Rest Home

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00424)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This case highlights the importance of systematic investigation and critical thinking when caring for an elderly consumer with restlessness, low mood, and confusion, and the need to monitor and record food and fluid intake.

2. The woman was transferred to a rest home for hospital-level care. It was documented that she had trouble moving, as both her legs were swollen. At times, the woman had a dry mouth, and fluids were encouraged. A care plan was established to detect and respond to any changes and decline in her mood or behaviour over the next six months. This included encouraging care staff to show expressions of concern to the woman, and to report any changes to the registered nurses.

3. A few months later, the nurses documented that the woman experienced periods of decline with symptoms of restlessness, low mood, and confusion. However, it was not clear whether nursing staff further investigated the reasons for the woman's decline.

4. The following month, the woman was found to have cellulitis, and was subsequently admitted to a public hospital. It was decided that active treatment would be stopped, and that palliative care would be commenced at the rest home. The woman passed away.

Findings

5. The Deputy Commissioner found that the rest home breached Right 4(1) of the Code by failing to systematically investigate and think critically about the woman's restlessness, low mood, and confusion, and by failing to record and monitor the woman's food and fluid intake.

6. The Deputy Commissioner made adverse comment about the lack of documentation about the woman's views on the treatment options for the cellulitis.

Recommendations

7. It is recommended that the rest home company provide a written apology to the family for the deficiencies identified in this report. It is also recommended that the rest home provide nursing staff with training on the new "Assessment & Management of the Acutely Unwell Resident" policy. In addition, it is recommended that the rest home provide all staff with training on the identification and management of infection in the elderly; assessment and management of general decline in the elderly; informed consent; supported decision-making; EPOAs; palliative care; and the implementation of the "Last Days of Life"[1] policy care planning throughout the rest home company's facilities.

[1] Ministry of Health, *Te Ara Whakapiri: Principles and guidance for the last days of life* (2nd edn). Wellington: Ministry of Health (2017).

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs B about the services provided to their late mother, Mrs A, by a rest home. The following issue was identified for investigation:

- *Whether the rest home provided Mrs A with an appropriate standard of care from 1 Month4[2] to 16 Month5 inclusive.*

9. This report is the opinion of Rose Wall, Deputy Health and Disability Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

10. The parties directly involved in the investigation were:

Mr B	Complainant/consumer's son
Mrs B	Complainant/consumer's daughter-in-law
The rest home	Provider/rest home

11. Further information was received from:

Ms C	Complainant's niece
Ms D	Rest home manager
Ms E	Rest home director
RN F	Registered nurse
RN G	Registered nurse
RN H	Registered nurse
RN I	Registered nurse
Health care assistants	
Medical centre	
Dr J	Doctor
Dr K	General practitioner (GP)
Ministry of Health (HealthCERT)	

12. In-house clinical advice was obtained from RN Hilda Johnson-Bogaerts (Appendix A).

[2] Relevant months are referred to as Months 1–5.

Information gathered during investigation

Background

Rest home

13. The rest home is an aged residential care facility owned and operated by a rest home company, which operates other care facilities within New Zealand.

14. The rest home accommodates up to 45 residents and provides rest-home and hospital-level care. The rest home has confirmed that it has a current Building Warrant of Fitness and MOH Certification, both of which are displayed on the wall inside the main entrance. Its current three-year certification ends in 2022.

Mrs A

15. At the time of events, Mrs A was in her late nineties, and her recorded medical history included asthma, bilateral limited range of shoulder movement,[3] heart failure, hernia,[4] heart disease,[5] osteoarthritis,[6] and reflux.[7] It was also documented that she suffered from chronic pain and hypertension, and was at risk of falling.

Initial transfer of Mrs A and assessments made

16. Mrs A was admitted to a room in the hospital wing of the rest home on 24 Month1. Mr and Mrs B told HDC that Mrs A had spent 18 months in another rest home and was transferred to the new rest home after being assessed as needing hospital-level care.

Assessments at rest home

17. On 24 Month1, the Resident's Transfer Form was provided by the first rest home. A copy of the relevant clinical notes, medication pack, advance directives[8] (including informed consent[9]), and doctor's medication prescribing chart were provided to the rest home.

18. The Initial Care Plan was completed on the same day of admission, and noted that Mrs A had a high risk of falling, and that she required one carer to assist her for toileting and two for transferring to a wheelchair, which she preferred to use when mobilising, as she was "unsteady". It was identified that she also had a moderate risk of developing pressure ulcers

[3] It was reported that Mrs A sustained a right shoulder injury following a fall in 2005.
[4] A hiatus hernia (part of the stomach pushes into the chest cavity and can cause heartburn and discomfort).
[5] Ischaemic heart disease (also known as coronary heart disease) — a heart problem caused by narrowed arteries that supply blood to the heart muscle.
[6] Deterioration of the cartilage (flexible tissue) at the ends of bones in the joints.
[7] Gastroesophageal reflux disease (GERD) — a chronic digestive disease that occurs when stomach acid or bile flows into the food pipe and irritates the lining.
[8] Mrs A signed a "Not for Resuscitation Authorisation" form on 20 Month1 prior to her transfer to the rest home.
[9] The informed consent document, which Mrs A also signed on 20 Month1, authorised the rest home to deliver treatment based on assessed needs that had been explained, discussed, and agreed with Mrs A (or her representative) with the nurse and a medical practitioner.

owing to her general immobility. It was also recorded that Mrs A weighed 70kg and had high blood pressure[10] on the day of admission.

19. The meal plan assessed for Mrs A showed that she had a normal diet but preferred small-sized meals. This was also supported by the assessment summary, which showed that she had "nil nutritional issues" and had no dehydration concerns.

20. Mrs A's family doctor, Dr J from a medical centre, continued to provide her primary care after she had transferred to the rest home. Dr J's clinical notes show that he first reviewed Mrs A at the rest home on 30 Month1. He documented that Mrs A's health was quite stable and she was to continue the medications as charted, noting only that she needed daily compression bandaging on both her lower limbs.

21. The interRAI assessment forms[11] completed for Mrs A in Month3 document that she had trouble moving, as her hip and knee "creak[ed]" when she walked.[12] Both her legs were swollen, and she declined to elevate her legs for any length of time. At times, Mrs A had a dry mouth, and fluids needed to be encouraged. Mrs A's increased frailty and high level of pain required her to have at least one full-time carer for most of her daily routines.

22. The interRAI assessment forms also established a plan to detect and respond to any changes in Mrs A's mood or behaviour over the next six months. This included encouraging care staff to show expressions of concern to Mrs A, and to report any changes to the registered nurses. It was also documented that Mrs A was still able to express her needs clearly.

23. The interRAI Assessment Summary also showed that the assessment protocol for Mrs A's mood required a care plan. The summary stated:

> "Daily monitoring to assess for a decline in mood or behaviour as previous assessments indicate there have been problems associated with cares. DRS ¼[13]."

Care provided in Month4

24. From 1 to 7 Month4, it was documented in the nurses' progress notes that Mrs A was generally eating and drinking well with "nil concerns". She was reportedly settled, slept well, and "appeared to be in good spirits".

25. On 3 Month4, the progress notes document that Mrs A was feeling unwell after eating too much lunch, and had to settle into bed early. However, it was reported that she had had a good food and fluid intake with no concerns. On the following day, Mrs A's weight was recorded as 70.9kg.

26. On 8 Month4, the progress notes show that Mrs A was very sleepy and was in a "low mood". She declined lunch, but ate dinner at a later time than usual. Mrs A was later given pain

[10] 160/71mmHg.
[11] The interRAI assessment is a suite of instruments used by clinical providers to assess an older person's care and needs, both in the community and in aged residential care.
[12] The interRAI assessment form reported that she was unsteady and preferred to use a wheelchair because of her swollen legs. She required two assistants to transfer her into a wheelchair.
[13] The Depression Rating Scale (DRS) is used as a clinical screen for depression.

relief[14] for her sore legs, which had good effect. However, there was no documentation on what had caused the sleepiness and low mood, or whether this was due to her ongoing pain. On the morning of 9 Month4, Mrs A declined all cares from the nurses.

27. From 9 to 13 Month4, the progress notes state that Mrs A was generally settled and eating and sleeping well.

28. On 14 Month4, it was documented in the progress notes that Mrs A was "not feeling well" and "looked so tired". On the morning of 16 Month4, she was noted to be very emotional. Mrs A required emotional reassurance from a health care assistant (HCA), who informed the nurse on duty. Later in the afternoon, Mrs A requested a review by her doctor, Dr J. The fax submitted by RN F to the medical centre stated:

> "[Mrs A] has requested to [be] reviewed. She states she is not 'feeling herself'. She feels as though she has no energy and states she would like to go to the hospital. Has denied any pain. Mobilising as normal and maintaining good diet and fluids. [Observed] this morning (bp) 153/89 (hr) 81 (rr) 16 (T) 35.4."

29. Dr J did not see Mrs A on 16 or 17 Month4. The progress notes document that Mrs A remained settled, had good fluid intake, and was eating well again.

30. Ms D (the Facility Manager) told HDC that a food chart was not completed, as Mrs A's weight was stable throughout her residence at the rest home. Ms D said that similarly, a fluid balance chart was not required, as the nurses believed Mrs A's fluid intake was adequate at the time.

Visit by Dr J

31. Mrs A was seen by Dr J on 18 Month4. The consultation notes record that Mrs A was reportedly upset because a staff member had been rude to her, although she could not recall who it was or what was said. Dr J told HDC that Mrs A had calmed down by the time he saw her. Dr J also made no changes to Mrs A's medications.

32. Dr J told HDC:

> "When I saw [Mrs A] at the time I had no particular concerns about her hydration, nutrition or mental health. As documented in my notes she had been upset as she had thought a staff member at [the rest home] had been rude to her …
>
> There were no specific new instructions given to the nursing staff at the time of that visit … I was not called to [the rest home] because the patient had 'increased anxiety' and of course the reason the patient had wanted to be transferred to the hospital was that she wanted to remove herself from the care of the staff member she had a clash with. There was no need to change the treatment plan …"

[14] Codeine phosphate (an opioid analgesic used for mild to moderate pain relief; it is less potent than morphine).

33. Despite this statement by Dr J, the nursing progress notes state that Mrs A continued to display increased anxiety after Dr J's visit.

34. On 20 Month4, the progress notes state that Mrs A was very unsettled. She reportedly rang the bell every half hour, switched between her bed and chair because she had a sore rear, and was a little confused. It was recorded that she maintained a good diet and fluid intake.

35. From 21 to 31 Month4, the progress notes record that Mrs A felt generally settled, had a good diet and fluid intake, and showed nothing remarkable except for instances of sleepiness.

36. Ms E, the Director of the rest home, explained to HDC that Mrs A's low mood appeared to have lasted for two days, and thereafter she was her normal self. Ms E stated that the staff can make suggestions and highlight problems to the doctors, but "it is the doctor's decision what he does for the resident". Her explanation on why the nurses did not perform further investigations into Mrs A's mood was that Mrs A was eating and drinking well during the months of Month2 to Month4.

Month5 — development of cellulitis

37. The progress notes show that from 1 to 5 Month5, Mrs A appeared mostly settled, with a good diet and fluid intake. However, from 3 Month5, it was reported that Mrs A's legs were sore and that she was in pain when being moved.

38. On 5 Month5, the progress notes state that in the early morning Mrs A experienced pain on both her heels, which required the nurses to elevate them in order to relieve the pain. Mrs A requested further pain relief and was given codeine phosphate. She later complained of being in severe pain in her legs and had difficulty mobilising. It was documented later in the evening that Mrs A was "very sleepy". She was observed to have had a "small diet" and was taking "good fluid".

39. On 6 Month5, the progress notes document that Mrs A had moderate pain in both her legs and feet. She complained of being "deeply cold" and requested to remain in bed. In the evening, it was documented that Mrs A was tired but settled in bed.

Visit by Ms C (niece)

40. On 6 Month5, Ms C visited her aunt. Ms C told HDC that she observed Mrs A to have suffered deterioration in her general condition. Ms C stated: "She was very dry, sunken eyes and very dry mouth and skin … but [my] aunt [was] totally coherent."

41. Ms C said that she conveyed her concerns to a staff member, and apparently these were faxed to the doctor. However, there is no evidence from the information provided to HDC that a fax was sent.

Discovery of cellulitis and consultation with Dr K

42. The progress notes document that at 10.45am on 7 Month5, Mrs B visited Mrs A in the morning. RN I documented that Mrs B was concerned about Mrs A's condition. Mrs A was observed to be sleepy and at times confused.

43. Two HCAs were responsible for Mrs A's care during the morning and afternoon of 7 Month5. Both HCAs told HDC that during the day they did not notice any changes in Mrs A's skin appearance or condition of her legs.

44. Mrs B told HDC that when she visited Mrs A on the same day, she found her in bed, and she was extremely dehydrated and "quite delirious". In contrast, RN F told HDC that Mrs A was fairly settled with no complaints of pain or discomfort. RN F said that throughout the afternoon shift, staff had been encouraging Mrs A to take fluids in response to her family's concerns about dehydration.

45. RN F told HDC that at approximately 8.15pm, she answered Mrs A's bell. RN F said that upon removal of Mrs A's bedcovers, she noticed that Mrs A's lower leg was very red and warm to touch. RN F stated that Mrs A told her that there was no pain. The progress notes document: "[C]ellulitis area from [left] leg tracking up to groin area."

46. RN G assisted RN F in providing care to Mrs A at that time. RN G noted the reddened area tracking down Mrs A's left leg, which was hot to touch. RN G said that despite this, Mrs A was not distressed and had not voiced any pain.

47. At approximately 8.30pm, RN G telephoned the on-call doctor, Dr K, to discuss their findings, and RN F documented Mrs A's vital signs. Dr K advised the nurses either to send Mrs A to the hospital for intravenous antibiotics, or alternatively for her to remain at the rest home, and be administered oral antibiotics.[15] After discussing the discovery of the cellulitis and the treatment options with Mrs A's family over the phone, it was decided by both Mrs B and Mr B that Mrs A should stay overnight at the rest home and receive oral antibiotics. Mrs B was told that Mrs A would be reviewed by Dr J the next day. Ms D was later informed of the situation by RN F.

48. Dr K told HDC that he was contacted by the rest home at around 9.40pm, not 8.30pm as stated by RN G, but he was unable to recollect Mrs A's wishes. Dr K's clinical notes document that Mrs A was in pain and had low blood pressure.

49. RN H was responsible for Mrs A's care during the night[16] of 7 Month5, after receiving the handover from RN F and RN G. RN H told HDC that she observed Mrs A half hourly during the night, and she appeared to be comfortable whilst tolerating sips of fluid when she was awake.

Consultation by Dr J and transfer to hospital

50. On 8 Month5, the progress notes show that Mrs A had a settled night and was tolerating food and fluids. RN I told HDC that Dr J visited Mrs A early in the morning, so Mrs A's family was not present when he reviewed Mrs A. On inspection, it was noted that the cellulitis area had spread further up her left leg. At 11.20am, she was noted to be difficult to roll over on her bed because of the pain.

[15] Erythromycin ethylsuccinate (an antibiotic used to treat infections of the chest, mouth, skin, and stomach).
[16] RN H told HDC that her shift on 7 Month5 started at 2245 hours and ended at 0715 hours.

51. Dr J recorded that almost all of Mrs A's left leg was inflamed. As a result of being dehydrated and feverish, Mrs A was unable to take further oral medication. Subsequently, she was transferred to the public hospital (the hospital) accompanied by Mrs B.

8–10 Month5 — admission and discharge from hospital

52. During her stay in hospital, Mrs A was diagnosed with cellulitis that was not improving with the antibiotics given. It was documented that the family and medical team discussed Mrs A's prognosis, with symptom control being the main priority. It was also decided that active treatment would be stopped, and that palliative care would commence.

53. On 10 Month5, Mrs A was discharged back to the rest home for ongoing symptom management with pain relief medication.[17]

11–17 Month5 — palliative care

54. Between 11–17 Month5, Mrs A was provided end-of-life cares by the nurses at the rest home. Mrs A passed away at around 9.40pm on 17 Month5.

Further information

55. Mr and Mrs B told HDC:

> "[Mrs A] was initially transferred to [the rest home] for hospital level care which eventually ended in palliative care … We do not believe that her time there and particularly the last 8 weeks were a dignified, respectful or peaceful end to her life."

Rest-home certification

56. HealthCERT advised HDC that the rest home has a three-year certification period that is due to expire in 2022. The most recent surveillance audit in 2020 found four partially attained standards.[18] A "moderate risk" finding related to the rest home having "inconsistent corrective actions, and the meeting minutes not documenting the corrective actions and responsibilities".

Responses to provisional opinion

Mrs A's family

57. Mr and Mrs B were given an opportunity to comment on the "information gathered during investigation" section of the provisional opinion. Where relevant, their response has been incorporated into the report.

Rest home

58. The rest home was given an opportunity to comment on the provisional opinion. It accepted my findings and recommendations, and confirmed that it had no further comment to make.

[17] A T34 syringe driver pump to dispense pain relief medication including fentanyl and midazolam.
[18] Five categories were measured. Four categories identified a low risk, and one category was rated as a moderate risk.

Opinion: Rest home — breach

Introduction

59. The rest home had a duty to provide Mrs A services with reasonable care and skill, which included being responsible for the actions of its staff at the rest home.

60. In Month1, Mrs A was transferred to the rest home because she required a higher level of care, that is, hospital-level care. Mrs A's medical history indicated that she was likely to experience a progressive decline in her general function. In particular, she was noted to be at risk of having a decline in her mood, and to experience high levels of pain in her legs. In light of this, the various nursing staff involved in her care should have been alert to a deterioration in Mrs A's condition, and intervened as required, including seeking medical attention when warranted. Staff should have ensured that Mrs A was well supported in an environment conducive to keeping her calm and comfortable.

61. I consider that Mrs A was let down by a combination of deficiencies in the care provided, as outlined below.

Lack of investigation of symptoms in Month4 and Month5

Symptoms of restlessness, low mood, and confusion

62. During Month4 2020 (outlined in more detail above), the nursing staff recorded a decline in Mrs A's condition, as well as days where she was "unsettled", "upset", "anxious", "a little confused", and experiencing "low mood".[19]

63. The interRAI assessment completed on 15 Month3 stated that Mrs A required daily monitoring to assess for decline in mood or behaviour. This is reinforced by the care plan implemented from 29 Month3, which stated that any changes in mood or behaviour for Mrs A were to be detected and responded to appropriately, including reporting the changes in behaviour to the registered nurses.

64. My in-house clinical advisor, RN Hilda Johnson-Bogaerts, stated that she was concerned that the clinical notes during Month4 did not include an investigation into the reasons for Mrs A's decline and the symptoms of restlessness, low mood, and confusion. RN Johnson-Bogaerts was concerned that there were:

a) No additional observations taken;
b) No further nursing interventions implemented;
c) No investigations into the possible causes; and
d) No measures documented to make Mrs A comfortable during these episodes.

65. RN Johnson-Bogaerts stated:

[19] This was observed on 8 Month4, 9 Month4, 14 Month4, 16 Month4, 20 Month4, 22 Month4, and 30 Month4.

> "Good nursing practice requires that the registered nurses not only pick up on decline but also investigate its potential cause, implement nursing interventions as for example ensure good fluid intake, and escalate to GP providing their reasoning … The lack of systematic investigation and critical reasoning by the nurses in the circumstances would be seen by my peers as a moderate to significant deviation from accepted practice."

66. I agree with RN Johnson-Bogaerts' advice that throughout Month4 and Month5, it is not clear whether further investigations into Mrs A's periods of low mood and lethargy were undertaken.

Dehydration

67. In Month5, Mrs A's progress notes documented that she had good food and fluid intake, although no food or fluid balance chart was used. On 8 Month5, Mrs A was assessed by Dr J, who noted that in addition to cellulitis, Mrs A was dehydrated. Subsequently, Mrs A was transferred to hospital.

68. RN Johnson-Bogaerts expressed concern that Mrs A's dehydration was not picked up earlier. RN Johnson-Bogaerts stated:

> "The use of observation chart to document food and fluid intake was indicated already during [Month4] when [Mrs A] had episodes of deterioration and lethargy. The progress notes include that fluids were offered during the night of 7 [Month5], however, it was not noted how much she had been drinking."

69. RN Johnson-Bogaerts considered this to be a mild departure from the accepted standard. I accept this advice. As mentioned above, Mrs A was demonstrating symptoms of decline, and the use of observation charts would have been a more robust way of monitoring her food and fluid intake.

Conclusion

70. Vulnerable consumers such as Mrs A rely on nursing staff to think critically and take action when warranted. The fact that Mrs A had shifted to hospital-level care indicated that her health needs had become more complex. She required more support on a day-to-day basis, and was reliant on staff to observe for signs of deterioration. Failure to do so would result not only in unnecessary pain and suffering for her, but would also mean that appropriate interventions were potentially delayed. The purpose of progress notes and systematically recording observations is to both facilitate the sharing of key information between staff from one shift to the next, and also to more readily highlight an emerging pattern of concern. I observe an issue of poor care in this respect.

71. In summary, RN Johnson-Bogaerts has identified missed opportunities on the part of the rest-home staff to identify, respond to, and escalate concerning symptoms displayed by Mrs A during Month4 and Month5. In particular, there was a failure to:

- Systematically investigate and think critically about Mrs A's restlessness, low mood, and confusion; and
- Record and monitor Mrs A's food and fluid intake.

72. Accordingly, I find that the rest home did not provide Mrs A services with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[20]

Other issues

Consent for treatment — adverse comment

73. RN Johnson-Bogaerts expressed concern about whether informed consent was obtained from Mrs A for her cellulitis treatment — namely, the decision to receive antibiotics at the rest home rather than in hospital. RN Johnson-Bogaerts noted that Mrs A did not have an activated EPOA[21] at the time, and she was able to express her own needs and decisions. However, the consent for her cellulitis treatment was obtained from the family rather than Mrs A herself.

74. Ms E provided HDC with the consent form signed by Mrs A on 20 Month1 (prior to her admission to the rest home). Clause two of the informed consent form gave authorisation for the rest home to deliver treatment based on assessed needs that had been explained, discussed, and agreed with Mrs A or a representative, and with a nurse or a medical practitioner. Ms E stated that when Mrs A was asked a question, she would always defer the decision to be made by her close relatives.

75. I accept that the family was very involved in Mrs A's care, as evidenced by their continued communications with the manager and staff, and that often Mrs A deferred decision-making to her close relatives. However, as Mrs A was competent to express her own needs and make decisions relating to her care, it was important that the rest home took steps to ascertain Mrs A's personal views ahead of implementing a treatment course. Given the lack of documentation about Mrs A's views, I am not confident that this occurred on this occasion.

Discovery and management of cellulitis — other comment

76. On the evening of 7 Month5, it was discovered by the nurses during their routine check that Mrs A had developed a reddened leg that was hot to touch and was indicative of cellulitis. Vital signs were taken by the nurse before informing Dr K of the results (which were within the normal range). Oral antibiotics were prescribed, and a care plan for the cellulitis was also prepared on the same night. Mrs A was reviewed by Dr J the next day and was admitted to hospital owing to her deterioration.

77. RN Johnson-Bogaerts explained to HDC that cellulitis is a common but potentially serious bacterial skin infection. Patients with cellulitis require prompt medical attention, and can be treated with oral antibiotics and continued monitoring. I accept that for Mrs A, the cellulitis progressed rapidly in a short timeframe.

78. RN Johnson-Bogaerts advised that the information provided by the registered nurse in charge showed that generally due process was followed for the management of Mrs A's

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

cellulitis. I accept my expert's findings, and view the nurses' discovery and management of Mrs A's cellulitis as appropriate and robust in the circumstances.

Changes made

New policy implemented — "Assessment & Management of the Acutely Unwell Resident"

79. Ms D advised HDC that upon reflection of this event, the rest home instigated a new policy. The policy[22] includes the STOP AND WATCH procedure, which requires the nurses to follow 12 steps to assess a deteriorating resident. The nurses are also required to use the ISBAR communication framework[23] to discuss an acutely unwell resident with another health professional (a doctor or allied health professional).

Recommendations

80. I recommend that the rest home company:

a) Provide a written apology to Mrs A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mrs B.

b) Provide evidence to HDC that all nursing staff have received training on the new "Assessment & Management of the Acutely Unwell Resident" policy. If not, a further education session for nursing staff is to be scheduled. Information regarding the training should be provided to HDC within three months of the date of this report.

c) Conduct, from a random sample of ten residents, an audit of compliance with the above policy. If it is found that the policy has not been adhered to, please outline corrective actions that the rest home will take to address the deviations from the policy. This information should be provided to HDC within four months of the date of this report.

d) Within three months of the date of this report, provide evidence to HDC that all staff, since the time of the events, have received training on:

   i. the identification and management of infection in the elderly;

   ii. the assessment and management of general decline in the elderly;

   iii. informed consent, supported decision-making, and EPOAs; and

   iv. palliative care and the implementation of the "Last Days of Life" [24] care planning.

[22] "Assessment & Management of the Acutely Unwell Resident" was implemented on October 2020.
[23] ISBAR stands for Identification, Situation, Background, Assessment, and Recommendation.
[24] Ministry of Health, *Te Ara Whakapiri: Principles and guidance for the last days of life* (2nd edn). Wellington: Ministry of Health (2017).

In the event that training has not been provided in these areas, measures are to be put in place to ensure that all nursing and caregiving (as appropriate) staff will receive training within six months of the date of this report.

e) Implement "The Last Days of Life" care planning throughout the rest home company's facilities. The rest home company is to provide evidence of the implementation of this within six months of the date of this report.

Follow-up actions

81. A copy of this report with details identifying the parties removed, except the rest home and the expert who advised on this case, will be sent to HealthCERT, the New Zealand Aged Care Association, and the district health board, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to the Commissioner

The following expert advice was obtained from in-house aged-care advisor RN Hilda Johnson-Bogaerts:

"1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by [the rest home] to [Mrs A]. 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. Specifically I have been asked to review identified complaints relating to resident safety, dehydration, delay in identification of cellulitis, and pain relief.

2. Documents reviewed

- Provider response including responses individual nurses dated 27 March 2020
- interRAI assessment 25 [Month3] and care plan 29 [Month3]
- Care Plan Cellulitis 7 [Month5]
- Medical notes
- Progress Notes
- Communications record sheet
- Incident form [#]
- Fax to [the medical centre] 6 [Month5] and 10 [Month5]
- Syringe driver monitoring chart 15 [Month5]

3. Review of documents and records

[Mrs A] moved into [the rest home] on 17 [Month2] to receive hospital level care. Her medical background included Heart Failure, Ischaemic Heart Disease, Osteoarthritis, and Asthma. The safety issues identified relating to her care included a high risk of falling, high risk for developing pressure injuries, and general frailty due to high age. She had an unsteady gait and preferred getting around with a wheelchair. Both legs had oedema reaching her knees but she did not like to elevate her legs for any length of time. She reported that mobilising was very painful and was prescribed Fentanyl patch and codeine prn to manage the pain. Due to functional deterioration related to increased frailty and pain she received full assistance with all her cares. She was able to express her needs clearly.

i. Dehydration and identification of cellulitis

The nursing progress notes show that during [Month4] [Mrs A] experienced some settled days and some days that she was '*unsettled', 'upset', 'anxious', 'a little confused', 'low mood'*. The notes do not include any investigation into these symptoms, no targeted observations were noted. There seemed to be no investigation into possible causes. There are no measures documented to make [Mrs A] more comfortable during these episodes.

6 [Month5], a fax was sent to the GP requesting a consultation because of 'increased pain' and 'general decline'. The fax does not include any vital signs or clinical reasoning. On 7 [Month5] in the morning, the notes include *'Daughter is concerned about her*

mum's condition — [Mrs A] confused at times and more sleepy' 'GP visiting tomorrow'. The notes do not include any further investigation into the symptoms of the noted decline.

Comments and advice

I am concerned that the clinical notes during [Month4] did not include an investigation into the reasons for the decline and the symptoms of restlessness, low mood and confusion. It would appear that no additional observations were taken or nursing intervention implemented. The fax sent on 6 [Month5] to the GP was very general and did not include any vital signs/observations or show relevant diagnostic reasoning. Good nursing practice requires that the registered nurses not only pick up on decline but also investigate its potential cause, implement nursing interventions as for example ensure good fluid intake, and escalate to GP providing their reasoning. This can be guided by and documented using the STOP AND WATCH tool and the SBAR tool (refer to Frailty Care Guides[1]) which is commonly used to communicate/escalate to the GP. The lack of systematic investigation and critical reasoning by the nurses in these circumstances would be seen by my peers as **a moderate to significant deviation from accepted practice**.

7 [Month5] around 20.00 hrs the nurses noticed redness on [Mrs A's] left leg from the bottom to the groin area indicative of cellulitis. Vital signs were taken which were within normal range; on-call GP was phoned; family was contacted and they were happy for [Mrs A] to remain at the care home and be monitored overnight, but be transferred to hospital if there was any decline. The care home Manager was also informed. A short term care plan was developed including the need for ongoing monitoring. Oral antibiotics were commenced same evening, her GP would come in to see her just after midday the next day. The registered nurse statement includes more detailed information including that a picture was taken of the leg, and details of the conversation with the GP and family. Regarding the conversation with the consumer, the following information was provided: *'I then went and explained to [Mrs A] that we were concerned about her leg and had called the on-call doctor who was going to start her on oral antibiotics for cellulitis'*. During the night [Mrs A] was regularly monitored including giving her fluids when she was awake. After consultation with the GP and family the next day, admission to hospital for treatment was decided. In addition to the cellulitis, dehydration was observed.

Comments and advice

Cellulitis is a common, potentially serious bacterial skin infection. The affected skin will appear swollen and red and is typically painful and warm to the touch. It is important to seek prompt medical advice for diagnosis and treatment. The condition is treated with antibiotics, in most cases oral antibiotics is all that is required. Continued monitoring of symptoms is needed because in severe cases where oral antibiotics don't

[1] https://www.hqsc.govt.nz/our-programmes/aged-residential-care/publications-and-resources/publication/3818/

seem to be effective hospitalisation and treatment with intravenous antibiotics may be required. The information provided by the registered nurse in charge shows that generally due process was followed managing the clinical emergency of cellulitis. I have some question however about the way informed consent was obtained from the consumer. I note that [Mrs A] did not have an activated EPOA and was able to express her own needs and make decisions. The progress notes are not clear as to why informed consent was not obtained from her but rather from her next of kin. The consumer seemed to have been informed after decisions were made although was throughout reported to be 'alerts and responsive'.

I have some reservations that the dehydration was not picked up earlier. The use of an observation chart to document food and fluid intake was indicated already during [Month4] when [Mrs A] had episodes of deterioration and lethargy. The progress notes include that fluids were offered during the night of 7 [Month5], however it was not noted how much she had been drinking.

In the circumstance these would be seen by my peers as a mild deviation from accepted practice.

ii. Resident safety

The provider's response states that on 21 [Month4] another resident who had an episode of wandering and was disoriented entered [Mrs A's] room. The nurse removed this resident from the room and redirected her back to her own room. An incident form was completed which included that the resident was found to be standing at the back of the bed. Family was informed of the incident. The disorientated resident was later reassessed as needing secure dementia care. From the incident report and other notes it would not appear that resident safety was at risk. Residents being disorientated and wandering inappropriately into the wrong room is commonly seen in care homes and is an indication for advancing dementia. It appears that appropriate action was taken by the nurses in relation to this incident. **Deviation from accepted practice — nil.**

iii. Delay in pain relief

The two registered nurses who were in charge on 15 [Month5] of the consumer's pain relief and management of the syringe driver provided an account.

At approximately 8.45hrs the first lot of pain medication was administered to [Mrs A] who was now receiving end of life cares. Her pain medication included a Fentanyl patch as well as other medications administered by way of a T34 syringe driver which was due for change at 9.55hrs. A family member notified the nurse who was in a conversation with someone else in the nurses' station that the syringe driver had started beeping. After another 5 minutes the nurse was reminded again of the beeping.

After the conversation finished in the nurses station, the two nurses on duty commenced the drug calculations and started drawing up the medications, having this double checked by the Clinical Nurse Manager. This is in line with good practice. The new syringe was started around 10.25 hrs. The notes include that in addition the batteries were replaced.

Clinical advice:

From the moment the syringe driver starts alerting that re-supply is needed, nurses have one hour to resupply medication in a new syringe. The syringe was replaced well within this time. Further as required pain relief was provided again at 13.05hrs and when visual signs of increased agitation was reported to the nurses by the family.

Further comment:

The notes don't include if the family was reassured and informed of the fact that when the alert starts there is still about 1 hour of medication available. Good clinical care in an end of life situation includes for the nurses to pick up on family anxiety and provide support, information and reassurance. Nursing care in end of life situations is to be expanded to include care of the family and manage their distress, including physical, psychological signs, behaviour change, fatigue, confusion, grief etc. I did not find any reference in the response and clinical documentation of the latter. While timely pain management was provided, I am concerned however that the clinical notes and nurses' responses were very task centric and did not refer to a family centric approach. For this I am referring to the Te Ara Whakapiri guidance document from the Ministry of Health[2] and the use of a Care Plan from the Last Days of Life. In this case no such a care plan was developed and used and I would recommend that it be implemented by the provider.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

The following further advice was obtained from RN Johnson-Bogaerts:

"Thanks for giving me the opportunity to review the response from the provider. I did not find anything that caused me to change my previously provided advice.

It seems the response confirmed my concerns.

You might also have noted my recommendation that the provider implements the MoH guidelines and format for The Last Days of Life care planning which includes a holistic approach to care.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

[2] https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life