Northbridge Lifecare Trust

Registered Nurse, Ms B

A Report by the

Deputy Health and Disability Commissioner

Case 09HDC02159

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

Background

1. In 2009, Mrs A (aged 90 years) was admitted to the hospital at Northbridge Lifecare Trust (Northbridge) for two weeks' respite care while her daughter went on an overseas trip. Prior to her admission, Mrs A was able to mobilise short distances with assistance using a walking frame, but required assistance with all her cares, including feeding.

2. On the third day of her admission, Northbridge experienced an outbreak of Norovirus and went into "lockdown". As a result, all residents infected by Norovirus were put into isolation. Additional bureau nurses were brought in to assist and were involved in nursing all uninfected residents, including Mrs A.

3. Throughout her admission Mrs A refused, or ate only very small amounts of many of her meals. She spent most days in either a reclining chair or bed. She also refused her medication on a number of occasions.

4. Two weeks later, Mrs A's daughter returned from her trip and was shocked by her mother's appearance. She reported that her mother had lost a considerable amount of weight, her mouth was "bone-dry", her eyes were dry and painful, her hands were white and her finger-tips were blue.

5. The following day, Mrs A lost consciousness at home and was taken to hospital. She died later that evening. Her death certificate lists cardiogenic shock (4 hours' duration),[1] myocardial infarction (6-24 hours' duration), dehydration (7 days' duration), ischemic heart disease (years) and possible lower respiratory tract infection (days) as the causes of death.

Decision summary

6. While Northbridge was clearly under a lot of pressure having to manage the Norovirus outbreak, it did not have adequate safety nets in place to ensure that Mrs A received adequate care and monitoring during her short stay. Accordingly, Northbridge breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). [2]

7. Despite being aware that Mrs A was refusing food and fluids, team leader Ms B failed to implement any form of monitoring of Mrs A. Although this failure did not amount to a breach of the Code, the Deputy Health and Disability Commissioner considered that Ms B should be reminded of the importance of initiating closer monitoring and providing adequate clinical leadership.

[1] Inadequate blood circulation due to failure of the heart.
[2] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

8. The Deputy Commissioner recommended that Northbridge apologise to Mrs A's daughter for its breach of the Code. She also recommended Northbridge take a number of steps to improve its services.

Complaint and investigation

9. On 3 December 2009, HDC received a complaint from Ms C about the services provided to her mother, Mrs A, by the hospital run by Northbridge Lifecare Trust. An investigation of the following issues was commenced on 8 April 2010:

- *Whether Mrs A received an appropriate standard of nursing services while receiving respite care in Northbridge Lifecare Trust Hospital[3] during the period of her admission in late 2009.*

10. The investigation was extended on 11 March 2011 to include:

- *Whether registered nurse Ms B provided health care of an appropriate standard to Mrs A during the period of her admission in late 2009.*

11. This report is the provisional opinion of Tania Thomas, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

12. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms C	Complainant/daughter
Northbridge Lifecare Trust	Provider
Ms B	Provider/registered nurse

Also mentioned in this report:

Ms G	Northbridge Lifecare Manager

13. Information was also reviewed from:

Ms D	Registered nurse
Ms E	Registered nurse (bureau)
Ms F	Registered nurse (bureau)

14. Independent expert advice was obtained from registered nurse Jenny Baker (**Appendix A**).

[3] This refers to the hospital section of Northbridge Lifecare Trust.

Information gathered during investigation

Mrs A

15. Mrs A, 90 years old at the time of this incident, had a history of strokes. She lived with her daughter, Ms C, her primary caregiver, in a granny flat separate to her home. Mrs A required full assistance with all her cares, including feeding. Her daughter advised that Mrs A had a good appetite and was able to eat a normal diet but ate and drank very slowly and would reject food and water when the person administering them was "unsympathetic to her needs". She was able to mobilise short distances using a walking frame.

Northbridge

16. Northbridge is a continuing care facility offering hospital, rest home care and retirement housing. The hospital section consists of 35 beds. The hospital is staffed full time by registered nurses (RNs). Nursing care is also provided by healthcare assistants under the supervision of the nurse team leader. Other therapists are available such as physiotherapists, occupational and diversion therapists, and a dietitian.

RN Team Leader Ms B

17. Ms B obtained her nursing registration in 1969. She worked for one year as a Staff Nurse in New Zealand, then left to work as a product specialist manager in the medical/surgical industry overseas. Ms B returned to nursing practice in 2007 and has been employed as RN Team Leader (RNTL) at Northbridge since November 2007.

18. The RNTL directly supervises RNs, enrolled nurses and healthcare assistants. The RNTL position description states that one of the RNTL's principal objectives is to "ensure appropriate, individualised and safe care through assessment planning and implementation while respecting rights, privacy and dignity of the residents in accordance with the Philosophy of 'Northbridge'." In addition, the RNTL must "… maintain a safe environment" and "uphold own professional standards and accountability."

Late 2009

19. Mrs A was admitted to Northbridge for two weeks' respite care while her daughter went on an overseas trip. Mrs A had stayed at Northbridge for respite on three previous occasions. No concerns have ever been raised in relation to any of these previous admissions.

20. Prior to Mrs A's admission, Northbridge sent Mrs A's general practitioner (GP), a standard form requesting that Mrs A be assessed prior to her respite stay and asking about his after-hours service. There is no information in Mrs A's records in relation to whether the GP completed an assessment or what his after-hours practices were. However, there is a list of Mrs A's medications provided by the GP dated 20 February 2009. These included:

- Quinapril Hydrochloride 5mg daily[4]
- Frusemide 40mg daily[5]
- Aspirin 100mg daily[6]
- Dipyridamole [trade name Persantin] 25 mg four times daily[7]
- Coloxyl with Senna once daily[8]
- Simvastatin 40mg daily[9]
- Etidrate 200mg daily[10]
- Nutraplus 10% cream as required[11]
- Resource Thicken Up Powder 250g as required[12]

21. At the time of admission a note was made in Mrs A's progress notes that she ate a normal diet with thickened fluids. It noted that she had a good appetite. Mrs A's medications were appropriately charted on her medication chart. In addition to her normal medications, one can of Ensure[13] was also on Mrs A's medication chart. Her temperature was recorded as 36.2°C and her blood pressure was 125/56mmHg (normal range is 100/60mmHg to 145/95mmHg).

22. On the day of Mrs A's admission a short-term care plan was completed by the RNTL Ms B. This plan documented that Mrs A required a puree and soft diet and full assistance. It also documented that Mrs A required her medications to be crushed. The 'nutritional profile' form, also completed by Ms B at the time of admission, requested a normal, medium-sized diet.

23. A Needs Assessment[14] completed in January 2009 states that Mrs A had a "good appetite! – eats smallish amounts. [Ms C] tends to chop up meals finely/mash. Thickened fluids." However, Ms B advised that this needs assessment was not available on Mrs A's file at the time of her admission.

24. On the second day of her admission, Mrs A's weight was 43.1kg.

Norovirus outbreak

25. A week prior to Mrs A's admission, a possible gastroenteritis[15] outbreak had been identified in the rest home and infection control precautions were initiated. These included restricted movement of staff, residents and visitors between the rest home and hospital. Any residents with symptoms were kept in isolation for 24 hours and careful hand-washing practises were observed.

[4] Used for the treatment of hypertension and congestive heart failure.
[5] A diuretic.
[6] A blood thinning drug.
[7] Used to prevent excessive blood clotting.
[8] A laxative.
[9] Used to treat high cholesterol.
[10] Used to treat osteoporosis.
[11] Used to treat dry skin.
[12] Thickens fluids.
[13] Ensure is a brand of nutritional supplement.
[14] A Needs Assessment is carried to determine the level of district health board disability support services a person is entitled to.
[15] An infection causing acute diarrhoea.

26. Two days after Mrs A's admission, a Norovirus outbreak[16] was declared and Northbridge went into "lockdown". As a result, any movement between the rest home and hospital continued to be prohibited and any staff working between the two facilities within a 24-hour period were required to shower and change uniforms when moving between the two facilities. Residents who were not sick were kept in isolation, and additional bureau nurses were brought in to assist in caring for these residents.

27. Northbridge advised that Mrs A was considered to be at high risk of contracting the disease. It advised that "[d]uring this time … [Mrs A] was taken to the lounge in a recliner or had the day in bed".

28. Northbridge lifted its "lockdown" on Day 14 of Mrs A's admission.

Day 3

29. At 6.15am on Day 3 of her admission, the progress notes state that Mrs A vomited. Her temperature was recorded as 36˚C.[17] The registered nurse on duty, Ms F, advised that she did not consider Mrs A was dehydrated at that time as this was her first vomit but considered that she should be closely monitored in case of illness. The progress notes state "Just needs monitoring in case of any illness starting."

30. A subsequent note states that Mrs A was "[a] bit sleepy [and] weak this [morning]". She was also noted to have had a loose bowel motion and have eaten only a very small amount.

31. After lunch the progress notes state that Mrs A vomited again. The records state that she "seems to swallow food without chewing it". A softer diet was suggested. No further comment was made about whether this suggestion was followed up and whether any action was taken.

Days 4-14

32. Over the next ten days, the progress notes record that Mrs A continued to refuse meals and remained in a reclining chair or her bed for a large portion of each day.

33. On Day 4, the progress notes state that Mrs A remained in bed all day. She ate only small amounts of breakfast and lunch but had a "good" evening meal and drank one can of Ensure.

34. On Day 5, Mrs A remained in bed all morning and then transferred to a reclining chair after lunch. She refused to eat either breakfast or lunch. It is not documented whether she ate her evening meal. Ensure is documented as being given but there is no comment about whether Mrs A drank it.

35. On Days 6 and 7, Mrs A is documented to have walked to the lunchroom and is reported to have been eating and drinking well.

[16] Norovirus is a virus causing gastroenteritis.
[17] Normal temperature is 37˚C.

36. On Day 8, it is again documented that Mrs A refused all her meals and "the RN was informed". On Day 9, it was noted that Mrs A "walked to the lounge, refused food all the time but managed to have some [food]". It is also recorded on Mrs A's medication chart that she refused her Persantin on the mornings of Days 8 and 9 and her Aspirin, Quinapril and Frusemide on Day 9. This is not documented in her progress notes.

37. The RN who nursed Mrs A on Days 8 and 9 advised that there was nothing in the progress notes to alert him that there was any concern in relation to Mrs A's condition. He advised that he does not believe that Mrs A exhibited any signs of dehydration and that she "… physically appeared well. She would be either in the lazy boy chair or in bed".

38. On Day 10, Mrs A remained in bed all day and again refused to eat breakfast and lunch. Again there is no comment about her evening meal or whether she drank her Ensure. Mrs A refused her morning Persantin and her Aspirin, Quinapril and Frusemide. Again this was not documented in her progress notes.

39. On Day 11, Mrs A reportedly had no appetite and refused all food. She is documented to have drunk the prescribed Ensure but to have remained in bed all day. RN Ms D documented that Mrs A was not given her regular medications because "no Sunday meds found". No further comment is made about what action, if any, was taken in relation to this other than a note which states that the next week's medications were found in the cupboard later that day.

40. On Day 12, Mrs A walked to the lunchroom but refused to eat her lunch. No comment is made about whether she ate breakfast or dinner.

41. On Day 13, Mrs A again refused to eat breakfast and ate "only 2 spoons of main meal at lunch time". On Day 14, she ate "¾ lunch [and] pudding". It is also recorded in her medication chart that she refused her morning Persantin.

42. On Day 15, Mrs A's mouth was noted to be "very dry". It is recorded that she drank her Ensure but no comment is made about whether she ate any of her meals. Prior to discharge Mrs A was recorded as weighing 38.4kg. The RNTL Ms B advised that she was responsible for serving lunch to all residents and checking their intake. Regarding Mrs A, Ms B was not "alerted by staff of any concerns with [Mrs A] [sic] condition during her stay". However, Ms B advised that she was "aware that [Mrs A] was refusing meals and fluids" and "advised staff to encourage [Mrs A] to eat and drink at am and pm handover and lunch, and to report on this". Ms B advised:

> "On her previous 3 admissions [Mrs A] pined for her daughter and towards the end of her stay started to decline food and fluids regularly.
>
> "On this admission [Mrs A] pined for her daughter again. To try and avoid her refusal of our interventions, we tried to care for her using regular and senior staff members. As I can remember and with re-reading her notes, her food intake fluctuated. Her fluids were normally taken without resistance."

43. Ms B commented that, on reflection, "[i]t clearly seems that [Mrs A] was unwell. She was in Hospital during noro-virus outbreak and it is possible she contracted that which would account for the vomiting and loose bowel motions from [Day 3] – the first episode of vomiting." Ms B also commented that Mrs A was a "very determined lady who was not easily persuaded to take food, fluids or medications."

44. Ms D, who worked as nursing supervisor on the weekends of Days 3/4 and Days 9/10 made similar observations:

> "… we endeavoured to give [Mrs A] a caregiver from our own staff, not an agency person as she reacted and responded better to someone she had met before. … Sometimes she ate well, other times she would close her mouth tightly and indicate with a pushing motion aware that she had had enough and she would not eat any more. …
>
> "I did not consider it necessary to call on Medical Staff at the weekend, as [Mrs A's] condition did not change over the time she was under my care. She was still eating and drinking sufficient for her tiny stature and was alert and responding well to staff."

45. In contrast, Mrs A's daughter advised that when she arrived to pick up her mother at approximately 3pm, Mrs A appeared dehydrated, advising that her mouth was "bone dry, [and] bright orange (from her medication pills) covering her tongue and mouth lining." She also advised that her mother's eyes were dry, her hands were white and her fingertips were blue. Ms C considered that Ms B did not appear concerned by her mother's appearance, commenting to Ms C that her mother "had just missed [her] [and had] been 'off her food'". Ms C advised that her mother was unable to stand or walk unaided and that she needed assistance to get her into the car. Because she had concerns about the care her mother had received during her two-week stay at Northbridge, Ms C insisted that the caregiver who was assisting her to the car, weigh Mrs A prior to her discharge. She commented that no discharge papers were signed or given to her when they left the hospital.

Public Hospital

46. The next day, Ms C called an ambulance because she had noticed that her mother had become increasingly lethargic throughout the day. An ambulance was dispatched and arrived at her home at 5.38pm. According to St John Ambulance records, Mrs A was reported as being "more lethargic than normal" while being fed and had "become more unresponsive throughout the day". By the time the ambulance arrived Mrs A was unresponsive. On examination she was noted to have a systolic blood pressure of 60mmHg[18] and an irregular pulse rate of between 92 and 120bpm.[19] An [intravenous] line was inserted and 700ml of fluid given. She was taken directly to hospital, arriving at 6.17pm.

[18] Normal systolic blood pressure is approximately 90-120mmHg
[19] A normal pulse rate is approximately 60-100bpm.

47. The Emergency Department clinical records document that Mrs A was dry, hypotensive[20] and tachycardic[21] on arrival. She was administered a further three and a half litres of intravenous fluid over the next two hours, and intravenous antibiotics were commenced. However, Mrs A was unable to sustain a reasonable cardiac output, and an electrocardiograph[22] suggested she had suffered a recent myocardial infarction.[23] Mrs A died at 9.30pm. In the clinical records the cause of death was listed as: "cardiogenic shock 4hrs, [myocardial infarction]? [three days ago], rapid [atrial fibrillation], dehydration [one week ago], possible [lower respiratory tract infection]".

Ms C's complaint

48. Ms C wrote a letter directly to Northbridge complaining about the care her mother received during her stay. Northbridge responded in writing on 20 October 2009. Ms C was unhappy with their response.

Northbridge response

49. In Northbridge's letter of 20 October to Ms C, Northbridge Lifecare Manager, Ms G, advised that a query was initially raised about the appropriateness of a normal diet for Mrs A after she vomited on the third day of her stay. However, she commented that Mrs A returned to her normal eating habits the following day and that this pattern of eating and then refusing meals continued for the duration of her stay. Ms G provided no further explanation or comment about the appropriateness of Mrs A's diet management.

50. In response to Ms C's complaint about the nurse's lack of concern at Mrs A's condition at the time of her discharge, Ms G explained that during Mrs A's admission the hospital went into "lockdown" due to an outbreak of Norovirus. As a result of the lockdown Mrs A remained in either a recliner chair in the lounge or in her bed during the day. No further comment was made about Mrs A's condition at the time of discharge or the nurse's lack of concern about this. Ms G did state that Mrs A "did not contract [Norovirus]" and apologised to Ms C for not informing her of the Norovirus outbreak at the time she picked up her mother due to a "break down in communication".

51. In a letter dated 20 April 2010 to HDC, Ms G explained that information about the Norovirus outbreak was not communicated to Ms C when she arrived to pick up her mother as it was meal time, which is a very busy time. Ms G stated that "[a]ll staff were shocked and saddened by the death of [Mrs A], a very frail delightful lady with a caring and dedicated daughter".

52. In an independent review commissioned by Northbridge following the receipt of Ms C's complaint, it is noted that Mrs A had refused her medications on three occasions which were not documented in the progress notes. The reviewer advised that this

[20] Low blood pressure.
[21] Fast heart rate.
[22] Used to measure heart rate.
[23] Heart attack caused by decreased blood flow to the heart.

information should have been passed onto Mrs A's GP and suggested that a fluid balance chart "could or would" have helped. The reviewer also suggested that any changes in the type of diet should trigger a new nutritional plan being developed and sent to the kitchen. The reviewer also commented that, in the view of the Northbridge medical officer, missing three doses of medication would not have contributed to Mrs A's death.

Northbridge Nutritional Guidelines

53. The Northbridge nutritional guidelines in place at the time of Mrs A's admission state that the RN is responsible for overall monitoring of food/fluid intake and assessing hydration and nutrition of a patient, and planning accordingly. All staff are to assist and encourage residents to eat their meals, take adequate fluids, and record and report any changes in food or fluid intake. Where food intake is a concern a "Food Intake Record" is to be taken for seven consecutive days. The guidelines do not specify who is responsible for implementing the Food Intake Record.

54. A resident's food intake is classified as "very poor" when the resident "never eats a complete meal. Rarely eats more than 1/3 of any food offered. … takes fluids poorly. …". When 25% or more of the patient's recommended intake is left at each meal, the resident should be referred to the dietitian in consultation with the Clinical Manager or GP.

55. Included in the nutritional guidelines is a 'dehydration assessment'. This includes assessing the resident's urine output and the state of their mouth. If the patient is assessed as being dehydrated for 24-48 hours, a three-step process is to be initiated including starting a fluid balance chart for three days, a minimum fluid intake of 1.6 litres per day and notifying the resident's GP as appropriate. A fluid balance chart is started only if ordered by a doctor, Clinical Manager or RNTL. The guidelines do not specify who is responsible for carrying out the dehydration assessment.

Documentation policy

56. The Northbridge "Documentation, Data and Record Control" policy states that progress notes are used by the RNs and caregivers (as well as other therapists such as physiotherapists or occupational therapists) to document "once in 24 hours". The policy requires that "a report is written on each resident on every morning shift or more frequently if needed".

Medication administration policy

57. The Northbridge medication administration policy states that medication which is "refused … or withheld for any reason is documented in Progress Notes and on Medication Administration Chart." Further to this it states that it is the RN's responsibility to "follow up on medication refused and possible intervention if required i.e. notify Medical Officer and document in Progress Notes." In addition, the "medication administration procedure" states that any medication which is not taken should be reported to the senior nurse on duty and recorded on the medication administration sheet and "if appropriate, in the progress notes".

Staff orientation

58. Northbridge has a comprehensive staff orientation policy which all bureau staff complete at the commencement of their employment. It includes orienting staff to the policies and procedures in place at Northbridge.

Action taken by Northbridge

59. In light of this complaint and following the external review completed in January 2010, Northbridge advised that it has made some changes to its policies and procedures. In particular, and of relevance to this complaint, the Nutritional Guidelines have been changed to include the requirement that a resident's nutritional profile is updated "when there is a change of food intake …" In addition, where food and fluid intake is of concern, a fluid balance sheet should be recorded for three days.

60. The discharge policy has also been changed to ensure that all respite residents are now admitted and discharged at 11am Monday to Friday to ensure adequate handover to the family or caregiver. In addition, every resident is discharged with a discharge form which includes relevant information about their admission with the aim of ensuring that the caregiver collecting the patient is given all relevant information about the patient.

61. In response to the recommendations of the provisional opinion, Northbridge updated its 'Document, Data and Record Control' policy to include the requirement that "staff will record in all short stay residents' progress notes on each duty." In addition, this requirement has also been implemented for every new long-term resident until their long-term care plan has been developed.

HealthCERT investigation

62. On 8 December 2009, HealthCERT[24] also received Ms C's complaint about the care provided to her mother by Northbridge. HealthCERT advised that Ms C's complaint included concerns about "the quality of care, weight loss, medication management and communication about an outbreak of Norovirus". HealthCERT investigated and concluded that "the aspect of the complaint concerning communication with the family about an outbreak of Norovirus was substantiated. However, the remaining issues were not substantiated."

Opinion: Breach — Northbridge Lifecare Trust

63. Mrs A was admitted to Northbridge for two weeks' respite care. Throughout her two-week admission Mrs A refused, or ate only very small amounts of, many of her meals. She spent most days in either a reclining chair or bed. She also refused her medication on a number of occasions.

[24] HeathCERT is part of the Ministry of Health and is "responsible for ensuring hospitals, rest homes and residential disability care facilities provide safe and reasonable levels of service for consumers, as required under the Health and Disability Service (Safety) Act 2001. HealthCERT's role is to administer and enforce the legislation, issue certifications, review audit reports and manage legal issues."

64. Despite Mrs A regularly refusing meals and fluids, no steps were taken to monitor this more closely or accurately assess her for signs of dehydration.

65. Although staff were aware that Mrs A was refusing food and fluids, they did not consider any further action needed to be taken. I note the view of the weekend supervisor that Mrs A was "still eating and drinking sufficient for her tiny stature". My independent nursing advisor, Ms Jenny Baker advised:

> "Given [Mrs A's] known tendency to refuse food and fluids whilst her daughter was away and the fact that she had experienced two vomits and one loose bowel motion, it was even more important that a food and fluid chart was commenced to ensure she was receiving adequate fluid in particular."

66. At the time of her discharge Mrs A had lost 4.7kg (more than 10% of her body weight). She was noted by staff to have a very dry mouth. Mrs A's daughter, Ms C, advised that when she arrived to pick up her mother she appeared dehydrated and was unable to stand or walk unaided. The following day, due to a further deterioration in Mrs A's condition, Ms C called an ambulance and Mrs A was admitted to hospital where she was noted to be significantly dehydrated. Mrs A died later that evening.

67. Mrs A was a frail, 90-year-old lady with a number of comorbidities.[25] That she did not eat well and lost weight during her short stay at Northbridge is not in itself evidence of a lack of care and skill. However, it is concerning that no-one identified or responded to this. At the time of Mrs A's admission, Northbridge was experiencing a norovirus outbreak. While I note that attempts were made to ensure Mrs A was nursed by regular staff members, Mrs A was nursed by several different nurses including bureau staff.

68. In my opinion, the failure of anyone to adequately assess Mrs A and identify, and respond to, her failure to adequately eat or drink highlights a number of systems failures at Northbridge. I consider that the poor policies in place at Northbridge contributed to the poor care provided to Mrs A.

69. As noted in a previous HDC opinion,[26] rest homes must have adequate systems in place to help staff identify and respond to patients who become physiologically unstable. In that opinion it was noted that "the key requirements are to recognise when a patient is deteriorating and respond promptly and appropriately".

70. There was no regular or clear documentation of Mrs A's food or fluid intake. The Northbridge 'Document, Data & Record Control' policy requires that staff document in the progress notes "once in 24 hours". While this approach may be adequate for a stable patient, as noted by Ms Baker: "[t]he system of routinely documenting in hospital residents' progress notes during the morning shift only does not give sufficient information of the care provided or any concerns about the hospital

[25] Diseases or conditions that co-exist with a primary disease/disorder, but they can also stand on their own as specific diseases.
[26] See: http://www.hdc.org.nz 08HDC20829

resident". Ms Baker advised that this systemic failure disadvantaged Mrs A's health in relation to her food and fluid intake.

71. By not clearly documenting Mrs A's food and fluid intake in her notes, staff missed important clues which may have helped identify the need for closer monitoring. As noted by Ms Baker:

> "… with lack of a food and fluid chart, fluid balance chart and no record of food and fluid intake for the afternoon shift, it would be easy for staff not to be as concerned as they should about [Mrs A's] health status".

72. Northbridge nutritional guidelines were unclear as to who was responsible for commencing a Food Intake Record and the guidelines only allowed a fluid balance chart to be commenced by the RNTL or clinical manager. I note Ms Baker's view that this may have resulted in an attitude among other staff that the responsibility for initiating such a chart also lay with the RNTL and clinical manager. Ms Baker advised:

> "I believe that this is a systemic failure as the policy did not allow for Registered Nurses to take the initiative to commence food and fluid charts (as per my report) however any Registered Nurse should commence a food and fluid chart when a frail elderly lady is not only refusing food and possibly fluids (unable to be confirmed either way without documentation) but particularly also in the presence of vomiting and loose bowel motions."

73. Further to this Ms Baker advised that, while all the registered nurses had a responsibility for adequately assessing and responding to Mrs A refusing food and fluids, a lack of continuity in supervision and care contributed to the failure in anyone implementing adequate monitoring.

74. A high standard of documentation is especially important where there are several people providing care. Over a two-week period, several different nurses, including bureau nurses, had responsibility for Mrs A's care. In such circumstances it is essential that details about observations, cares, assessments, and instructions to caregivers are recorded regularly and accurately, so that any changes in the resident's condition can be picked up and responded to in a timely and appropriate manner.

Conclusion

75. As the owner of Northbridge Lifecare Trust Hospital, Northbridge has the ultimate responsibility for ensuring its patients receive appropriate, timely and safe care.

76. Northbridge did not have sufficient policies in place, which contributed to staff failing to identify and act upon early warning signs of Mrs A's deterioration. Therefore, Northbridge failed to ensure Mrs A was provided with services with reasonable care and skill and breached Right 4(1) of the Code.

Opinion: Adverse comment — Ms B

77. As the RNTL, Ms B had overall responsibility for managing and supervising all nursing staff and healthcare assistants. Her job description states that one of the RNTL's principal objectives is to "ensure appropriate, individualised and safe care through assessment planning and implementation while respecting rights, privacy and dignity of the residents in accordance with the Philosophy of 'Northbridge'." Ms B advised that she was also responsible for serving lunch to all residents and checking their intake. Ms Baker advised:

> "Northbridge's Team Leader should have ensured that she/he was cognizant of the hospital residents' health status and any concerns, particularly in relation to the Norovirus outbreak …"

78. I note Ms Baker's advice that "[a]ll Registered Nurses, whether they were Northbridge Hospital or Bureau Registered Nurses, who were involved with Mrs A's care were responsible for the appropriate assessment and management of her health status as per the Nursing Council of New Zealand's Competencies for registered nurses …". This requirement is reinforced in the Northbridge nutritional guidelines which state that the RN is responsible for assessing the food and fluid intake of a patient and all staff were to record and report any changes in food or fluid intake.

79. In her statement to HDC, Ms B stated that she was "aware that Mrs A was refusing meals and fluids" and that she asked staff to report on Mrs A's intake of food and fluids. She also commented that Mrs A was a "very determined lady who was not easily persuaded to take food, fluids or medications". She further notes that during previous admissions Mrs A had displayed a decreased interest in food towards the end of her admission and to combat this they tried to ensure she was staffed by regular staff members.

80. Despite being aware that Mrs A was refusing food and fluids, Ms B failed to implement adequate monitoring. It is not sufficient to say that she was regularly "offered" drinks or that the Ensure was signed for on the medication sheet. As discussed above, the lack of adequate systems in place contributed to the failure to identify and respond to Mrs A's deterioration. However, Ms B is a registered nurse and as such should use her clinical judgement about whether a person needs medical intervention. This did not happen in Mrs A's case.

81. While I do not consider this failure to monitor Mrs A's food and fluid intake warrants a finding of a breach of the Code, I take this opportunity to remind Ms B of the importance of initiating closer monitoring and providing adequate clinical leadership.

Other comment

Missed medication

82. Mrs A refused her medications on a number of occasions. I acknowledge the view of the Northbridge medical officer that this is unlikely to have contributed to Mrs A's

demise. However, I am concerned by the unclear medication administration policy at Northbridge.

83. The Northbridge medication administration policy is unclear as to what the medication administration requirements are. The policy states that any missed medications must be documented in the progress notes and that the RN has a responsibility to follow this up. However, its "medication administration procedure" states that missed medications should be reported to the senior nurse on duty and recorded on the medication administration sheet and "if appropriate" in the progress notes.

84. I am concerned that Northbridge's unclear medication administration policy may have contributed to the failure of staff to document Mrs A's missed medication and to take responsibility for following up the missed medication.

Communication about norovirus

85. A possible gastroenteritis outbreak was first identified at Northbridge eight days prior to Mrs A's admission. It was confirmed as norovirus on the third day of her admission. In response to this outbreak Northbridge undertook infection control measures to prevent its spread. This included restricting movement of staff and residents between the hospital and rest home and employing bureau nurses to look after hospital residents who were not infected by the virus.

86. While it appears that Mrs A did not contract norovirus during her stay, Ms C is upset that neither she (nor her sister) were informed of the outbreak either at the time it was confirmed or when she arrived home from overseas.

87. Ms G apologised that Ms C was not informed of the Norovirus outbreak at the time she picked up her mother. She explained to this Office that Ms C arrived to pick up her mother at meal time and so staff were very busy.

88. I accept that Northbridge did not deliberately withhold this information from Ms C. I am pleased that it has since changed its discharge policy so that discharge now occurs at 11am to allow adequate handover and that it has developed a discharge form to ensure that all relevant information is communicated to the resident's caregiver. I note, however, Ms Baker's advice that this could be restrictive where families have a commitment at that time. I hope that Northbridge will work with individual family requirements regarding alternative discharge times and days to ensure families receive adequate information and follow-up on discharge.

Recommendations

I recommend that Northbridge:

- review its medication administration policy to ensure that it is consistent so that staff are clear about the procedure to follow in the case of missed medication;
- consider developing a policy for managing respite patients to ensure close monitoring and adequate follow-up is provided; and
- consider the recommendation made by Ms Baker that the nutritional guidelines should authorise any RN to commence a fluid balance chart.

Northbridge should advise this Office of what changes it has made in light of these recommendations by **9 March 2012**.

Follow-up actions

- A copy of this report will be sent to the Ministry of Health (HealthCERT) and the Nursing Council of New Zealand.
- A copy of this report with details identifying the parties removed, except the name of Northbridge Lifecare Trust and the expert who advised on this case, will be sent to the District Health Board, NZ Aged Care Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert nursing advice from Jenny Baker

"I have been asked to provide independent expert advice about whether Northbridge Hospital provided [Mrs A] an appropriate standard of care. I have read and agreed to follow the Commissioner's Guidelines for Independent Advisors.

Professional Profile
I registered as a Registered Nurse in 1978. From 1978 to 1981 I worked as a Staff Nurse in Oncology. From 1981 until 1995 I worked as a staff nurse in acute wards, initially in medical wards and then in continuing care (post children) and then across all acute wards at Wairau Hospital. In 1995, I was Clinical Nurse Co-ordinator in an Assessment, Treatment and Rehabilitation Ward (A, T & R) before taking up the position of Unit Manager, A, T & R Unit, The Princess Margaret Hospital. I then held the position of Nurse Manager of a 99 bed private hospital for Aged Care. This included a Dementia wing, and palliative and young disabled residents. From 2002 to 2004 I worked as a Nurse Consultant providing documentation development and implementation for the Health and Disability Standards Certification and the Ministry of Health Contract. I also provided general consulting advice and training for both staff and managers. This was primarily with Aged Care facilities nationwide. During that time I kept my clinical skills current by working as an Agency Nurse in both the Public and Private sectors. From 2003 to 2004 I was a Lead Auditor for a Designated Auditing Agency against the Health and Disability Standards Certification. From 2004 until 2005, I worked as a National Quality and Training Manager for a company who owned retirement villages with rest homes and hospitals nationwide. From 2006 to 2007, I worked as a Care Manager in a rest home and rest home dementia, from 2007 to 2008 I worked in a generalist medical ward for a DHB public hospital and from 2008 to 2009 I worked as a Practice Manager for a very large General Practice. Since May 2009 I have worked in an acute orthopaedic ward and trauma unit which involved caring for patients with dementia and/or delirium and am currently a Charge Nurse Manager of an acute orthopaedic ward. I have provided expert advice to the Health and Disability Commissioner in the Aged Care area since 2002.

…

[At this stage Ms Baker lists the documents she was provided and the background summary of the complaint. This has been removed to prevent repetition.]

1. In your opinion was the care provided to [Mrs A] at Northbridge Hospital of an appropriate standard and, if not, please explain any failings?

[Mrs A] was admitted to Northbridge Hospital for respite care on [Day 1]. Staff noted in her daily progress notes that she ate normal foods, drank thickened fluids and that her appetite was good […][27]; this information appears to have been obtained from [Ms C's] handwritten information […].

[27] With reference to the numerous […] that appear throughout Ms Baker's advice, these refer to page numbers of documents supplied to her by this Office and have been deleted in the interests of brevity.

A short term care plan was documented on [Day 1] and signed by a Registered Nurse […]; this care plan included full assistance for mouth care of upper dentures; nutrition as puree and soft with full assistance and medication crushed. The Nutritional Profile dated [Day 1] documents the diet as normal and medium with one copy being held on the client file and one in the kitchen folder […].

A copy of Support Needs Assessment completed on 9/1/09 […] is on file; it is not clear when Northbridge Hospital received the copy which gives valuable assessment and care plan information from which the hospital could base their short term care plan on.

Northbridge sent [Mrs A's GP] a form requesting the doctor to assess [Mrs A] prior to her respite stay and also asking about his after hours service […]. [The GP] provided Northbridge Hospital with a list of [Mrs A's] current long term medications […].

I note that [Mrs A] was prescribed Frusemide 40mg, 0.5 tab daily, this was documented as being administered each day of her respite stay apart from [Days 8 and 9] […]. Frusemide is a diuretic and is given to reduce oedema (swelling found in ankles, feet and legs) and/or hypertension. Side effects of this can include hypotension, oliguria (decreased urine production) and dehydration (with reduced fluid intake).

The Registered Nurse documented on [Day 11] at 1530 that [Mrs A] did not have her meds as they could not find them […] therefore she did not receive her meds at breakfast and lunchtime, including Quinapril, Persantin and Frusemide. There were a number of occasions that [Mrs A] refused her medication. She refused her Quinapril and Frusemide on [Days 8 and 9] […]; her breakfast dose of Persantin on [Days 9 and 10] […], and her Persantin dose three times on [Day 10] and at breakfast on [Day 13] […].

[Mrs A] had recordings documented on the Temp/BP Chart […]. The first entry was documented on [Day 6], a previous admission to this one with [Mrs A's] BP (blood pressure) being 101/46. A blood pressure of 101/46 is low but could be expected when on Persantin, Quinapril and Frusemide; as Persantin and Frusemide can have an adverse effect of hypotension (low blood pressure) and Quinapril is a medication given as a treatment for hypertension (high blood pressure) which can also result in hypotension as a side effect. On [Day 1], [Mrs A] temperature and BP were taken and recorded. [Mrs A] temperature was normal at 36.2 and her BP was 125/56, again on the lower side but acceptable.

[Mrs A] was weighed the day after admission and recorded as 43.1kg and again on the day of discharge as 38.4kg; a weight loss of 4.7kg during her respite stay […]. [Mrs A's] bowel motions were recorded on the Elimination Record […]. She was given supps (suppositories) on day 5 and then day 4 of no bowel motions […].

Staff document that [Mrs A] was given washes and showers during her stay at Northbridge, given full mouth cares on [Day 11, 13 and 15] […]. On [Day 15] staff documented that [Mrs A] mouth was very dry and they cleaned her tongue […].

On [Day 3] [Mrs A] vomited at 0615 while being changed […]; clearly before her breakfast. The Registered Nurse documented her temp at 36 C, which is normal, and requested monitoring in case she was developing an illness […].

On [Day 3], [Mrs A] was sleepy, feeling nauseated, had a loose bowel motion, eating very small amount and then vomited undigested food after lunch. Staff noted she appeared to swallow the food without chewing, that her dentures were falling out and probably to have a softer diet […]. On [Day 4] she did not eat much of her breakfast but managed a bit of her lunch. She was fed the rest of her lunch later and completed her can of ensure […]. Later that day [Mrs A] ate a good evening meal […].

On [Day 5], [Mrs A] refused her breakfast and lunch […]; she ate all her breakfast and lunch on [Day 6] […]. [Mrs A] ate okay at lunchtime on [Day 7] but did not have any food or fluid on [Day 8]; staff informing the Registered nurse of this […].

Staff document that on [Day 9], [Mrs A] refused food all the time but that she managed some […]. [Mrs A] refused breakfast and lunch on [Day 10] and on [Day 11] [Mrs A] had no appetite but drank her ensure and that she refused to take any food that day […].

[Mrs A] continued to refuse food on [Days 12 and 13], eating only 2 mouthfuls at lunch on [Day 13]. On [Day 14], [Mrs A] ate ¾ of her lunch and pudding, drank her ensure on [Day 15] and was discharged later [that day] at 5pm […].

[Mrs A] received one can of Ensure daily at 0800 and this was signed off as given each day […]. With no food and fluid chart it is difficult to determine whether [Mrs A] actually drank her ensure each day.

The Nutritional Guidelines documents […]: *"Where there food intake is of concern, the Food Intake Record is taken for seven consecutive days. Intake Guidelines to be read in conjunction with the recordings"*. The Food Intake Record is a comprehensive record and has a section for in between meal drinks to be recorded; there is no Food Intake Record documented for [Mrs A]. Staff have only documented daily during the morning shift apart from at admission, during the night shift on [Day 5] and on discharge. There is no documentation of [Mrs A] food and fluid intake during the afternoon shift.

With the lack of a food and fluid chart, fluid balance chart and no record of food and fluid intake for the afternoon shift, it would be easy for staff not to be as concerned as they should about [Mrs A's] health status. In addition the Nutritional Guidelines only authorise the Doctor, Clinical Manager and Team Leader to start a fluid balance chart. I note that because of the Norovirus outbreak, [Mrs A] was cared for by Bureau Nurses […], which I have been informed included bureau Registered Nurses. I have been informed that Northbridge Hospital's Team Leader still maintained oversight of [Mrs A's] care during the Norovirus outbreak.

In my opinion, it is clear from the documentation that [Mrs A's] basic daily care needs were met by Northbridge Hospital. However, [Mrs A's] health status in relation

to her food and fluid intake was disadvantaged by the systemic failures: in only documenting on the morning shift instead of all three shifts, all Registered Nurses on each shift not being authorised to commence fluid balance charts, and the potential "resulting" attitude" that the responsibility lay with the Team Leader and Clinical Manager. All Registered Nurses, whether they were Northbridge Hospital or Bureau Registered Nurses, who were involved with [Mrs A's] care were responsible for the appropriate assessment and management of her health status as per the Nursing Council of New Zealand's Competencies for registered nurses: 1.4, 2.2, 2.3, 2.6 and 4.2.

Northbridge's Team Leader should have ensured that she/he was cognizant of the hospital residents' health status and any concerns, particularly in relation to the Norovirus outbreak and that Bureau Registered Nurses were caring for the residents not affected by Norovirus. I note the mitigating circumstances of the Norovirus outbreak, resulting lock down and the significant increased workload for the Registered Nurses and Team Leader; however it does not excuse their lack of action in relation to [Mrs A]. In my opinion peers would view the Registered Nurses' conduct with moderate disapproval and the Team Leader's with mild disapproval. In my opinion Northbridge Hospital peers would view this systemic failure with mild disapproval.

2. If there have been deficiencies above will the revised Northbridge Hospital policies lead to improved quality care?

3. If not, please indicate how the policies could be improved.

I will address questions two and three together.

The Nutritional Guidelines reviewed May 2009 […] were based on the RN Care Guidelines for Residential Aged Care which were developed in collaboration with [the DHB] Gerontology Nursing Service, Home and Older Adult Services and leaders and clinicians working and practicing in residential aged care; this policy was a comprehensive policy overall. The revised Nutritional Guidelines (pages 00069-71) have the following additional instructions: *"This profile* (Nutritional Profile) *is updated PRN or when there is a change in food intake and reviewed 6 monthly in conjunction with Resident Review;* (Where food and fluid intake is of concern, the Food Intake Record is taken for seven consecutive days.) *A Fluid Balance Chart is recorded for 3 days;* (Dehydration Assessment) *Refusal of fluids;* (Fluid Balance Chart) *Forms are kept in Nurses Station or Care Centre)".* These additions to the policy will allow for improved quality care as it is important to review and update a resident's nutritional profile with the care plan review and as required; recording fluid input and output along with food and fluid intake gives a more comprehensive assessment of the resident's hydration and nutritional status; and identifying where the forms are kept and in easy reach for the Registered Nurses and care givers is good. However, there is no reference to the Medication Manual.

To ensure that this policy will lead to optimum improved quality care, it could be improved by the following: authorising any Registered Nurse to commence a fluid

balance chart and not just on the orders of the Doctor, Clinical Manager or Team Leader […] as all Registered Nurses need to be able to instigate assessment of the resident when they recognise an issue, and not have to obtain permission to do so, so that assessment is commenced as soon as possible. The policy lists contributing causes which are identified and ruled out in consultation with GP […]; these include Medications. The policy could be improved by further attention to medications as they need to be looked at first and reassessed with the GP particularly if they include diuretics which would potentiate dehydration and linked with the Medication Manual policies and procedures.

The revised Fluid Balance Chart […] has had the following added to it: *"24 Hour From Midnight to Midnight"*; this addition will lead to improved quality care as it defines the 24 period in which the fluid balance is completed. I would be concerned if a patient was identified as requiring a fluid balance chart during the morning for example and the fluid balance chart was not started until midnight as this would be delaying essential assessment and potentially changed management of medication, food and fluid for the resident. The Nutritional Guidelines policy could document that a fluid balance chart can be started immediately but must have 3 complete days which effectively means that a fluid balance chart could be documented for 3 days plus a part day.

The Medication Manual current at the time of [Mrs A's] tenure at Northbridge Hospital was not available to me. I was provided with the updated Medication Manual which included the Medication Administration Procedure and New Residents and Short Stay Residents. The Medication Manual is comprehensive and appropriate. The Medication Administration Procedure […] states: *"Medication refused (see Code of Rights) or withheld for any reason is documented in Progress Notes and on Medication Administration Chart. It is the Registered Nurses responsibility to follow up on medication refused and possible intervention if required i.e. notify Medical Officer and document in Progress Notes"*. This statement covers refused medication appropriately. The New Residents and Short Stay Residents policy […] is appropriate.

I note that there is no reference within the Medication Manual to ensure that the Registered Nurses and Carers who administer medication notify the GP with concerns of low fluid intake for residents on diuretics. There is no reference to the Nutritional Guidelines.

To ensure that this policy will lead to optimum improved quality care, it could be improved by the following: linking with the Nutritional Guidelines and giving clear outlines as to what to do if the resident is refusing fluids and is on diuretics.

The Residential Home & Hospital Information Booklet for New Residents is appropriate. I note the inclusion of discharges being at 11am Monday to Friday accept by prior arrangement; this will help ensure that the family meet with the Team Leader or Clinical Manager for a discharge handover, however, it will disadvantage many families who work or have regular commitments at that time. I would hope that Northbridge Hospitals will continue to work with individual family requirements of

discharge times and days ensuring that the families receive adequate information and follow up. If a discharge handover report is given to them, I assume this is in written format and would be able to be given to family in the weekend or out of office hours. As all hospitals require Registered Nurses' on duty at all times, they would be available to talk with the families at discharge times.

The Admission of a New Resident Procedure […] is appropriate. The Discharge of a Resident Policy […] is appropriate, however, as above; the requirement for discharge at 11am Monday to Friday is restrictive and limiting to individual family needs. The Discharge/Transfer Form […] is comprehensive and appropriate.

The Orientation Workbook […] is a list of places, forms and policies the new staff member has to identify and find and have signed off.

There are no competency orientation checklists or questions the new staff member has to answer included.

There is a Bureau Nurse Folder Index for the Rest Home and the Hospital […] which gives information on the Mission/Philosophy of Northbridge, Statement of Understanding had Philosophy, Bed Plan of Residents, Incident/Accident Form and Managers' Report form, Evacuation Plan & Emergencies and location of Manual Handling Equipment. There is no information included about the Residents' or where to find policies and procedures such as the Medications Manual and the Nutritional Guidelines.

4. Are there any aspects of the care provided by Northbridge Hospital that you consider warrant additional comment?

The system of routinely documenting in hospital residents' progress notes during the morning shift only does not give sufficient information of the care provided or any concerns about the hospital resident. Although it could be considered sufficient, in my opinion, it is not best practice and it would be advisable for Northbridge Hospital to change its requirements and have documentation in hospital residents progress notes every shift and as required for any concerns or issues that arise."

Further advice from Ms Baker — May 2011

Ms Baker was provided with additional information collected, including statements from the registered nurses identified as being involved in Mrs A's care, the team leader Ms B, as well as an additional statement from Northbridge. Ms Baker was asked to review this information and change or add to her original advice report as appropriate.]

"I have been asked to provide further advice on Northbridge Hospital following the provision of further information to the Health and Disability Commissioner.

…

[At this stage Ms Baker lists the additional documents she has reviewed. This has been removed for the sake of brevity.]

Registered Nurses

I agree with [Ms G] that [Mrs A's] pattern of behaviour was consistently described by the Registered Nurses' letters. Given [Mrs A's] known tendency to refuse food and fluids whilst her daughter was away and the fact that she had experienced two vomits and one loose bowel motion, it was even more important that a food and fluid chart was commenced to ensure she was receiving adequate fluid in particular. I believe that this is a systemic failure as the policy did not allow for Registered Nurses to take the initiative to commence food and fluid charts (as per my report) however any Registered Nurse should commence a food and fluid chart when a frail elderly lady is not only refusing food and possibly fluids (unable to be confirmed either way without documentation) but particularly also in the presence of vomiting and loose bowel motions. A frail and elderly lady would dehydrate very quickly in these circumstances.

[HDC] informed me that the Health and Disability office was unable to obtain a response from all the Registered Nurses who had oversight of [Mrs A] during her tenure at Northbridge Hospital. [Ms F] was on night duty [Days 2/3] prior to the of [Mrs A's] commencement of vomiting and loose bowel motions and reported [Mrs A] being offered drinks on turns and her first vomit. [Ms D] supervised [Mrs A] on two weekends and reported [Mrs A] as eating well or pushing the food away. She also reported [Mrs A] drinking the Ensure and her morning and afternoon tea drinks (a reasonable amount of fluid in 8 hours). [Ms E] reported that [Mrs A] ate moderately well and drank some fluid on his shifts [Days 7/8]. He also reported that [Mrs A] did not appear dehydrated to him and if she had shown signs he would have contacted the Doctor for subcut fluids; this is an appropriate response.

In view of the three Registered Nurse responses and the dates they supervised [Mrs A] care (prior to the seven days of dehydration on the Death Certificate and the second weekend being day 2 and 3 of the seven day dehydration period for [Ms D] but with adequate fluid intake), none of these Registered Nurses gave inadequate care to [Mrs A]. The seven days period prior to [Mrs A] leaving Northbridge on [Day 15] were the critical days for [Mrs A's] dehydration. The Registered Nurses supervising [Mrs A's] care during the seven day period should have recognised her dehydration and responded accordingly; they all have responsibility for her subsequent deterioration. In view of the use of Bureau Registered Nurses and probable lack of continuity in supervision of [Mrs A], I will change my view from moderate disapproval for each Registered Nurse to a systemic moderate disapproval; this does not however detract from my view that all the Registered Nurses during this period bore some responsibility.

[Ms B], Team Leader

I note that [Ms B] states in her report: '*It clearly seems that [Mrs A] was unwell. She was in Hospital during noro-virus outbreak and it is possible she contracted that*

which would account for the vomiting and loose bowel motions from [Day 3]...Observations were done and were within normal range ... [Day 7] [Mrs A] appears to be much better, walking and eating well. [Day 8] Refusing food and fluids and continues to do so on and off until discharge'. [Ms B] goes on to say: '*I was aware that [Mrs A] was refusing meals and fluids. I advised staff to encourage [Mrs A] to eat and drink at am and pm handover and lunch, and to report on this'*. This is evidence that [Ms B] understood the significance of [Mrs A's] unwellness during her admission yet she apparently failed to act accordingly by arranging a medical review. A doctor may well have ordered sub cut fluids (given via a needle through the skin) to correct any dehydration present. The doctor may also have withheld [Mrs A's] Frusemide while she was refusing fluids and until she was rehydrated as it can cause fluid depletion and electrolyte imbalance and would have exacerbated [Mrs A's] dehydration. In view of [Ms B's] admission of her knowledge that [Mrs A] was refusing food and fluids, was clearly unwell and likely to have noro-virus and her responsibility as Team Leader, I would view her conduct with moderate disapproval, not mild as per my report."

Further advice from Ms Baker — July 2011

"I have been asked to provide further advice on Northbridge Hospital following the provision of further information to the Health and Disability Commissioner.

Telephone interview – [Ms B] 10 June 2011

…

[HDC Investigator] asked [Ms B] to explain whether her statement "It clearly seems [Mrs A] was unwell" was what she thought at the time or was made in hindsight.

[Ms B] advised that the comment was made in hindsight. [Ms B] was asked to outline what action was taken at the time in relation to this vomit. [Ms B] advised consideration was given to the fact that [Mrs A] was on a normal diet when she had previously been on a soft diet during previous admissions.

[Ms B] has inferred that she did not know about [Mrs A] being unwell and she did not provide an explanation of what action was taken in relation to [Mrs A's] vomit. [Ms B] has not indicated that [Mrs A] vomited on previous admissions; the vomiting could be an indication of unwellness or of food becoming caught in the esophagus and not being swallowed properly. I note that [Ms B] states: '*[Mrs A] was on a normal diet whereas she had been on a soft diet during previous admissions'*. If [Mrs A] had eaten normal food but not enough fluids, this could have contributed to the vomiting. Either way, the vomiting is an indication of a problem and should have been followed up with close monitoring and advice sought from the Doctor if it continued. As [Mrs A] was on Frusemide, refused food and fluids and now vomiting; there was high risk of her becoming dehydrated and given the outbreak of Norovirus within the facility and

the ability of the virus to spread rapidly [Mrs A] vomiting should have been monitored very closely.

[HDC Investigator] then asked about [Mrs A] refusing food and fluids and [Ms B's] statement that this was a behaviour [Mrs A] had displayed on previous admissions.

In my report I quoted [Ms B] as saying: '*I was aware that [Mrs A] was refusing meals and fluids. I advised staff to encourage [Mrs A] to eat and drink at am and pm handover and lunch, and to report on this'*. In the telephone interview, [Ms B] confirmed this and added '*[Mrs A] had displayed this type of behaviour before and related it to her pining for her daughter'*. [Ms B] was asked if she had considered taking any further steps to monitor [Mrs A] and she replied no. She did not consider it necessary for closer monitoring, apart from the progress notes, as this was normal behavior for [Mrs A].

Although [Mrs A] had developed a pattern of refusing food and fluids on previous admissions, she was at high risk of dehydration based on her Frusemide medication and she should have had closer monitoring such as a food and fluid chart and not just monitoring within the progress notes. The progress notes do not usually record precise amounts of food and fluids taken and therefore cannot give the Registered Nurses and Team Leader the full information to be able to assess [Mrs A] accurately and thus respond appropriately.

[HDC Investigator] asked [Ms B] to clarify what she meant in relation to her statement that she was responsible for serving lunch.

[Ms B's] response was she served lunch from the bain-marie and did not feed the residents. The care staff had that responsibility and would feed back any concerns.

This practice is normal within the residential setting.

[HDC Investigator] clarified that as Team Leader she is responsible for all the registered nurses, enrolled nurses and health care assistants.

[Ms B] confirmed this.

In my opinion, although [Mrs A] had a pattern of refusing food and fluids in previous admissions, she had changed from a soft diet to a normal diet, was on Frusemide medication and vomited; she was at high risk of developing dehydration. She was also residing in a facility which had Norovirus present; this virus is difficult to contain despite all infection control measures put in place and can spread to other areas within a facility as it is airborne. Given the risk factors [Mrs A] had and was exposed to as well as developing vomiting, [Mrs A] should have been more closely monitored with the use of a food and fluid chart and oversight by the Registered Nurses and Team Leader.

I have noted that [Ms B] was not cognizant of [Mrs A] being unwell at the time and that her comment had been made in hindsight. I realize that [Ms B] would have been extremely busy during this time with the Norovirus in the facility; however she had overall responsibility and leadership. In this role, it was her responsibility, along with the registered nurses to ensure that [Mrs A] was assessed and an appropriate care plan put in place to minimize the risks of dehydration, not only for this admission but for the previous admissions.

In view of this, I would view [Ms B's] conduct with mild disapproval."