Heritage Lifecare Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC01030)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman by Heritage Lifecare Limited (trading as Colwyn House), in particular the provision of her oral nutrition supplement Ensure and the monitoring of her weight loss.

2. The woman's advanced Alzheimer's disease and behavioural issues placed her at risk of weight loss, and she had been prescribed with six scoops of Ensure to be taken three times a day. During her time at Colwyn House, some nursing staff were confused by the woman's prescription, and on occasion she was administered one "scoop" of Ensure instead of the prescribed one "dose", which was six scoops.

3. Over a four-month period, the woman lost just under 10 kilograms of weight. This should have triggered multiple follow-up actions (such as a referral to a nutritionist), as per Colwyn House's "Weight Loss — Assessment and Management" policy. However, timely action and appropriate follow-up did not occur.

Findings

4. The Deputy Commissioner was critical of multiple failures by Colwyn House, including not ensuring that on admission a complete care plan was prepared to guide staff; the failure of multiple staff to administer the woman's Ensure in accordance with her prescription; the failure to seek clarification of the Ensure prescription in a timely manner; and the failure of multiple staff to act on evident weight loss, despite it being recorded monthly.

5. The Deputy Commissioner considered that the number of staff involved in the inadequate care provided to the woman suggested a lack of staff understanding of Colwyn House's expectations, a lack of critical thinking, and a lack of oversight by Colwyn House. Accordingly, the Deputy Commissioner found Heritage Lifecare Limited in breach of Right 4(1) of the Code.

Recommendations

6. The Deputy Commissioner recommended that Heritage Lifecare Limited provide training to all nursing staff on care planning requirements; monitoring and managing residents' nutritional needs; administering medication as per a resident's prescription; and the professional responsibility of nursing staff to question any ambiguities and raise any concerns. She also recommended that Heritage Lifecare Limited consider whether any of the learnings from this investigation can be translated into improvements throughout its other aged-care services; undertake an audit to confirm compliance with its weight loss policy; and provide the family with a written apology.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided by Heritage Lifecare Limited (trading as Colwyn House Lifecare). The following issue was identified for investigation:

- *Whether Heritage Lifecare Limited (trading as Colwyn House Lifecare) provided Mrs A with an appropriate standard of care in 2018 and 2019.*

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

9. The parties directly involved in the investigation were:

Mr A	Complainant/Mrs A's husband
Colwyn House Lifecare	Provider/rest home

10. Further information was received from Dr B, a general practitioner (GP).

11. Independent expert advice was obtained from Registered Nurse (RN) Rachel Parmee (Appendix A), and in-house advice was obtained from GP Dr David Maplesden (Appendix B).

Information gathered during investigation

Background

12. Mrs A (aged in her sixties at the time of these events) had a medical history that included hearing loss, osteoporosis,[1] and advanced Alzheimer's disease.[2]

13. As Mrs A's Alzheimer's disease progressed, her needs began to exceed that of the care available at her previous rest home, and on 8 Month1[3] she was transferred to Colwyn House Lifecare (Colwyn House). Colwyn House is a rest home owned and operated by Heritage Lifecare Limited, and provides care for up to 67 residents who require psychogeriatric, medical, and geriatric hospital-level care.[4]

[1] A condition in which the density and quality of the bones is reduced, making them weak, brittle, and more likely to fracture.
[2] A progressive disease that destroys memory and other important mental functions.
[3] Relevant months are referred to as Months 1–7 to protect privacy.
[4] Secure dementia care homes are a subset of rest homes. The main difference is that dementia care homes are safeguarded to maintain the personal safety of the people in them. Psychogeriatric care homes are a subset of hospital-level care.

14. Mrs A would wander around the rest home actively, increasing her energy expenditure, and often would refuse to be fed by closing her mouth when offered food. As a result, she was at risk of weight loss and had been prescribed Ensure[5] by her GP, Dr B, since 2017. The prescription for Mrs A's Ensure was set to repeat every three months, and read as follows:

> "Ensure Powder 850g (new formulation, chocolate) [1]
>
> Sig [directions]: add 6 level scoops to 195ml of cold water and mix until dissolved, tid1, serving tid [1 serving three times a day], or as able
>
> Mitte [prescription amount]: 3 [months]"

15. This report concerns the care provided to Mrs A regarding the provision of her Ensure and the monitoring of her weight loss from the time of her admission to Colwyn House until 3 Month6.

Care planning

16. On admission to Colwyn House, a partially completed interim care plan for Mrs A was published to its care-planning database on 18 Month2. The Oral Meals and Drinking section had not been completed. However, under the section "swallowing difficulties", the plan noted Mrs A's Ensure supplement and documented:

> "**Nutritional supplements**
> Name of supplement: Ensure
> Dose: 6 scoops (1 serving)
> Frequency: BD [twice daily]"

17. Mrs A's interRAI assessment (dated 7 Month2) documented that family had concerns about her gradual weight loss, and noted that she had weighed 63.8kg in 2017, and on admission to Colwyn House she weighed 56kg.

Provision of Ensure to Mrs A

Ensure prescription

18. Mrs A's Ensure prescription was charted in Colwyn House's MediMap[6] system as "1", indicating "1 dose".

19. Dr B told HDC that originally she had charted the Ensure in 2017 as "1 serving" (a standard serving is six scoops) in Medtech,[7] and when she charted the medication on MediMap at Mrs A's previous rest home, she translated this to "1 dose". Dr B stated that at the time, this seemed to be the closest translation from the prescribing options offered in MediMap.

20. Colwyn House told HDC that one of the key issues in this instance was the way the Ensure prescription was written, as it was unusual and did not match other scripts for Ensure

[5] Ensure is an oral nutrition supplement containing vitamins, minerals, proteins, and omega fatty acids.
[6] A platform that manages medication in a facility-based environment.
[7] A patient management system commonly used by general practices.

prescribed by other GPs for residents at the time. Colwyn House stated that Mrs A was the only resident who had a dose recorded as "1", and all other residents had a dose of "6" or "9" (meaning 6 or 9 scoops) recorded.

21. Dr B noted that the Ensure had been charted this way since 2017, and that Mrs A had received a normal serving size of six scoops throughout the time she resided at her previous rest home.

Administration of Ensure to Mrs A

22. Mr A told HDC that in response to Mrs A's weight loss (discussed further below), he began to investigate the cause, and was told by a Colwyn House staff member that Mrs A's Ensure had been reduced from six scoops to one scoop per serving. Mr A also raised his concerns directly with Colwyn House. An internal investigation was commenced, and Colwyn House found that Mrs A's Ensure had not been reduced to one scoop, but that there was confusion around the way the Ensure had been charted in MediMap by the GP.

23. Mrs A's medication administration chart showed that she was being provided with "1" dose of Ensure at Colwyn House, approximately three times a day. Colwyn House asked eight of its registered nurses what one dose of Ensure (as charted in MediMap) meant to them. Five understood that it meant six scoops, and three nurses thought that it meant one scoop.

24. Not all of the nurses could confirm that they had read the administration instructions as well as the instructions on the tin.

25. Photographs of the Ensure tins were provided to HDC. The instructions for use read:

> "1. To prepare a 230ml feeding, put 195ml of cold water in a glass.
>
> 2. Gradually add 6 level scoops (scoop enclosed) or 53.8g of Ensure powder while stirring and mix until dissolved."

26. In addition, the pharmacy labels for Mrs A's Ensure prescription stated: "Mix together 6 scoops of powder with 195ml of water or milk and stir until dissolved." Colwyn House confirmed that these labels would have been on Mrs A's Ensure tins.

27. Colwyn House stated:

> "While it is correct that we had three nurses who indicated that they would read 1 on the Medimap record as meaning one scoop, it has to be taken into account that only two of those nurses actually provided Ensure to [Mrs A] during the relevant time period. They also administered less than half of the doses during the relevant time period …"

28. Colwyn House told HDC that part of its nursing orientation addresses how to administer medications safely, and that this included the procedure of "cross-checking" what was to be administered against what had been prescribed. Colwyn House confirmed that both of

the nurses identified had received this orientation, and that when asked, the nurses could not provide an explanation as to why they failed to cross-check against the stickers on the cans describing the correct amount of Ensure to be administered.

Monitoring of weight loss

29. On admission to Colwyn House, Mrs A weighed 56kg. As noted above, Mrs A's behaviour associated with her Alzheimer's disease made her at risk of weight loss, and her interRAI assessment documented her family's concerns about her gradual weight loss.

30. At the time of these events, Colwyn House had a policy entitled "Weight Loss — Assessment and Management", to ensure the early identification and appropriate management of weight loss in its residents. The policy stipulated:

"**Weight recording**

- A weight record will be maintained for each resident …
- All residents will have their weight recorded on admission — this is vital for assessing existing or ongoing weight loss.
- The frequency of weight recording will be monthly, or as otherwise directed for an individual resident.

Weight loss calculation

- **ALL** registered nurses are responsible for calculating weight loss in order to determine loss levels that require further intervention or further follow up.

...

Weight loss — follow up actions

- Weight loss will be followed up when
  i. It is unexplained or involuntary
  ii. It exceeds 5% of body weight in a month
  iii. It exceeds 7.5% of body weight in 3 months
  iv. It exceeds 10% of body weight in 6 months
- The residents GP must be informed …
- Referral to a Dietician SLT [Speech Language Therapist] will be through the GP — or by nursing staff at the request of the GP …

…

- Oral assessment

…

- Ensure a food and fluid record is commenced and maintained
- Review care plan and identify goals and interventions
- Evaluate daily or weekly and weigh as frequently as directed by dietetic and medical staff."

31. Mrs A's weight was recorded at least once a month, and was documented in her medical record as follows:

Date	Weight
23 Month1	56kg
11 Month2	51.4kg
21 Month2	52.3kg
21 Month3	50.3kg
21 Month4	49.9kg
5 Month5	50.5kg
11 Month5	51.8kg
21 Month5	46.2kg
10 Month6	50.5kg

32. As indicated in the chart above, Mrs A had two periods of significant weight loss from Month1 to Month6. The first was documented on 11 Month2, and showed that Mrs A had lost 4.6kg — a loss of 8.2% of her body weight in one month. However, there is no entry in Mrs A's progress notes at that time regarding her weight loss, and no evidence that her family were informed. Despite her weight loss exceeding 5% of her body weight, none of the follow-up actions for weight loss that should have occurred as per Colwyn House's policy were commenced.

33. The second period of significant weight loss was documented on 21 Month5, and showed that Mrs A had lost 5.6kg — a loss of 10.8% of her body weight in one month. By this time, although her weight had fluctuated, Mrs A had lost just under 10kg since her admission to Colwyn House. Again, there is no entry in Mrs A's progress notes at that time regarding her weight loss, and no evidence that her family were informed. Despite her weight loss exceeding 5% of her body weight, none of the follow-up actions for weight loss that should have occurred as per Colwyn House's policy were commenced until two weeks later.

Subsequent events

34. Mrs A's weight loss was not followed up until 3 Month6, when a food and fluid record chart, along with a weight loss chart, were commenced. A referral was sent to Dr B on 8 Month6, querying Mrs A's Ensure prescription and requesting a GP review. The referral

stated: "[T]here is some confusion [with] Ensure that [is] charted in Medimap (1 scoop) and as per the box (6 scoop)."

35. Mrs A was reviewed by Dr B the same day, and she clarified that the prescription for "1" meant a serving, not a scoop. Dr B documented her review in Mrs A's clinical notes as follows:

> "Confusion around quantity of Ensure to give — Medimap indicates 1 serving tid, but some staff are interpreting this as 1 scoop, rather than 1 serving (6 scoops) … has lost significant weight past few weeks: [Month5] weight was recorded at 46.2kg ([Month3] was 50.2). I have clarified that '1' means a serving (just like a 'dose'), not a scoop — it has been charted like this since 2017, and she has been offered 'servings' rather than 'scoops' for most of that time — the [prescriptions] printed for pharmacy every 3 [months] also indicate this."

36. Subsequently, from 10 Month6 Mrs A's weighing became more frequent, and a referral for a nutrition assessment was sent to a dietician at the District Health Board on 15 Month6. Despite these actions, Mrs A deteriorated rapidly with respect to frailty associated with her severe dementia, and she passed away in Month7.

Further information

37. Heritage Lifecare acquired Colwyn House from a previous provider and took possession of the premises on 1 April 2017 (almost two years prior to these events).

38. In a letter to Mr A, the Home Care Manager for Colwyn House acknowledged that it did not follow correct procedures in regard to Mrs A's weight loss. The Home Care Manager told Mr A:

> "I sincerely apologise for the inadequate monitoring of [Mrs A's] weight, staff not following Heritage Lifecare policy and the confusion around the GP charting of her nutritional supplement."

39. Colwyn House told HDC that this case has been used for educational purposes through discussion with registered nurses and clinical service managers at regional seminars throughout New Zealand. Colwyn House stated that further information has been provided to Colwyn House nurses about Ensure and other common medications, and that a new "Nutrition and Hydration" policy has been created.

Responses to provisional opinion

40. Mr A was provided with the opportunity to comment on the "information gathered" section of the provisional opinion. He stated:

> "From what I understand I find it impossible to believe that my dear wife wasn't slowly starved resulting in her dying before she otherwise would have. Heritage Life Care needs to be held responsible for negligence. This makes me so angry, and

naturally I am wanting someone to say 'Yes, it was my fault'. And to have the person prevented from being employed in the elderly healthcare system."

41. Colwyn House was provided with the opportunity to comment on the provisional opinion, and advised that it accepts all the findings and recommendations made.

Opinion: Heritage Lifecare Limited — breach

Introduction

42. Mrs A had been a resident of Colwyn House since Month1 owing to progression of her advanced Alzheimer's disease. She was a particularly vulnerable resident and had complex care needs, with a history of gradual weight loss, a tendency to wander the residence, and a refusal to eat, and in this context it was even more important that efforts were made to ensure that her intake was adequate and to monitor any further weight loss.

43. In the six months that Mrs A resided at Colwyn House, nursing staff failed to ensure that she was receiving her nutrition supplement as per her prescription, and failed to follow up on two significant periods of weight loss.

44. I am unable to determine the extent to which the issues with the administration of Ensure contributed to Mrs A's weight loss. Mrs A had a complex medical and behavioural history, and even if she had been given the correct serving of Ensure each time, she may still have lost weight. Nonetheless, it is clear that the failure to provide Mrs A with Ensure in accordance with her prescription, and the failure to follow up on her weight loss, are two instances where Colwyn House failed to provide Mrs A with services with reasonable care and skill.

Provision of Ensure to Mrs A

45. Mrs A had been prescribed Ensure as a nutritional supplement by her GP since 2017, as she was at risk of losing weight. After Mr A raised concerns with Colwyn House about the possibility that Mrs A's Ensure had been reduced, it was discovered that some staff were confused about how the supplement had been charted in MediMap. Colwyn House told HDC that it spoke to eight registered nurses, and five understood that one dose meant six scoops, and three thought that it meant one scoop. Colwyn House stated that out of these three nurses, two had administered Ensure to Mrs A since her admission.

46. Whilst it cannot be ascertained exactly how many times Mrs A was given only one scoop of Ensure instead of six scoops, it is clear that the error occurred multiple times, by at least two nurses at Colwyn House.

47. Colwyn House has submitted that one of the key issues in this instance was the way in which the Ensure prescription was written. Colwyn House noted that the prescription did

not match other scripts for Ensure prescribed by other GPs for residents at the time, and that Mrs A was the only resident who had a dose recorded as "1".

48. In-house advice relating to the prescription was sought from GP Dr David Maplesden. He advised:

> "With the benefit of hindsight, clarification of the term 'dose' in this instance might have prevented confusion although I am also of the view that nursing staff should have been familiar with what constituted a standard dose of Ensure … and the prescribing GP would reasonably expect this familiarity and also that administration instructions would be visible in a label on the can itself."

49. The correct instructions for Mrs A's Ensure prescription were available in her care plan under the section "Swallowing Difficulties" — documented as "Dose: 6 scoops (1 serving)". In addition, the instructions (mix 6 scoops with 195ml of cold water) were specified on the Ensure tin itself, and on the pharmacy labels. Colwyn House confirmed that the pharmacy labels would have been on Mrs A's Ensure tins. Accordingly, I consider that regardless of the confusion around the charting of Ensure, it is reasonable to expect the nursing staff to know that "1" dose in Mrs A's case referred to one serving of six scoops of Ensure.

50. My expert nursing advisor, RN Rachel Parmee, advised:

> "While there was clearly room for confusion in terms of the charting of the Ensure, it is the professional responsibility of the Registered Nurse to apply critical thinking skills and question any prescription using their knowledge of the medication (supplement) and the context of its prescription.
>
> The use of Ensure as a dietary supplement is common in situations such as this and it is noted that there were other residents in the facility taking this supplement. I would expect Registered Nurses to be aware of the recommended dose and immediately question any prescription that fell out of that range unless specifically noted by the prescriber."

51. RN Parmee considered there to have been a "severe departure from the standard of care in terms of the effect on the health of a vulnerable resident, through failing to seek clarification and use critical thinking skills on the part of Registered Nurses". I accept this advice.

52. Mrs A was prescribed Ensure within the context of high levels of activity and severe dementia causing her to refuse to eat, making her at risk of weight loss. This information was known to the staff at Colwyn House, and staff were provided with ample guidance in the form of Mrs A's care plan, the Ensure tin, and the pharmacy labels, to make sure that Mrs A received the correct dosage of the supplement. In order for the supplement to be effective, the intended dosage needed to be provided. In addition, Mrs A was entitled to have her Ensure administered as per her prescription. This did not occur on more than one occasion, for which I am critical.

53. Additionally, I consider that any confusion around the way the Ensure was charted in MediMap should have been clarified with the GP by the registered nurses at Colwyn House. It is concerning that clarification was not sought until 8 Month6, after Mrs A had resided at Colwyn House for five months. I remind the nurses of their professional responsibility to question any ambiguities and raise any concerns they may have.

Failure to act on Mrs A's weight loss

54. As noted above, Mrs A was at risk of losing weight owing to her habits of actively wandering around the rest home, and refusing to be fed when offered food. Weight recordings from the period of Mrs A's admission to Colwyn House on 8 Month1 to 21 Month5 showed that she had lost almost 10kg in the four months she had resided at Colwyn House.

55. An interim care plan for Mrs A was completed on 18 Month2 — almost five weeks after her admission to Colwyn House. The interim care plan was only partially completed, and despite Ensure being one of Mrs A's prescribed medications, the "Oral Meals and Drinking" section of the care plan had not been completed.

56. RN Parmee advised:

> "The standard of practice is that full care plans are completed in full within 3 weeks of admission. In this case an interim care plan was incomplete over 5 weeks after admission. Given that [Mrs A] came with a history of gradual weight loss and severe dementia it was especially important that a clear plan was in place to ensure that her nutritional requirements were being monitored and met."

57. In my view, this also contributed to the failure to monitor Mrs A's weight loss appropriately. Whilst it may not have prevented her weight loss, it may have helped to guide the nursing and care staff at Colwyn House in their care provision to Mrs A, and to minimise the risk of weight loss. A care plan is a basic requirement for consumers in residential care, and I am critical that this was not completed to accepted standards for Mrs A.

58. At the time of these events, Colwyn House had a policy entitled "Weight Loss — Assessment and Management". The policy stipulated that weight loss was to be followed up when it was unexplained or involuntary, or when it exceeded 5% of body weight in a month, 7.5% of body weight in three months, or 10% of body weight in six months.

59. If a resident's weight loss met one of the above thresholds, the policy stipulated the following interventions:

> "
> - The residents GP must be informed …
> - Referral to a Dietician SLT [Speech Language Therapist] will be through the GP — or by nursing staff at the request of the GP …
> - Oral assessment
> - Ensure a food and fluid record is commenced and maintained

- Review care plan and identify goals and interventions
- Evaluate daily or weekly and weigh as frequently as directed by dietetic and medical staff"

60. Mrs A's weight loss first surpassed the 5% weight loss threshold on 11 Month2, when it was recorded that she had lost 4.6kg since her last weighing — 8.2% of her body weight in one month. This should have triggered interventions to manage Mrs A's weight loss, as per the above policy; however, there is no evidence of any action having occurred. Instead, Mrs A's weight continued to be recorded on a monthly basis. On 21 Month5, Mrs A's weight for the month had again surpassed the 5% weight loss threshold, this time losing 10.8% of her body weight.

61. In relation to the deficiencies identified in Mrs A's care planning, and the monitoring of her weight loss, RN Parmee considers there to have been a "severe departure from the standard of care" in terms of planning and implementing care for Mrs A. RN Parmee stated that this was particularly in relation to monitoring and meeting Mrs A's nutritional needs.

62. A number of nurses recorded Mrs A's weight and provided care to her on a day-to-day basis. I am critical that despite her weight loss being documented, it did not result in appropriate interventions, as per Colwyn House's policy, to combat the weight loss. Moreover, having knowledge of Mrs A's gradual weight loss prior to her admission to Colwyn House, as well as her medical and behavioural history, I am concerned about the lack of critical thinking from Colwyn House staff in providing Mrs A with the care she needed. Staff at Colwyn House individually and as a team failed to recognise the seriousness of Mrs A's weight loss, and therefore failed to take action.

63. Had the "Weight Loss — Assessment and Management" policy been followed after Mrs A's first instance of significant weight loss, a food and fluid chart, more frequent weighing, notification to her GP, and a referral to a nutritionist would have been triggered on 11 Month2. I am critical that instead, these interventions were not implemented until four months later, well after Mrs A had surpassed the 5% weight loss threshold.

Conclusion

64. In summary, I am critical of the following aspects of the care provided to Mrs A by Colwyn House:

- The failure to ensure that Mrs A was provided with a complete care plan on admission to Colwyn House in order to guide staff;
- The failure of multiple staff members to administer Mrs A's Ensure in accordance with her prescription and the instructions on the tin and in her care plan;
- The failure to seek clarification of the Ensure prescription until 8 Month6, after Mrs A had resided at Colwyn House for five months; and
- The failure of multiple staff members to act upon Mrs A's evident weight loss, despite it being recorded monthly.

65. In addition, I consider that the nursing staff's actions represent repeated failures to comply with Heritage Lifecare Limited policies and procedures and the requirements in Mrs A's care plan, and show a lack of critical thinking.

66. RN Parmee advised that the Heritage Lifecare Limited policies and procedures are adequate and provided clear guidance around the events related to this case. It is also noted that registered nurses employed in the facility were given an orientation that included access to these relevant policies and procedures. However, as this Office has stated previously,[8] inaction and failure by multiple staff to adhere to policies and procedures points towards an environment that does not support and assist staff sufficiently to do what is required of them and ensure that its residents receive optimal support.

67. The number of Colwyn House staff involved in the care provided to Mrs A suggests a lack of understanding of what was expected, a lack of critical thinking, and a lack of oversight by Colwyn House. In my view, the widespread and repeated nature of these omissions reflects a pattern of poor care and failure to comply with policy, for which ultimately Heritage Lifecare Limited is responsible. Accordingly, for the reasons above, I find that Heritage Lifecare Limited failed to provide Mrs A with services with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[9]

Recommendations

68. I recommend that Heritage Lifecare Limited:

a) Provide educational training sessions to all nursing staff, covering the following topics:

   I. Care planning requirements.

   II. Monitoring and managing residents' nutritional needs.

   III. Administering medication as per a resident's prescription.

   IV. The professional responsibility nursing staff have to question any ambiguities and raise any concerns they may have.

   Evidence that this has been done is to be provided to HDC within six months of the date of this report.

b) Consider whether any of the learnings from this investigation can be translated into improvements throughout its other aged care services, and report back to HDC on its consideration within one month of the date of this report.

[8] See Opinion 16HDC01380.

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

c) Undertake an audit of a sample of 40 residents' weight records to confirm whether the "Weight Loss — Assessment and Management" policy is being complied with in the case of weight loss. Evidence that this has been done is to be provided to HDC within six months of the date of this report.

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

Follow-up actions

69. A copy of this report with details identifying the parties removed, except the experts who advised on this case and Heritage Lifecare Limited (trading as Colwyn House), will be sent to the District Health Board, the New Zealand Aged Care Association, the Nursing Council of New Zealand, and HealthCERT, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from RN Rachel Parmee:

"1. Thank you for the request to provide clinical advice regarding the care provided by Colwyn House to [Mrs A] between 7 [Month1] and 30 [Month6], limited to the management of [Mrs A's] weight loss and falls management. In preparing the advice on this case, to the best of my knowledge, I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

2. I registered as a nurse in 1985. Upon registration I worked as a RN in the Haematology ward at Christchurch Hospital. This included care of acutely ill elderly patients. In 1986 I engaged in study for a Diploma in Social Sciences (Nursing) and worked 2 nights a week in the Oncology Ward at Palmerston North Hospital. On return to Christchurch, I worked as a staff nurse in the Ear, Nose and Throat Ward and became Charge Nurse of that ward from 1987 through to 1992. I then moved to Dunedin and worked as a senior lecturer at Otago Polytechnic during the development of the Bachelor of Nursing programme. I completed my Master of Nursing at Victoria University in 1998. My thesis studied patient education and chronic illness. In 1999 I was appointed Charge Nurse of the Children's Unit at Dunedin Hospital. I returned to Otago Polytechnic in 2001 and was appointed Principal Lecturer and Programme Manager of the Postgraduate Programme in 2003. In 2005 through to 2006 I worked as a sole charge Practice Nurse in a local General Practice. In 2008–2010 I worked as Co-ordinator of Education Programmes for Southlink Health. In 2011 I moved to Christchurch where I worked as an RN in the Hospital wings of 2 large Residential Villages and a senior lecturer at Christchurch Polytechnic specialising in care of the elderly. In 2013, upon return to Dunedin, I worked as a Clinical Co-ordinator at Dunedin Hospital. In 2014, I worked as an Academic Advisor at Otago Polytechnic. In 2015 I worked as Nurse Manager at a local Rest Home. My current role is coordinating courses in the Enrolled Nurse programme at Otago Polytechnic. I am currently a member of the Nursing Council of New Zealand's Professional Conduct Committee.

3. The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by Colwyn House was reasonable in the circumstances and why.

With particular comment on:

1. [Mr A's] concerns regarding the amount of Ensure provided
2. The monitoring of [Mrs A's] weight, and the adequacy and timeliness of the steps taken to address [Mrs A's] weight loss
3. Whether [Mrs A's] falls were appropriately managed between 29 [Month5] and 5 [Month6]
4. Any other matters that I consider warrant comment.

For each question I am asked to advise:

a. What is the standard of care/accepted practice?
b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.
c. How would it be viewed by my peers?
d. Recommendations for improvement that may help to prevent a similar occurrence in future.

4. In preparing this report I have reviewed the documentation on file:

1. Letter of complaint dated …
2. Colwyn House's response dated [2019]
3. Clinical records from Colwyn House from [Month1] onwards
4. Clinical records from [the medical centre]
5. A copy of Colwyn House's policy on nutrition and weight loss.

4. Background

[Mr A] raises concerns about the care provided to his late wife [Mrs A]. [Mrs A] was a resident at Colwyn House, until she passed away on 9 [Month7]. Colwyn House report that [Mrs A's] dose of Ensure was recorded as '1 x 3 Daily' in Medimap since 2017. According to the records provided by Colwyn House, [Mrs A] lost a total of 11.8 kg [over a period of 8 months].

Clinical notes document that [Mrs A] fell on 4 occasions between 29 [Month5], and 5 [Month6].

[Mr A] raises concerns about the dose of Ensure his late wife received, her weight monitoring and the management of her weight and strength loss.

Review of Documents

1. [Mr A's] concerns regarding the amount of Ensure provided

In his letter of complaint (dated …) [Mr A] states that he was told by a staff member that his wife's dosage of Ensure supplement had been reduced from 6 scoops to 1 scoop per serving. He was told this in the context of raising concerns about his wife's significant weight loss (4 kilos in one month) and resulting decreased strength and mobility. Upon further investigation he found that the reduction in dosage was without the knowledge of the GP or facility management.

It appears that the administration of a reduced amount of Ensure was the result of misinterpretation of the GP prescription by Registered Nurses administering the Ensure and ambiguous charting by the GP.

[Mr A] met with [the] (Care Home Manager) on 7th [Month6]. In her follow up letter to [Mr A], [the Care Home Manager] explained that:

- The GP ([Dr B]) had charted the Ensure dose as 1 on the Medimap chart intending this to be interpreted as 1 dose rather than 1 scoop. (1 dose is usually 6 scoops).
- On checking with the Pharmacy, she found that the usual practice was to prescribe the supplement by using the number of scoops rather than doses.
- The packaging of Ensure does not indicate the amount required for a dose, stating 'take as recommended by your doctor or dietitian'.

She also states that while this explains the confusion, it does not excuse the error regarding the dose of supplement and that she had communicated with the GP that in future all Ensure prescriptions are to be indicated by number of scoops.

In her letter to HDC (dated [2019]) [the] (Quality Assurance Lead, Heritage Life) reports the findings of her investigation of [Mr A's] concerns. She notes that on the 18th [Month6] a fax was sent to the GP asking for clarification of the dosage of Ensure. The GP clarified that 1 means a serving of 6 scoops not 1 scoop and that it had been charted that way since 2017.

[The Quality Assurance Lead] also states that of eight RNs asked how they would interpret one (1) dose on Medimap, three said they thought it meant one scoop. She also noted that [Mrs A] was the only resident who had a dose of Ensure recorded on Medimap as 1 — all the others were recorded as 6 or 9 (scoops).

a. What is the standard of care/accepted practice?

While there was clearly room for confusion in terms of the charting of the Ensure, it is the professional responsibility of the Registered Nurse to apply critical thinking skills and question any prescription using their knowledge of the medication (supplement) and the context of its prescription.

The use of Ensure as a dietary supplement is common in situations such as this and it is noted that there were other residents in the facility taking this supplement. I would expect Registered Nurses to be aware of the recommended dose and immediately question any prescription that fell out of that range unless specifically noted by the prescriber.

[Mrs A] was prescribed Ensure within the context of severe dementia causing her to forget or refuse to eat, weight loss and high levels of activity. This would indicate that she would require the recommended dosage to meet the objectives of improved nutrition and weight gain.

I note from the Medications administered record for [Mrs A], that the dosage of Ensure is recorded as (6) after 2 [Month7] and (1) prior to this date. It is difficult to ascertain the amount that was given prior to the change in recording because of variations in interpretation of dose. However, there is clear evidence in [Mrs A's]

weight loss that the supplement was not sufficient to maintain her weight. This evidence should have triggered further assessment.

b. If there has been a departure from the standard of care or accepted practice, and how significant a departure this is?

I believe there to have been a severe departure from the standard of care in terms of the effect on the health of a vulnerable resident, through failing to seek clarification and use critical thinking skills on the part of Registered Nurses.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this.

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

I note that the facility has asked that prescriptions for Ensure are indicated by number of scoops. While this removes the potential for confusion in this case, there is also the need to raise the level of Registered Nurses' knowledge of medications/supplements in terms of their dosage and interactions and their professional responsibility to question any ambiguities.

2. The monitoring of [Mrs A's] weight, and the adequacy and timeliness of the steps taken to address [Mrs A's] weight loss

In her response to [Mr A] (30th [Month6]) [the Care Home Manager] acknowledges that Colwyn House did not follow correct procedures when [Mrs A] lost weight. In particular, the requirements for a short-term care plan, food and fluid record and weekly weighs were not implemented until she reviewed [Mrs A's] file on the 6th [Month6].

[The] (Quality Assurance Lead) in her letter dated [2019], provides documentation of the monitoring and interventions related to [Mrs A's] weight loss between 23 [Month1] and 30 [Month6]. There are several significant inadequacies in this documentation. These include:

- A change in weight of 9.8 kg over a five-month period (recorded on same scales) with no evidence of implementing relevant Life Care Nutrition Policy guidelines.
- An incomplete interim care plan which excluded the oral meds and drinking section. The incomplete interim care plan was posted on 18th [Month2], 38 days after [Mrs A's] admission on 09 [Month1]. InterRAI assessments completed prior to [Mrs A's] admission referred to a gradual decline in weight over the previous 12 months.
- Food and fluid and weight loss charts not commenced until 03 [Month6]. Following this, entries were found to be inconsistent at a time when [Mrs A] was recorded as being too unwell to eat.

- A dietician referral and short-term care plan relating to [Mrs A's] weight loss were not implemented until the 15th and 17th [Month6] respectively after [Mrs A] having lost 17.5% of her body weight.

a. What is the standard of care/accepted practice?

The standard of practice is that full care plans are completed in full within 3 weeks of admission. In this case an interim careplan was incomplete over 5 weeks after admission. Given that [Mrs A] came with a history of gradual weight loss and severe dementia it was especially important that a clear plan was in place to ensure that her nutritional requirements were being monitored and met.

The Heritage Lifecare Resident Nutrition Policy provides a weight loss calculation with a threshold of 5% loss over one month triggering the following interventions:

- GP to be informed to assess for malnutrition and/or dehydration
- Referral to Dietician
- Ensure food and fluid chart commenced and maintained
- Review of care plan
- Evaluate daily or weekly and weigh as frequently as directed by dietetic and medical staff.

It appears that, although these interventions were eventually implemented it was well after the 5% weight loss threshold had been passed and not on the initiative of Registered Nurses responsible for planning the care of [Mrs A].

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.

I believe there to have been a severe departure from the standard of care in terms of planning and implementing care for [Mrs A], particularly in relation to monitoring and meeting her nutritional needs.

c. How would it be viewed by my peers?

My peers in education and practice would agree with my findings.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

In her letter to [Mr A], [the Care Home Manager] reassures him that [Mrs A] was supplied with further nutritional supplements and a commitment to monitor her weight weekly.

There also needs to be education of Registered Nurses about their responsibilities to adhere to care planning requirements and ensure that they follow Facility policy in relation to monitoring and management of residents' nutritional needs.

3. Whether [Mrs A's] falls were appropriately managed between 29th [Month5] and 5th [Month6]

In his letter of complaint [Mr A] states that he was not made aware of the 3 falls that his wife experienced in one week and was concerned that the manager was not aware of this.

In her response letter dated [2019], [the Quality Assurance Lead] refers to incident and event reports related to [Mrs A's] falls.

This information states that [Mrs A] had the following falls

- 29th [Month5], unwitnessed fall and EPA notified
- 31st [Month5] witnessed fall. No record of notification of relatives
- 5th [Month6], unwitnessed fall. No record of notification of relatives

Progress notes for 29th [Month5] 31st [Month5] and 5th [Month6] all provide detail of the fall, assessments completed, interventions and note under the heading 'Family' that EPOA was notified.

While there is a discrepancy in terms of the incident reports provided in Appendix 2 and the notes in the progress notes, it does appear that [Mr A] was notified of [Mrs A's] falls. There is also a note in the progress notes of the 6th [Month6] recording a conversation with [Mr A] regarding ways to prevent further falls which would indicate that he was aware of [Mrs A's] recent falls.

a. What is the standard of care/accepted practice?

The Heritage Lifecare Falls — Prevention and Management document provides a post fall management procedure. The information provided in the progress notes for each fall indicates that this procedure was followed including notifying EPOA.

b. If there has been a departure from the standard of care or accepted practice, and clearly identify whether I consider the departure to be mild/moderate/severe.

There does not appear a departure from accepted practice in relation to the management of [Mrs A's] falls between 29th [Month5] and 5th [Month6].

c. How would it be viewed by my peers?

My peers in education and practice would agree with my findings.

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

My only recommendation would be that the method of contact of EPOA is recorded along with time and the name of the person contacted.

4. Any other matters in this case I consider warrant comment

There are no other matters that I consider warrant attention.

Rachel Parmee
RGON"

The following further expert advice was obtained from RN Parmee:

"Re: C19HDC01030

Thank you for the opportunity to review this case for which I provided initial advice on the … 2020.

I have received the following information:

1. Response from Colwyn House dated … 2020 written by [the] (GM — Clinical and Quality, Heritage Lifecare) which includes:
   - Comment on my initial advice,
   - Report of an internal investigation,
   - Registered nurse job description
   - Medication Administration Policy
   - Policy on Visits by Medical practitioners
   - Nutrition and Hydration Policy
2. Email from Colwyn House written by [the] (Quality Assurance Manager, Heritage Lifecare

You have requested that I view this information and advise whether it changes any aspects of my initial advice, and comment on the following:

1) The adequacy of the changes made at Colwyn House since these events
2) The adequacy of the record keeping at Colwyn House.
3) The adequacy of the relevant policies and procedures in place at Colwyn House at the time of these events.
4) Any other matters in this case that you consider warrant comment/to be a departure from the accepted standards.

I also note that you have sought general practitioner (GP) advice on the care provided by the GP who prescribed the Ensure, and no concerns were identified.

Comments on my initial advice
I maintain that my comments on the interpretation of the GP prescription and expectation that RNs should question an unusual prescription are valid. This is borne out by:

- the advice HDC received about the care provided by the GP who prescribed the Ensure and
- information provided in the email from [the Quality Assurance Lead] which identifies that the dosage information was freely available to the registered nurses.

I also maintain that the Ensure was prescribed to enhance [Mrs A's] nutrition and that in order for this to be effective the intended dosage needed to be provided.

I do not accept that International Registration can be justified as a reason for not meeting the expectation that a Registered Nurse seek clarification and use critical thinking skills. As the email from [the Quality Assurance Lead] confirms the dosage information was, in fact, available on the Ensure can.

The information provided in the response and subsequent email does not alter my initial advice.

The adequacy of changes made at Colwyn House since these events

[The GM — Clinical and Quality] notes the introduction of a Nutrition and Hydration policy which provides clear pathways for nutrition assessment and monitoring. It also provides parameters for reporting and seeking further professional input in the event of weight loss.

The introduction of this policy along with further information to staff about Ensure are relevant and adequate changes.

The adequacy of record keeping at Colwyn House

The information provided in the internal investigation indicates gaps in the interim care planning documentation, particularly around oral meals and drinking. It is also noted that progress notes did not describe food and fluid intake.

Monitoring of [Mrs A's] weight is recorded on at least a monthly basis which meets the accepted standard for weight monitoring. It is noted that there were measures put in place in response to [Mrs A's] weight loss such as a food and fluid chart, weekly weighing, short term care plan and referral to a dietician.

The review found that there was irregular documentation when [Mrs A] was acutely unwell, lack of short-term care plans, inadequate monitoring of bowel status and inadequate reference to [Mrs A's] health status being discussed with her husband.

As I have noted there is evidence of some good record keeping, however inconsistencies in other areas mean that the record keeping is inadequate. There is a need for consistent record keeping ensuring that practice is clearly documented and able to be audited.

Adequacy of relevant policies and procedures in place at Colwyn House at the time of these events

The policies and procedures provided are adequate and provided clear guidance around the events related to this case.

As noted by [the Quality Assurance Lead] registered nurses employed in the facility were given an orientation which included access to relevant policies and procedures.

I have not identified any other matters which warrant comment.

Rachel Parmee"

Appendix B: In-house advice to the Commissioner

The following expert advice was obtained from Dr David Maplesden:

> "Thank you for the request that I provide clinical advice in relation specific aspects of [Mrs A's] care by [Dr B].
>
> ***1) Whether there are any prescribing concerns in relation to [Dr B's] prescribing of Ensure.***
>
> [Mrs A] had been residing in Colwyn House (CH) since [Month1]. She suffered from end-stage dementia. She had been taking Ensure as a nutritional supplement prior to her admission to CH and GP [Dr B] continued to prescribe this in the same manner she had done previously. I have viewed copies of the prescriptions provided to [the] Pharmacy in [Month1] and [Month4]. The instructions are all as recorded below:
>
> **Ensure Powder 850g (new formulation, chocolate) [1]**
> Sig: add 6 level scoops to 195ml of cold water and mix until dissolved, tid1 serving tid, or as able
> Mitte: 3 mths
> (Generic Substitution Allowed)
>
> I would expect the pharmacy to fix a label on each can of Ensure dispensed with these instructions clearly visible on the label (this might need to be checked with the pharmacy but given the Ensure was prescribed rather than bought over the counter I think this should be the case). I would expect nursing staff to follow the instructions or, if there appeared to be a discrepancy between the instructions on the label and those appearing on the prescribing chart, for the nurse to query the discrepancy with the prescriber or pharmacy. The instructions as noted above are quite clear and mirror the prescribing instructions in the NZ Formulary[1] which read: *Standard dilution (1 kcal per mL) add 6 level scoops of powder (approximately 53.5 gram) to 195 mL of water to yield 230 mL; for more concentrated liquid, see product literature.* Nutritional supplements are widely used in long-term care facilities and I would expect nursing staff to be familiar with 'usual' doses of these products, and to query if their perception of a dose appeared to differ significantly from the norm (which it did in this case). [Dr B] notes in her response dated … 2020 that in addition to providing the pharmacy with the prescriptions noted above, she prescribed [Mrs A's] Ensure in Medimap as '1 dose' TDS with the assumption being staff would recognise a standard dose as being 6 scoops in 230 mL. She had prescribed [Mrs A's] Ensure in this manner at her previous rest home with no issues arising. I am not familiar with the capabilities of Medimap in terms of flexible prescribing, but the prescribing module in some PMSs would not allow as standard the dosing term 'scoop' and this would require clarification in a free text field if available. With the benefit of hindsight, clarification of the term 'dose' in this instance might have prevented confusion although I am also

[1] https://nzf.org.nz/nzf_70119 Accessed 30 June 2020

of the view that nursing staff should have been familiar with what constituted a standard dose of Ensure as discussed above, and the prescribing GP would reasonably expect this familiarity and also that administration instructions would be visible in a label on the can itself as discussed above.

2) Whether there are any communication issues between [Dr B] and the rest home.

Aside from the misunderstanding regarding Ensure dosage communication from [Dr B] to rest home staff appears very reasonable based on my review of the clinical notes. There may have been a delay in rest home staff notifying [Dr B] of [Mrs A's] rapid weight loss between [Month3] and [Month5].

3) Whether there are any concerns regarding [Dr B's] follow up of [Mrs A's] weight loss.

[Dr B] was aware of [Mrs A's] weight loss from 2017 and this was reasonably attributed to [Mrs A's] dementia and associated feeding difficulties. A standard and acceptable approach was taken by [Dr B] to management of this component of [Mrs A's] illness by way of nutritional supplements and monitoring. Dementia is a well-recognised cause of weight loss and weight loss accrues with dementia severity. It may in part be explained by reduced food intake because of impaired autonomy, eating disturbances, and reduced appetite but other mechanisms underlying weight loss in dementia remain unclear[2].

4) Any other matters that you consider warrant comment or amount to a departure from the accepted standard of care.

I have no additional comments or recommendations regarding the care provided to [Mrs A] by [Dr B]."

[2] Albanese E et al. Dementia severity and weight loss: A comparison across eight cohorts. The 10/66 study. Alzheimers Dement. 2013; 9(6): 649–656.