrs B was discharged from the care home) shows that she should have had 43 weight entries. However, Mrs B was weighed only 18 times. No times were recorded, and there was no mention of the type of scales used. I am critical that Mrs B's weight was not recorded diligently, as this was an essential part of managing her pulmonary oedema to alert staff to any increase in her weight, so that they could escalate her care.

95. RN Ferreira identified a moderate departure from care in these areas. She noted that FBCs 'form a part of an integrated care record and need to be considered in partnership with progress note entries and a nursing care plan'. She considered that while the FBCs indicate poor record-keeping, the 'progress note entries provide discussion of other elements of supportive care occurring'. RN Ferreira advised:

> 'Care teams need to be aware of individual hydration needs and understand the importance of accurate record keeping, such as the volume of oral intake or frequency of weight recording as data is used to inform care management.'

96. Although I am critical of the poor record-keeping in the FBCs and the inconsistent weight management, I accept that it appears that nursing interventions and care occurred as shown in the nursing notes.

Management of compression stockings

97. Mrs B was required to wear medical compression stockings on her legs. They were to be placed on her in the morning and removed in the evening. These stockings formed part of Mrs B's clinical management.

98. In Mrs B's initial care plan, there was no guidance for staff regarding the application, positioning, and removal of the stockings, and no specific care plan for Mrs B was developed to guide management.

99. RN Ferreira identified a moderate departure from accepted practice in this area. She noted that accepted practice would have been to develop a specific care plan for the management of Mrs B's compression stockings, and for the plan to include the rationale for use, the 'stocking size and compression rating, frequency of skin assessment, care and safety needs as a wrinkle-free stocking position', how Mrs B mobilised, and the appropriate footwear to be worn while using the stockings. I agree with RN Ferreira.

100. I am concerned that it appears that staff lacked training in the application of Mrs B's compression stockings. I acknowledge that her family said that at times Mrs B's stockings were not placed on her in the morning, or, if they were, they were at different heights or inside-out. Mrs B's family said that they were happy to show staff how to apply the

stockings, but it is unclear whether staff took this opportunity. I consider that all staff should understand how to apply compression stockings and the rationale for using them. This should be noted in a specific/individualised care plan, and regular training should be provided to all staff to increase their competency in this area.

Management of pain and prescribed medications

101. At the time of events, the care home had a Pain Assessment and Management Policy, the purpose of which was to guide staff to 'effectively assess, address and relieve pain for all residents'.

102. Mrs B was prescribed morphine for pain and distress, shortness of breath, and anxiety. On 8 September 2021 progress notes record that Mrs B was concerned about the addictive component of morphine and declined to take it. On 13 September 2021, Mrs B and her daughter, Mrs A, met with a hospice nurse to discuss Mrs B's refusal of pain relief. Following the meeting, Mrs B 'agreed with this and promised not to refuse' the morphine. Mrs B's Medi-map instructed that anti-nausea medication was to be administered with her morphine. The care home told HDC that 'a strict and clear directive [was] given to the Nurses to administer Morphine … regardless of the absence of pain'. RN Ferreira noted that no pain assessment forms were created for Mrs B.

103. A table was produced to summarise when Mrs B was given her morphine and anti-nausea medication, whether the rationale for giving the medication was recorded, and whether the effect of the medication was noted and recorded on Mrs B's electronic medication record. I note that all 16 entries recorded a rationale for why the medication was given. However, I am concerned that 11 out of the 16 entries did not record the effect of the medication (such as 'pain relieved', 'nausea relieved').

104. Mrs B's progress notes show that she was assessed by her GP on 23 July 2021 and 3 September 2021, but RN Ferreira advised that '[i]t is unclear if a consultation or medication review occurred outside these [two] visits', which would have been accepted practice given Mrs B's initial reluctance to take morphine and the nausea she experienced when taking it. RN Ferreira considered that in the absence of evidence in Mrs B's clinical records regarding whether she was reviewed more than twice, this was a moderate departure from accepted practice.

105. The Age-Related Residential Care (ARRC) Services Agreement is a contract between Health NZ and aged residential care providers for delivery of services to older people. Section D16.5 (e)(ii)(1) of the ARRC states:

> 'After the initial examination [by a general practitioner] the Resident must be examined not less than once a month and as clinically indicated (as assessed by a Registered Nurse) except where the Resident's medical condition is stable as assessed by the General Practitioner … in which case the Resident may be examined by a General Practitioner … less frequently than monthly, but at least every 3 months.'

106. I consider that Mrs B was not clinically stable, and therefore should have been seen by a GP at least monthly.

107. Based on the documentation, I find it more likely than not that Mrs B was assessed by a GP only twice between July and September, and I accept RN Ferreira's advice that the lack of review constitutes a moderate departure from accepted practice.

Personal hygiene, care, safety needs, and privacy issues

108. Mrs B's family raised concerns regarding care delivery such as support with toileting and call-bell response times, the condition of Mrs B's room, and missed care during Mrs B's admission, which affected her safety.

109. To aid in Mrs B's care delivery, Mrs A provided the care home with a one-page document that outlined her mother's plan of care, such as that she was on a fluid restriction and required compression stockings. Mrs A positioned the document on Mrs B's toilet door. Mrs A provided photographic evidence of extra local documents, signage, and care instructions that staff positioned on the walls, doors, mirrors, and table in Mrs B's room. RN Ferreira commented that this raised questions 'regarding confidentiality of information, person-centred care, privacy, dignity and respect'. In my opinion, these extra care instructions put up by staff should have been stored securely and privately within Mrs B's file, for staff to familiarise themselves with, and not displayed in such a public manner.

110. In relation to the concern that staff were not getting Mrs B to the toilet on time, the care home told HDC that it had experienced a high turnover of registered nursing staff and that this affected 'the level of service that [could] be provided'. However, although I acknowledge the care home's response regarding toileting, usually this is conducted by caregivers, sometimes assisted by registered nursing staff, and therefore Mrs B should have been assisted to use the toilet when she required it. I am concerned that Mrs B was made to wait to use the toilet. This was unacceptable, and a plan should have been put in place earlier to ensure that her toileting needs were met.

111. RN Ferriera acknowledged the concerns from the family regarding the care delivery mentioned above and identified a moderate departure from accepted practice. I agree. I also note that several maintenance issues for Mrs B's room were identified and, unfortunately, were not completed, although it appears that Mrs A was told that they would be.

Assessment and management of deteriorating condition and escalation of care

112. Mrs B's family expressed concern that on 24 August 2021 when Mrs B needed to go to the hospital, there was delay in escalating her care. RN Ferreira noted that there was a two-hour delay in communication from the GP, who advised that Mrs B should be transferred to hospital immediately for further care. From the information reviewed, however, it appears the nurse on duty did escalate Mrs B's care and consulted with a senior nurse, which RN Ferreira advised was accepted practice in the circumstances.

113. Mrs B had a COAST in place dated 15 July 2021. The instructions noted that she was not for resuscitation and that she was to have 'comfort-focused treatment', including the relief of any pain with medication, and for her not to be transferred to hospital unless her needs could not be met in the care home. The nurse on duty on 24 August 2021 did liaise with Mrs B's EPOA to ask whether Mrs B could go to hospital for treatment, to which Mrs A agreed after a conversation with her mother. This process may have been perceived as a delay, but because Mrs B had a COAST, I consider that it was an appropriate action to inform Mrs A.

114. RN Ferreira noted that although Mrs B did have a COAST instruction not to be transferred to hospital, 'given Mrs B's hyperglycaemia presentation with suspected infection and related delays in receiving medical advice, accepted practice would be for the RN to seek paramedic support and assessment for a medical emergency'. RN Ferreira advised that registered nurses 'need to be able to recognise, assess and respond appropriately to signs of acute and gradual deterioration'.

115. RN Ferreira noted that there was no evidence of communication with the GP following Mrs B's return to the care home, or nursing assessments or care plans commenced in light of her 'care needs for a urinary infection with ESBL, or delivery of relevant infection prevention and control education to the care team', which would have been accepted practice. RN Ferreira considered that this was a moderate to significant departure from accepted practice. I am critical that assessments and care plans were not completed for Mrs B on her return to the care home.

Nursing assessment and care planning

116. Section D16.2a of the Age-Related Care (ARRC) services agreement states that providers of aged-care services must ensure that 'each Resident's health and personal care needs are assessed on admission in order to establish an initial Care Plan to cover a period of up to 21 days'.

117. Although an initial care plan was developed for Mrs B on her admission to the care home, there is no evidence that nursing assessments were completed to inform the interim plan of care, or that short-term care plans were developed, or that a long-term care plan was completed.

118. There is no evidence that a nursing assessment was completed on Mrs B's return to the care home on 25 August 2021, particularly regarding the management of her urinary tract infection with ESBL, and it appears that staff did not receive any guidance on how they could prevent the potential spread of infection.

119. RN Ferreira advised that a nursing assessment and a care plan were a contractual responsibility of the care home, and in their absence, 'essential care information was not available to the care team, which raises risk to resident health and safety needs'. RN Ferreira considered this to be a moderate to significant departure from accepted practice.

120. I accept RN Ferreira's advice and consider that assessments and care planning are an essential cornerstone of good nursing practice. I am critical that essential care plans were

not developed for Mrs B, thereby contributing to inconsistent delivery of personalised care across all shifts and an increase in the risk of essential care being missed.

Communication with Mrs B and her family and care coordination

121. Section D3.1(h) of the ARRC services agreement states that service providers must 'acknowledge, value and encourage the involvement of families/whānau in the provision of care'.

122. Ngā Parewa Health and Disability services standards promote the safe provision of services for people and whānau in New Zealand. There is an expectation that service providers ensure that residents and their family are 'empowered to make decisions about their own care and support in order to achieve their goals'.

123. There is evidence of communication between Mrs A and the care home through different mediums such as email or text messaging, but there is no evidence that any agreed action points were identified and shared with Mrs A, or whether there were any discussions about advanced/palliative care. RN Ferreira considered that this aspect of communication 'met the minimum standard of accepted practice'.

124. RN Ferreira advised that on review of the clinical notes received, whilst there is evidence of communication between allied clinical teams, such as physiotherapists, hospice and nurse specialists, there is no evidence that these discussions were 'integrated into an agreed and personalised plan of care for [Mrs B]'.

125. RN Ferreira identified a moderate departure from accepted practice in relation to the communication with Mrs B's family. I agree. Communication is essential in good healthcare delivery and fosters good working relationships. While Mrs A had access to different forms of communication with the care home, as identified by RN Ferreira, if there are no meeting minutes or action points, then potentially there is no follow through by staff. I am critical that although allied health teams communicated between themselves regarding Mrs B's care, there was no follow through by way of integrating these discussions into her care plan as actions, to better meet Mrs B's needs. In making these comments, I acknowledge the challenges the care home described in its communications with Mrs A.

Conclusion

126. In summary, I find that Presbyterian Support Southland did not provide an appropriate standard of care to Mrs B between July 2021 and September 2021 (inclusive), for the following reasons:

a) Mrs B's initial care plan did not include her baseline vital observations such as her oxygen saturation, which would have informed staff on when to escalate her care. In addition, there was only one record within her electronic medication record to show that she was administered the prescribed oxygen therapy.

b) There was poor documentation of Mrs B's FBCs, and her initial care plan did not provide guidance on managing the care of a resident on a fluid restriction. Also, Mrs B was not weighed regularly as part of her clinical management.

c) There was no guidance in Mrs B's initial care plan on how to apply, position, and remove her compression stockings.

d) There is no evidence of pain assessment forms, and 11 out of 16 entries on Mrs B's electronic medication record did not document the effect of her medication.

e) There were privacy concerns regarding signage and care instructions positioned on Mrs B's mirror, walls, and doors.

f) Due to staffing constraints, Mrs B was not attended to quickly when she needed assistance to go to the toilet.

g) Although an initial care plan was completed for Mrs B on her admission to the care home, there is no evidence that nursing assessments were completed to inform the interim care plan, or that short-term care plans or a long-term care plan were developed.

h) There is no evidence that a nursing assessment was completed for Mrs B on her return from hospital on 25 August 2021, particularly regarding the management of Mrs B's urinary tract infection with ESBL, or that staff were educated on how to prevent the potential spread of infection.

i) Although Mrs A was able to communicate with the care home, there is no evidence that any agreed action points were identified and shared with Mrs A and then integrated into Mrs B's care plan. Also, while there is evidence of communication between allied care teams, these discussions and action points were not integrated into Mrs B's care plan.

127. Accordingly, I find that Presbyterian Support Southland breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[15]

Opinion: Health NZ Southern — adverse comment

128. On 26 June 2021, Mrs B fell out of bed and was unable to get up. She was admitted to Health NZ Southern and the admitting medical team diagnosed pulmonary oedema due to congestive heart failure, and a compression fracture in Mrs B's back (T11), and assessment notes indicate that she had sacral oedema and pitting oedema up to her waist. Mrs B told hospital staff that for at least the past month she had been experiencing increasing shortness of breath when she exerted herself, and she struggled to walk to the rest home for dinner (which previously she could do with 'ease'), and she had noticed that her legs had become more swollen.

[15] Right 4(1) stipulates that '[e]very consumer has the right to have services provided with reasonable care and skill'.

129. As part of her ongoing medical management, Mrs B was prescribed continuous oxygen therapy at 2 litres/minute, and this was commenced while she was an inpatient.

130. On 15 July 2021, Mrs B was discharged from Health NZ Southern to the care home. It was noted on her discharge form from the hospital that she was not on oxygen, and that it had not been prescribed by the hospital.

131. In response to the provisional opinion, the care home submitted that Mrs B was no longer requiring oxygen and that her diagnosis of heart failure was not an indication for community oxygen therapy. I have considered this response, but I remain of the view that this was not explicitly noted in Mrs B's discharge documents, and when she returned to the care home this led to confusion for both the staff and her family, as to whether or not she was on oxygen.

Recommendations

Presbyterian Support Southland

132. In the provisional opinion, I recommended that Presbyterian Support Southland provide a written apology to Mrs B's family for the issues identified in the report. This apology was sent to HDC and has been forwarded to the family.

133. I recommend that Presbyterian Support Southland undertake the following and report to HDC within three months of the date of this report:

a) Review its oxygen management policy in terms of including instructions on competencies required by staff when managing the care of residents on oxygen therapy and provide HDC with evidence of education/training for staff regarding safe oxygen administration and management.

b) Review its nutrition and hydration policy in terms of including instructions on how to manage the care of older persons who require a fluid restriction and a fluid balance chart and provide HDC with evidence of education/training for staff on the importance of accurate record-keeping when managing the care of a resident on a fluid restriction and/or a fluid balance chart.

c) Provide HDC with evidence of education/training for staff on how to apply compression stockings, the rationale for this, and the details required to be noted in the individualised care plan (such as compression rating, and when the resident needs the stockings to be removed and replaced).

d) Provide HDC with evidence of education/training for staff on the importance of updating residents' care plans regularly if there has been discussion with family about the resident, or if action points have been identified by the medical team.

e) Provide HDC with evidence of education/training for staff on privacy, how to identify a potential privacy breach, and how to report and manage this.

f) Provide HDC with evidence of education/training for staff on how to identify a potential infection control issue and what steps need to be taken to manage this.

g) Consider implementing an intentional rounding policy or similar process by which residents' needs are met in a timely or anticipated manner and provide HDC with the outcome of this consideration.

h) Provide HDC with evidence of education/training regarding staff completing nursing assessments and care plans.

Health NZ Southern

134. In the provisional opinion, I recommended that Health NZ Southern confirm that patients who are discharged on community oxygen therapy have the appropriate prescription and oxygen supplies. Health NZ Southern advised HDC that on discharge from hospital, Mrs B was no longer receiving oxygen therapy and, according to the Ministry of Health, her diagnosis of congestive heart failure was not an indication for community oxygen therapy, and therefore it could not be prescribed on discharge. However, Health NZ Southern acknowledged that this was not detailed explicitly in Mrs B's discharge summary.

135. Based on Health NZ Southern's response, I consider that this recommendation has been met.

Follow-up actions

136. A copy of this report with details identifying the parties removed, except Presbyterian Support Southland, Health NZ Southern (Southland Hospital), and the advisor on this case, will be sent to HealthCERT and Health NZ|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Mrs B's fluid balance records — on FBC sheet

Date	Fluid restriction amount noted on FBC?	Running balance done?
17 July 2021	No	No
18 July 2021	No	No
19 July 2021	No	No
20 July 2021	No	No
22 July 2021, 23 July and 24 July all on one sheet		
22 July 2021	1.5 litres	No
23 July 2021	1.5 litres	Running balance attempted but calculation incorrect
24 July 2021	1.5 litres	Running balance incomplete
25 and 26 July 2021 were recorded on the same sheet with the 26 July entry needing another FBC after 2pm due to lack of space		
25 July 2021	No	No
26 July 2021	1.5 litres	Yes
The entries for 27 and 28 July 2021 were on the one FBC		
27 July 2021	1.5 litres	Running balance incomplete
28 July 2021	No	No
29 July 2021	2 litres	No
31 July 2021 and part of 1 August 2021 were recorded on the same FBC		
31 July 2021	2 litres	No
1 August 2021	2 litres	No

2, 3, and 4 August 2021 are all recorded on the same FBC		
2 August 2021	No	No
3 August 2021	No	No
4 August 2021	No	Running balance attempted but calculation incorrect
6 August 2021	2 litres	No
7 August 2021	2 litres	No
9 August 2021	2 litres	No
10 August 2021	2 litres	No
11 August 2021	2 litres	No
12 August 2021	2 litres	No
13 August 2021	2 litres	No
14 August 2021	2 litres	No
15 August 2021	2 litres	No
16 August 2021	2 litres	No
8 September 2021	2 litres	No
9 September 2021	2 litres	No
10 September 2021	2 litres	No
11 September 2021	2 litres	No
12 September 2021	2 litres	No
13 September 2021	2 litres	Running balance incomplete

Appendix B: Mrs B's fluid balance records — in progress notes

July 2021 progress notes recordings

July date and time	Fluid intake noted in progress notes?		July date and time	Fluid intake noted in progress notes?
15 July 2021 at 10.41pm	600 ml		23 July 2021 at 2.20pm	'good … fluid intake'
16 July 2021 at 2.57pm	'Intake: 100%'		24 July 2021 at 2.24pm	625 ml
16 July 2021 at 10.34pm	'Intake: eating and drinking all'		25 July 2021 at 6.39am	125 ml
16 July 2021 at 10.53pm	'Total fluid intake is 1500ml/day'		25 July 2021 at 1.13pm	'… fluid intake fine'
17 July 2021 at 6.46am	215ml		25 July 2021 at 2.34pm	'… drinking well'
17 July 2021 at 10.13pm	300ml		25 July 2021 at 10.03pm	'… drinking well'
18 July 2021 at 2.21pm	'Intake: what [has] been offered'		26 July 2021 at 7.36am	'FBC maintained'
18 July 2021 at 3.32pm	450ml		26 July 2021 at 10.45am	'good restricted fluid intake'
18 July 2021 at 10.14pm	'Intake: … drinking water'		No record for 27 July 2021	
19 July 2021 at 9.46pm	'Intake: had everything except soup'		28 July 2021 at 2.33pm	'… drinking well'
20 July 2021 at 6.27am	540ml		29 July 2021 at 2.52pm	685ml
20 July 2021 at 1.57pm	'Intake: … under fluid restriction … 350ml supplied in the morning…'		30 July 2021 at 6.29am	'FBC maintained and now changed to 2 [litres] per day'

20 July 2021 at 10.14pm	'Intake: … drinking well'		30 July 2021 at 2.11pm	'… please refer to FBC in her room'
21 July 2021 at 3.06pm	850ml		30 July 2021 at 9.21pm	'… drinking well'
22 July 2021 at 2.35pm	850ml		31 July 2021 at 3.30pm	'Good … fluid intake'
22 July 2021 at 9.47pm	'[Mrs B] is being maintained religiously on a 1.5 [litre] fluid restriction'		31 July 2021 at 10.23pm	'2 litres fluid restriction/24 hours'

August 2021 progress notes recordings

August date and time	Fluid intake noted in progress notes?		August date and time	Fluid intake noted in progress notes?
1 August 2021 at 2.37pm	825ml		15 August 2021 at 10.38pm	'Fluid balance chart maintained'
1 August 2021 at 9.44pm	'had … fluid intake'		16 August 2021 at 3.20pm	'completed 1350ml fluid …'
2 August 2021 at 2.08pm	'… drinking well'		16 August 2021 at 10.42pm	'On fluid restriction of 2l/day …'
2 August 2021 at 10.50pm	'Minimal fluids this shift as had 1600mls in [morning] shift …'		No record for 17 August 2021	
3 August 2021 at 9.21pm	'… drinking'		18 August 2021 at 8.13pm	'Drunk 1375 ml fluid …'
5 August 2021 at 2.43pm	'Fluid restriction chart with [Clinical Manager]'		19 August 2021 at 5.07am	'FBC calculated and new sheet in place'
6 August 2021 at 2.26pm	'New FBC paper kept in her room. Please enter intake of fluid accurately'		No record for 20 August 2021	

7 August 2021 at 4.57am	'… FBC maintained'		21 August 2021 at 6.37am	'… FBC maintained'
7 August 2021 at 2.52pm	'Fluid restriction chart has been maintained …'		21 August 2021 at 12.56pm	'… FBC updated … [weight] completed today 67.4kg'
8 August 2021 at 7.11am	'FBC maintained'		22 August 2021 at 4.55am	'FBC completed'
8 August 2021 at 1.47pm	'Fluid restriction chart has been maintained …'		No record for 23 August 2021	
8 August 2021 at 2.43pm	'Daughter informed that fluid balance chart has not been maintained the past 2 days'		No record for 24 August 2021 as Mrs B was transferred to hospital	
9 August 2021 at 7.14am	'FBC maintained'		25 August 2021 at 2.39pm	'Remain on … 2L fluid restriction'
10 August 2021 at 2.54pm	'Fluid restriction chart has been maintained …'		26 August 2021 at 2.10pm	'Continued in fluid chart …'
No record for 11 August 2021			26 August 2021 at 10.35pm	'Have finished 1220 ml today'
12 August 2021 at 11.00pm	'fluid balance chart in place'		No record for 27 August 2021	
13 August 2021 at 7.15am	'… FBC maintained'		28 August 2021 at 4.38am	'FBC maintained'
13 August 2021 at 10.07pm	'Total fluid intake during my shift: 705ml. Both legs are [oedematous]'		28 August 2021 at 8.52pm	'Had 1660 ml fluid …'
14 August 2021 at 4.12am	'… FBC maintained'		29 August 2021 at 5.23am	'… FBC maintained'

14 August 2021 at 10.44pm	'Fluid balance chart maintained … both legs are [oedematous]'		30 August 2021 at 3.07pm	'FBC in place.'
15 August 2021 at 3.25pm	'Fluid restriction chart has been maintained …'		31 August 2021 at 11.10pm	'FBC in place'

September 2021 progress notes recordings

September date and time	Fluid intake noted in progress notes?		September date and time	Fluid intake noted in progress notes?
1 September 2021 at 10.59pm	'FBC in place'		12 September 2021 at 1.28pm	'On 2L fluid chart and had 930ml by 130pm … [weight] 71.8kg'
2 September 2021 at 1.20pm	'Pitting oedema grade 2 noted … [w]eight today 72.6kg …'		13 September 2021 at 8.50pm	'Had 1400ml fluid today'
3 September 2021 at 2.33pm	'Fluid balance chart maintained'		14 September 2021 at 3.18pm	'FBC … in place'
4 September 2021 at 2.10pm	'Fluid balance chart maintained'		14 September 2021 at 9.52pm	'… had 1600ml fluid.'
5 September 2021 at 2.39pm	'FBC maintained'		15 September 2021 at 6.52pm	'On 2 [litre] FBC'
No record for 6 September 2021			16 September 2021 at 5.03am	'FBC maintained'
7 September 2021 at 2.36pm	'On 2 [litre] FBC'		17 September 2021 at 7.31am	'FBC maintained'
8 September 2021 at 6.39am	'FBC maintained …'		18 September 2021 at 12.45pm	'On 2 litre FBC and had 745ml until 1200hr …'
9 September 2021 at 10.27pm	'FBC maintained'		18 September 2021 at 10.40pm	'Total fluid intake: 1515ml'

No record for 10 September 2021			19 September 2021 at 1.04pm	'On 2 L fluid balance chart'
11 September 2021 at 2.41pm	'Fluid intake 1240 ml …'		19 September 2021 at 10.27pm	'Fluid balance chart maintained'
			20 September 2021 Mrs B was discharged from the care home	

Appendix C: Mrs B's daily weigh records

Date of weight measurement	Time of weight measurement recorded?	Type of scales used recorded?	Mrs B's weight
15 July 2021	No	No	68.8kg
16 July 2021	No	No	69kg
17 July 2021	No	No	70.6kg
18 July 2021	No	No	69.6kg
20 July 2021	No	No	69.6kg
21 July 2021	No	No	68.6kg
22 July 2021	No	No	68.8kg
29 July 2021	No	No	67.8kg
31 July 2021	No	No	67.2kg
6 August 2021	No	No	76.2kg
6 August 2021 Instructions in progress notes that Mrs B was to be now weighed every second day			
12 August 2021	No	No	70.4kg
16 August 2021	No	No	70kg
21 August 2021	No	No	67.4kg
27 August 2021	No	No	70.8kg
31 August 2021	No	No	72.2kg
2 September 2021	No	No	72.6kg
6 September 2021	No	No	71.5kg
12 September 2021	No	No	71.8kg

Appendix D: Mrs B's medication administration

Date and time	Medication and dose	Rationale noted?	Outcome/ effect noted?	Recorded in Medi-map
18 July 2021 at 9.02pm	Morphine liquid 2.5ml	'Complaining of pain around the shoulders and back'	No	Yes
21 July 2021 at 6.21pm	Morphine liquid 2.5ml	'Persistent back pain'	Yes	Yes
26 July 2021 at 6.25pm	Morphine liquid 2.5ml	'For back pain' Pain noted to be 8/10 on pain scale	Yes	Yes
3 September 2021 at 3.04pm	Morphine liquid 2.5ml	'distress'	No	Yes
9 September 2021 at 10.17am	Morphine liquid 2.5ml	'Given for pain …'	Yes	Yes
10 September 2021 at 2.29pm	Morphine liquid 2.5ml	'for pain'	No	Yes
14 September 2021 at 6.07am	Morphine liquid 2.5ml	'As per directions pre cares'	No	Yes
14 September 2021 at 6.08am	Ondansetron 4mg tablet	'Given prophylactically for nausea prevention post morphine'	No	Yes
15 September 2021 at 6.25am	Morphine liquid 2.5ml	'As per directions pre cares'	No	Yes
15 September 2021 at 6.25am	Ondansetron 4mg tablet	'Given prophylactically for	No	Yes

		nausea prevention post morphine'		
16 September 2021 at 6.21am	Morphine liquid 2.5ml	'As per instruction'	No	Yes
16 September 2021 at 7.37am	Metoclopramide 10mg tablet	'Given as per … instruction'	No	Yes
17 September 2021 at 5.58am	Morphine liquid 2.5ml	'As per instruction'	Yes	Yes
17 September 2021 at 6.25am	Metoclopramide 10mg tablet	'As per instruction'	Yes	Yes
20 September 2021 at 9.14am	Morphine liquid 2.5ml	'As per instructions'	No	Yes
20 September 2021 at 9.37am	Metoclopramide 10mg tablet	'As per instruction'	No	Yes

Appendix E: In-house clinical advice to Commissioner

The following in-house advice was obtained from Aged Care Advisor RN Jane Ferreira:

> '1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the care home]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> 2. **Documents reviewed**
>
> Consumer complaint submitted by [Mrs B's] daughter
>
> Provider response dated 16 December 2021
>
> Clinical file documentation including medical and nursing notes, communication records and monitoring forms
>
> Organisational policies including Medication Management, Nutrition and Hydration, Pain Management, Open Disclosure, education plans
>
> Additional evidence received 27 March 2023 including medication records, education records and corrective actions outlining quality improvements in response to the complaint
>
> 3. **Complaint** [Mrs B's] daughter, [Mrs A], has expressed concern regarding the clinical care, communication and treatment her late mother received while resident at [the care home].
>
> 4. **Review of clinical records** For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future. In particular, comment on:
>
> Management of heart failure, including monitoring of oral intake, weight recording, oxygen therapy and compression stockings
>
> Management of pain and administration of prescribed medications
>
> Personal hygiene, care and safety needs
>
> Nursing assessment and care planning
>
> Assessment and management of deteriorating conditions, and care escalation
>
> Communication between staff, resident and family/whānau
>
> **Background**
>
> [Mrs B] was admitted to [the care home] at hospital level care from Southland Hospital on 15 July 2021, following a fall event at [the care home]. Her medical history included Type 2 Diabetes, heart failure, pulmonary oedema with fluid overload, bilateral lower

leg oedema, hypertension, osteoarthritis, essential thrombocythaemia, Vitamin B12 deficiency and increasing frailty. According to hospital discharge information [Mrs B] required moderate assistance from staff to meet her activities of daily living. She was able to weight bear and mobilise short distances using a walking frame with staff assistance. … Due to expressed care concerns, [Mrs B] transferred to another care home on 20 September 2021, and passed away [a few weeks later]. I extend my condolences to [Mrs B's] family at this time.

a) **Whether the care provided to [Mrs B] was acceptable in the circumstances.** As outlined in hospital discharge information 15 July 2021, [Mrs B] was living with multiple long-term health conditions and assessed as requiring hospital level care. Her medical management plan, nursing handover and list of prescribed medications indicated she required close support to meet her health and wellbeing needs.

Oral intake and weight recording Care interventions on the discharge documents state that [Mrs B] required a restricted fluid intake of 1.5L (1500mls) per day, a diabetic diet, daily weighs and prescribed medication interventions as part of her ongoing plan of care. The organisation's Nutrition and Hydration policy, 11 March 2021 states that a registered nurse (RN) or enrolled nurse (EN) will complete a nutritional assessment on Day 1 of the resident's long-term admission. The policy references the Health Quality and Safety Commission's (HQSC) Frailty Care Guides, resources designed to guide and support clinical decision-making (HQSC, 2019). The policy provides guidance about weight monitoring, nutritional needs including signs of dehydration or malnutrition, general practitioner (GP) and dietician involvement, but does not provide specific guidance about caring for older people with fluid restrictions, which presents an improvement opportunity.

The clinical records evidence that an initial care plan (case plan summary report) was developed between 16 and 21 July 2021 however there is no corresponding evidence that any nursing assessments were completed on admission to inform the interim plan of care, which is accepted practice as outlined in service provider contractual responsibilities. The care plan summary report provides generic interventions outlining [Mrs B's] care requirements during the settling-in phase of her admission. The report discusses dietary needs with a requirement for daily weighs but lacks guidance regarding a specific management plan for restricted fluids. There is no discussion provided or rationale for accurately monitoring [Mrs B's] fluid intake in the report. As a newly admitted resident it would be recommended to include personalised detail in an interim care plan to provide information to the care team regarding preferred fluids, timeframes for offering fluids per shift, strategies to manage safe fluid intake to reduce the risks of dehydration, or any feedback from the EPOA or family/whānau regarding supportive care needs.

[Mrs B's] family have raised concern regarding inaccuracies in fluid balance records during her admission. Progress note entries provide discussion of vital signs and weight recording across shifts during [Mrs B's] admission, however only a small sample of monitoring forms were provided by [the care home] as supporting evidence of appropriate care intervention. Documentation dated 15–22 July 2021, shows that blood pressure, pulse and weight monitoring was occurring. Fluid balance charts (FBC), 9–12 September 2021, appear to indicate that [Mrs B] received oral fluids within the recommended range. Comments on the reviewed forms refer to fluid restrictions of 1.5L due to oedema, noting "Daily BP & FBC & Weights, on frusemide medication". It is unclear from the submitted evidence if this data was consistently monitored by the RN team. From the nursing notes and small sample of forms reviewed there are discrepancies in documentation standards and related clinical oversight. This has been acknowledged in the provider's corrective action plan as an ongoing development area.

Care teams need to be aware of individual hydration needs and understand the importance of accurate record keeping, such as the volume of oral intake or frequency of weight recording as data is used to inform care management. It's important for care teams to be aware of resident output patterns and dehydration risk, especially for residents on prescribed diuretic or oxygen therapy. Low-intake dehydration can contribute to confusion, increased falls risk and wider health issues, which do not appear to be recognised in admission nursing assessments or care planning, which would be accepted practice.

Departure from accepted practice: Moderate

<u>Oxygen Therapy</u>

The organisation's Medication Management policy reviewed 23 June 2021 provides guidance regarding the administration of prescribed medications, which includes oxygen therapy. Section 19 of the policy provides appropriate information regarding resident use, safe care and storage, and documentation responsibilities. The policy provides discussion of staff training to achieve medication-competency, however does not provide guidance regarding the specific knowledge and skills required for safe and competent oxygen management. There is also no specific information relating to health education of consumers or their nominated representatives for oxygen use within or away from [the care home]. I note the provider has identified this as an improvement area within their corrective action plan.

The care plan summary report provides good discussion of generic interventions aligned to policy guidance, but does not provide personalised clinical information such as baseline vital sign data, oxygen saturation rates, signs that may indicate resident distress or supportive actions to assist staff to deliver clinically appropriate care. Accepted practice would be to include individualised care strategies in care planning, with clear guidance for clinical escalation.

It appears there were delays in charting oxygen therapy for [Mrs B]. The discharging clinical information from Southland Hospital does not discuss the use of oxygen therapy, with 'No' selected to Oxygen use on Form 63014. Admission progress notes and the provider response letter discuss contacting [Mrs B's] GP for advice which is accepted practice. I note from the provider response that [Mrs B] had retained her own GP rather than transferring to [the care home] GP. It is unclear what process was in place for after-hours care. Clinical records show that [Mrs B] was seen by her GP on 23 July 2021 and admission documentation completed, however Medimap electronic medication records show that oxygen was prescribed for use on 12 August 2021. It is unclear if an interim paper-based prescription was in place at this time which may account for the discrepancy in timeframe, however there is no supporting administration record identified in the clinical file.

The electronic prescription reflects that [Mrs B] was prescribed oxygen therapy as a PRN (as required) medication. The prescription comments refer to continuous administration of oxygen via concentrator, noting "2L unlimited frequency via nasal prongs for palliative oxygen therapy". I note there is no further nursing guidance provided about advance care directives or palliative care pathways within care planning which would be accepted practice in the circumstances.

The InterRAI assessment comment 13 August 2021, states "continuous flow oxygen 2L via nasal prongs 24/7 as charted". This suggests that oxygen therapy was prescribed as a regular medication rather than an as-required intervention. Progress notes regularly discuss oxygen administration as continuous use via nasal prongs, however there is only one entry (13 August 2021, 0542hrs) within the electronic medication administration records to evidence administration of prescribed oxygen therapy during [Mrs B's] stay. There is no evidence within the care record that qualified nurses sought clarity from the GP regarding prescribed oxygen therapy which would be accepted practice. As outlined in the organisation's Medication Management policy it is the responsibility of the Clinical Manager and RN team to lead and provide safe resident care, with clear risk mitigation strategies in place. The provider response has acknowledged and apologised for noncompliance to oxygen safety; however there appears to be a need for wider improvement regarding medication safety and the application of organisational policies to staff practice.

Departure from accepted practice: Significant

<u>Compression stockings</u>

The admission care plan summary report does not provide guidance for carers regarding the application, positioning and removal of compression stockings which would be accepted practice. It appears a local document (not dated or signed) with a photograph was developed in response to family concerns with [Mrs B's] care. Progress notes discuss the use of compression stockings and entries note "washed and hanging up" appear to evidence that care was occurring as outlined in the local

guidance document. Accepted practice would be to develop a specific care plan to guide the care team about the required interventions for resident care. This may include educational resources or input from a nurse specialist. It would be recommended to discuss the rationale for use, stocking size and compression rating, frequency of skin assessment, care and safety needs such as wrinkle-free stocking position, resident mobility or footwear use, and pathway for escalating care concerns.

Departure from accepted practice: Moderate

Management of pain and administration of prescribed medications

The organisation's Medication Management policy reviewed 23 June 2021 provides guidance regarding the administration of medications and management of resident symptoms. Section 14 of the policy discusses administration of as-required (PRN) medications and role responsibilities of clinical assessment, evaluation of effectiveness and escalation responsibilities. The Pain Management policy reviewed 12 March 2019 directs staff to report medication effectiveness within Medimap. Accepted practice would be to ensure that a corresponding entry is reflected in the resident's contemporaneous nursing record.

Medication administration records dated 15 July to 21 September 2021 reflect that all prescribed regular medications were administered as charted, with no evidence of refusal. Prescribed PRN medications administered during [Mrs B's] stay at [the care home] provide a rationale for every dose within the comment section, which is accepted practice. Short course medications appear to be given as prescribed. Progress notes provide discussion of reported or assessed pain with pain scores, however there were no pain assessment forms included in the evidence bundle to support this.

[Mrs B's] family have raised concern regarding the management and administration of prescribed morphine and anti-nausea medication. The Medication Management policy provides guidelines for administration of regular and PRN medications, including anticipatory palliative care medications. Progress note entries and Medimap records provide discussion of pain scores following nursing assessment, and refer to pre-emptive administration of anti-emetic medications with comments of nil active symptoms. There is regular evidence of RN contact with [Mrs B's] EPOA regarding care consultation and informed consent, which supports whānau involvement and participation in care.

The provider response has discussed Hospice involvement in care, however it is unclear how frequently [Mrs B's] GP was informed of care concerns. Clinical records show she was medically assessed by her GP on 23 July 2021 and 3 September 2021. It is unclear if a consultation or medication review occurred outside of these visits which would be accepted practice given the raised concerns. There is evidence of nursing leadership and guidance in Medimap and V-Care nursing records by the

clinical leaders at [the care home], however there is no evidence of recognised nursing assessment tools or a coordinated nursing care plan to guide safe and continuous delivery of care across all shifts, which would be accepted practice.

Departure from accepted practice: Moderate

Personal hygiene, care and safety needs

[Mrs B's] family have raised concerns regarding the care and environment on admission and episodes of delayed or missed care during [Mrs B's] admission which impacted her safety and wellbeing. Concerns relate to personal care delivery and hand hygiene, support with regular toileting, safe positioning of oxygen nasal prongs and tubing, appropriate monitoring of fluids and dietary needs, access to physical therapy and call bell response times.

Nursing and carer progress notes discuss [Mrs B's] daily care needs across all shifts during her admission, as outlined in the interim care plan 16–21 July 2021. Needs and actions are reflected within InterRAI assessment comments 13 August 2021, and in a locally introduced document outlining [Mrs B's] care requirements. File evidence and photographs of local documents, signage and care instructions positioned on bedroom and bathroom doors, walls and mirrors, raise questions regarding confidentiality of information, person-centred care, privacy, dignity and respect. In addition to progress note entries a shift checklist was introduced to support carer accountability, however there is no evidence that an overarching long-term care plan was developed to provide relevant care instruction, aligned to contractual responsibilities and accepted practice standards.

The provider response letter, statements and entries in the care record evidence regular meetings occurred with [Mrs B's] family in response to raised issues. It is unclear if meeting minutes outlining content and action points were shared with [Mrs B's] EPOA, as outlined in the Open Disclosure policy. It is also unclear how care concerns were communicated from the clinical leaders to the care team to ensure evidence-based, personalised care delivery consistently occurred. Platforms such as clinical review meetings, qualified staff meetings or shift handovers are good opportunities to collaboratively review and evaluate resident care needs or provide education. The submitted corrective action plan 27 March 2023 evidences the provider has considered and acted on areas for clinical improvement related to personal care, safety and hygiene needs, supported by evidence of additional education and training records. There is an opportunity to strengthen the preadmission flow sheet to ensure operational responsibilities and clinical requirements are completed in preparation for resident admission.

Departure from accepted practice: Moderate

Nursing assessment and care planning

The Age-Related Residential Care (ARRC) Services Agreement provides specific guidance regarding admission assessment and care planning responsibilities for

service providers. Section D16.2a states that "*each resident's health and personal care needs will be assessed on admission in order to establish an initial care plan to cover a period of up to 21 days"*. D16.3a states that "*each resident will have a care plan that is based on assessments of the resident carried out using InterRAI, and that all staff will follow the care plan".*

As previously discussed, the clinical file provides evidence that an initial care plan (care plan summary report) was developed between 16 and 21 July 2021 but there is no corresponding evidence that nursing assessments were completed on admission to inform the interim plan of care, which is accepted practice. There is no discussion of falls risk or specific strategies to meet care and safety needs in a new environment during the settling-in phase, particularly considering [Mrs B] had a recent history of a fall event. There is evidence that [Mrs B's] first InterRAI assessment was completed on 13 August 2021, however only assessment comments were provided in the evidence bundle, rather than the comprehensive report which reflects scoring, identified risk and trend data to inform care planning. Nursing assessments are used to inform care plans which are designed to guide consistent delivery of personalised care across shifts. This means essential care information was not available to the care team, which raises risk to resident health and safety needs.

While there is discussion of family meetings and emails within the electronic care record, there is no evidence that a long-term care plan was developed by the organisation for [Mrs B] which is a departure from service provider contractual responsibilities. It is unclear if internal audits of nursing documentation were completed by the clinical manager to monitor timeliness of admission nursing assessments and development of initial and long-term care plans as part of organisational responsibilities to clinical governance standards. I note local documents outlining care instructions with shift checklists were created in response to concerns raised by family, however these documents do not meet professional care and documentation standards, with no opportunity for evidence-based evaluation as part of the nursing process. File communication indicates support and involvement was available from local hospital and needs assessment services to facilitate care planning. It is unclear what factors contributed to the delays in meeting service responsibilities or why [the care home's] electronic care platform was not used to develop a specific plan of care.

Departure from accepted practice: moderate to significant

<u>Assessment and management of deteriorating conditions, and care escalation</u>

[Mrs B] was admitted from hospital with a clinical order articulating scope of treatment (COAST), dated 15 July 2021, which showed a do not resuscitate order and a comfort-focused treatment plan.

According to the submitted medical records [Mrs B] was seen by her GP on 23 July 2021 with clinical notes indicating that [Mrs B] was frail and approaching end of life. "*Sleepy, poor respiratory reserve function with bibasal creps. Impression: Near end of life".* The clinical plan refers to comfort cares as outlined in the COAST order with activation of [Mrs B's] enduring power of attorney (EPOA). Palliative and end of life care planning is considered a responsibility of the clinical team and is an important part of the therapeutic relationship between the consumer, nominated representative and service provider. It is unclear if [Mrs B] and her family met with [the care home] clinical team at this time to discuss advance care wishes to inform a palliative care plan, such as "Te Ara Whakapiri", which would be accepted practice to plan ongoing care (HQSC, 2019, 2021; MoH, 2017).

Clinical file documentation and statements from key staff indicate [Mrs B] showed a change in behaviour with signs of confusion on 23 August 2021. Progress notes discuss urine odour with urine dipstick results showing a high presence of nitrates. The GP was informed via fax communication, a urine sample was collected and sent to the laboratory for analysis, EPOA informed and monitoring of vital signs commenced, which is accepted practice in the circumstances. There does not appear to be a short-term care plan commenced to coordinate these actions which would be accepted practice for an unwell resident with a suspected infection. According to the care record the GP ordered Ural sachets on 23 August 2021, 2249hrs, and advised the care team to await MSU results before starting antibiotics. There does not appear to be an RN AM shift entry on 24 August 2021. The PM shift RN has reported finding [Mrs B] unwell with a blood glucose level (BSL) of 30.1mmol. There is evidence of event escalation and consultation with a senior nurse which is accepted practice in the circumstances. At 1700hrs the on-call RN informed the duty RN that laboratory results indicated urinary infection and guidance was sought from [Mrs B's] GP and acute care services. There appears to be a two hour delay in communication from GP services, who advised at 1900hrs to transfer [Mrs B] to hospital for further assessment and care.

The COAST order notes "*DO NOT transfer to hospital unless needs are unable to be met in the community",* however given [Mrs B's] hyperglycaemic presentation with suspected infection and related delays in receiving medical advice, accepted practice would be for the RN to seek paramedic support and assessment for a medical emergency. As outlined in the Frailty Care Guides nurses need to be able to recognise, assess and respond appropriately to signs of acute and gradual deterioration. Two recommended approaches to support nursing practice include the use of the STOP AND WATCH tool to assist clinical assessment, and the ISBAR tool to communicate findings.

Clinical notes indicate [Mrs B] was transferred back to [the care home] on 25 August 2021, and was seen by her GP on 3 September 2021. There is no evidence of nursing assessment completed on her return to [the care home], commencement of relevant care planning to guide care needs for a urinary infection with ESBL, or

delivery of relevant infection prevention and control education to the care team which would be accepted practice in the circumstances. There is no evidence of communication with the GP on [Mrs B's] return to [the care home] nor guidance sought for ongoing medical care which would be recommended practice.

Departure from accepted practice: moderate to significant

From the evidence reviewed to respond to this question, I consider there are moderate to significant departures in the clinical care provided to [Mrs B] during her admission. As discussed under the requested subsections, there are opportunities for improvement in clinically safe resident admissions, professional nursing assessment, care planning and documentation standards, clinical leadership, communication and decision-making, which would be viewed similarly by my peers. **Departures from accepted practice: moderate to significant**

b) Whether the communication with [Mrs B] and her family was appropriate.

Residents have the right to be informed, to feel safe and supported and receive services of an appropriate standard. Residents, family/whānau or nominated representatives are encouraged to communicate with their service provider as part of the therapeutic relationship, and as outlined in contractual requirements. The ARRC Services Agreement; D3.1 (h) states that service providers will acknowledge, value and encourage the involvement of families/whānau in the provision of care. Ngā Paerewa Health and Disability Service Standards (HDSS), A2.3 (2iii) states service providers will ensure residents and their whānau are empowered to make decisions about their own care and provide support in order to achieve their goals.

There is limited file evidence that an initial meeting was held with [Mrs B] and her family on admission to [the care home] to discuss her care wishes and determine her goals for care. It is unclear if the goals listed in the care plan summary report and any ongoing care requirements were planned, reviewed and evaluated in a timely way with [Mrs B] and her EPOA, per service provider responsibilities outlined in the ARRC agreement.

There are four entries in the family communication record which provide accounts of interactions between the EPOA and care home team in August and September 2021, although progress note entries reflect regular EPOA involvement in care decisions and GP visits. In addition to nursing and medical information, file notes, reflective staff statements, texts and email communication indicate there was regular dialogue between [Mrs B's] EPOA and [the care home's] leadership team. Content reviewed indicates that meetings occurred but there is no evidence that formal meeting minutes, outlining agreed action points, were shared with [Mrs B's] EPOA, which would be accepted practice. The provider has submitted evidence of the Open Disclosure policy and a pre-entry admission flow sheet which refers to information on complaint processes in the admission pack, but there is no evidence that care concerns were recorded through a consumer feedback process or

reported through an event management system for formal escalation and action which is accepted complaint management practice to support quality and service improvement.

The care record provides evidence of communication and care escalation between carers and nurses to care home leaders, and there is evidence of professional collaboration and consultation with allied health teams including physiotherapy, podiatry, nurse specialists, hospice and acute-care colleagues, however this was not integrated into an agreed and personalised plan of care for [Mrs B]. The corrective action plan has acknowledged a need for wider education and training, and supporting evidence shows input by external health professionals in a range of development sessions.

From the evidence reviewed to respond to this question it appears the communication between [the care home] and [Mrs B's] family met the minimum standard of accepted practice in the circumstances. The case review has identified opportunities for strengthening communication about clinical and operational practices to align to organisational systems and processes. There are opportunities for improvement with pre-admission and day of admission interactions, management of feedback and complaint processes and documentation standards to reflect interaction with family/whānau to support effective consumer-focused care delivery.

Departure from accepted standards: moderate

5. Clinical advice

I note that the events occurred during the COVID-19 pandemic period 2020–2022 and would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams and health service providers during this time.

Based on this review I recommend [the care home] team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the family in the resident's clinical record, and implementing the use of the ISBAR communication tool to better inform clinical assessments, actions and safe, evidence-based decision-making. To support this approach I recommend that [the care home] team complete the new online modules for further learning — https://www.hdc.org.nz/education/online-learning/

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

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Additional comment — 23 February 2024.

Thank you for the opportunity to review my advice 14 April 2023. I have been asked to review the subsection of question (a) "oral intake and weight recording" and provide comment regarding fluid balance monitoring forms and provide rationale for a moderate deviation in accepted practice.

Fluid balance charts form part of an integrated care record and need to be considered in partnership with progress note entries and a nursing care plan in [the care home] setting. While the viewed evidence of fluid balance charts reflects poor record-keeping, progress note entries provide discussion of other elements of supportive care occurring. My comment and decision refer to this, and to service provider responsibilities to improve clinical care and documentation standards in line with policy guidance. The provider has identified that documentation standards were less than desirable and acknowledged this is an area for improvement.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

Reference

Ausmed (2023). Improving Fluid Balance Charts. Fluid Balance Charts, Hypervolaemia & Hypovolaemia'