Summerset Care Ltd

Nurse Manager, Ms C

A Report by the

Health and Disability Commissioner

Case 08HDC20829

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mrs A, aged 85 years, was discharged from a public hospital to the care of Summerset Trentham Rest Home and Hospital (Summerset Trentham).[1] She had been admitted to hospital following a fall, and had been treated for pneumonia. The hospital discharge summary stated that Mrs A's hydration must be carefully monitored.

Over the next seven days, Mrs A's hydration was not well monitored, and her condition deteriorated. Mrs A's welfare guardian was not informed of the change in her condition or of the decision to administer antibiotics. Mrs A began coughing purulent sputum and was re-admitted to hospital, where she died six days later, of dehydration and respiratory arrest.

Complaint and investigation

On 18 December 2008, the Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother by Summerset Care Ltd. An investigation of the following issues was commenced on 3 April 2009:

- *Whether Summerset Care Ltd, Trentham provided health care of an appropriate standard to Mrs A over a period of a week in mid-2008.*
- *Whether Summerset Care Ltd, Trentham communicated appropriately with Mrs A's welfare guardian, Ms B, over a period of a week in mid-2008.*
- *Whether Nurse Manager Ms C provided health care of an appropriate standard to Mrs A over a period of a week in mid-2008.*
- *Whether Nurse Manager Ms C communicated appropriately with Mrs A's welfare guardian, Ms B, over a period of a week in mid-2008.*

The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant
Ms C	Provider/Nurse Manager
Summerset Care Ltd	Provider
Dr D	General practitioner
Ms E	Registered nurse
Ms F	Mrs A's friend

[1] Also known as "Summerset at the Course".

Information was reviewed from:

Summerset Care Ltd
A Barrister on behalf of Ms B
The District Health Board
Ministry of Health

Ms C chose not to respond to Ms B's complaint, or provide information during the investigation.

Independent expert advice was obtained from registered nurse Wendy Rowe, and is attached as Appendix A.

Information gathered during investigation

Mrs A
In June 2008, Mrs A, aged 85 years, was living at home with significant support from her church, family and carers. Her daughter, Ms B, had been appointed Mrs A's welfare guardian and property manager from 17 September 2007.

On 11 June 2008, Mrs A was admitted to the public hospital following a fall, and remained in hospital for four weeks. During this time, she developed pneumonia and was successfully treated with antibiotics. She had an in-dwelling catheter (IDC) inserted, and was also assessed as requiring full-time hospital care.

Summerset Trentham
Summerset Trentham is a large facility, with a range of accommodation options including 92 self-contained villas, 12 apartments, 20 serviced apartments, and 40 rest-home beds, including hospital-level care beds.

Summerset Trentham is part of the Summerset Care Ltd group of retirement complexes situated throughout New Zealand. Summerset Trentham uses policies and processes that are generic to the Summerset Care Ltd group.

Nurse Manager Ms C
Ms C graduated as a registered nurse in 2004 and has been involved in the care of the elderly since registration. She was employed as Nurse Manager of Summerset Trentham from 9 June 2008 to 2 September 2008, and had previous experience at other Summerset Care Ltd rest homes.

The position description for Nurse Manager states:

> "The Nurse Manager is responsible for motivating and organising a team of staff who are responsible for the delivery of health based services throughout

> the Village to support the customers to live a safe, satisfying and dignified life within the Summerset Village."

The position description goes on to state the values to be promoted by the Nurse Manager:

> "People First: The customers, staff and people ... are the primary focus of the [Nurse Manager's] position and is to ensure that they are contented, their issues are listened to and addressed and they feel that they can contribute to the success of Summerset."

Mrs A's admission to Summerset Trentham

On a Tuesday in mid-2008, Mrs A was discharged from a public hospital to Summerset Trentham, in a stable condition. Her transfer to Summerset Trentham was authorised by Nurse Manager Ms C. Mrs A's hospital discharge summary noted a primary diagnosis of reduced mobility, and a number of other medical conditions.[2] An entry under post-discharge follow-up arrangements instructed:

> "Caregivers please note — [Mrs A's] fluid intake needs to be carefully managed or she will dehydrate. Please maintain a daily intake chart. If her oral intake by 7pm is less than 800ml she will require a 1000ml bag of normal saline sub-cut[aneous] ... to run overnight."

Ms B had spoken to Ms C by phone prior to her mother's admission about monitoring her mother's fluid intake. Ms B indicated that Ms C did not appear to consider this a problem.

Mrs A was transferred to Summerset Trentham by ambulance, accompanied by Ms B. She arrived at approximately 10.30am, and was admitted by registered nurse Ms E. Ms E showed Mrs A to her room, and documented her admission details, medical history, and current care needs in the progress notes. Specifically, Ms E noted:

> "Needs pushed fluids as is reluctant to drink ... Fluid balance chart in place as this resident is prone to dehydration."

Nurse Manager Ms C documented a care and support plan to record Mrs A's specific needs (including hygiene, mobility, incontinence, dementia, hearing and sight impairment and transient ischemic attacks (TIAs)), to guide staff caring for her. Ms C commenced a hydration chart for Mrs A, which was placed in her room, but did not document the hospital's discharge instructions in the care and support plan.

Ms C telephoned Summerset Trentham's GP, Dr D. As Dr D was engaged by the rest home to visit every Wednesday morning, it was arranged that he would assess Mrs A on his scheduled visit the next day. Dr D was also available on an as needed basis and in his absence the facility is covered by the local medical centre.

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[2] Including recent recurrent falls, dementia, osteoarthritis in her left hip and lumbar spine, osteoporosis, hearing loss, cataract and decreased vision, and a history of TIAs and gastric ulcer perforation.

Although Ms C documented that she wrote on the whiteboard in the nurses' station and verbally advised care staff that Mrs A's fluid balance chart must be completed, no entries were made after 2pm. Night care staff documented in the progress notes "fluids encouraged", but did not document any intake in the fluid balance chart. The fluid balance chart recorded an intake of only 200mls for Tuesday.

Dr D assessed Mrs A on Wednesday and noted the post-discharge instructions in Mrs A's prescribed medication chart and in the medical continuation notes. Dr D made a note that Mrs A was prone to dehydration and required accurate fluid balance charting. He also repeated the direction to administer subcutaneous fluids overnight if 800mls had not been taken orally by 7pm.

Throughout the day, care staff documented in the hydration chart that Mrs A had an intake of 670mls before 7pm, and a total input of 920mls, with her IDC draining 1000mls. The night nurse noted in the progress notes that "[it is important] that [Mrs A] has a minimum of 800mls/24 hours".

On Thursday, staff noted that Mrs A's fluid intake was "good" but documented a fluid intake of only 550mls, with an IDC output of 500mls. The night nurse documented in the progress notes that Mrs A had not taken sufficient fluids, but took no action to administer additional oral or subcutaneous fluids, as per the prescribed treatment plan.

On Friday, staff again documented that Mrs A's fluid intake was "good", but documented in the fluid balance chart an input of only 770mls and an IDC output of 500mls. The night nurse documented that Mrs A's intake was adequate, although it had not been accurately recorded in the fluid balance chart, noting "this is really important for all staff to maintain". An undated note on the hydration chart reads "This must be completed daily — 800ml intakes needed — very important".

On Saturday, staff documented in the progress notes that Mrs A "drank well", but only 100mls input was recorded in the fluid balance chart all day. The night nurse again documented her concern:

> "This resident must have a minimum 800ml/24 hours ... will be forced into having [subcutaneous fluids]. This is extremely bad care. Please maintain the hydration chart correctly."

However, the night nurse did not initiate the prescribed treatment plan and administer subcutaneous fluids to Mrs A.

Ms B became concerned that her mother's condition was deteriorating and spoke to staff on Friday and Saturday, raising concerns that her mother needed to be assessed by a doctor and placed on antibiotics for pneumonia, that her fluid intake was poor, and that she was unable to take oral medications. Ms B was told that her mother would be seen by Dr D at his next weekly visit. Ms B recalls advising the nurse on duty that her mother required medical attention much sooner than the planned GP review. Following this conversation she expected that her mother would receive a GP

visit on Saturday or Sunday. This discussion was not recorded in Mrs A's notes, although Summerset accepts that it took place.

The next day, Mrs A refused to eat lunch, but her food and fluid intake during dinner was recorded as "good". No fluid intake was documented before 7pm and, although night carers recorded a total input of 800mls in the fluid balance chart, times were documented only once. The progress notes state that Mrs A passed urine in the morning, and in the evening passed "urine mixed with blood". However, only one 300mls IDC output is documented in the fluid balance chart.

Deteriorating condition
On Monday, during a visit from Ms F, a family friend who is a registered nurse with experience in geriatric care, Mrs A was noted to be coughing up "purulent blood-tinged sputum", and the registered nurse on duty was notified. Ms F asked the nurse if the doctor would be able to come and see Mrs A and was told that the next scheduled visit was for Wednesday. The progress notes document that Mrs A was unwell, with a "rattly" chest and coughing up yellow blood-tinged sputum.

The nurse sent a fax to Dr D at approximately 1.30pm, describing Mrs A's condition. Dr D responded with a prescription for antibiotics at around 2.15pm.

Before Ms F left, she again queried whether Mrs A would be seen by a doctor that day and was told by the nurse that he had sent a fax to the doctor, but had not heard back. As she was still concerned, Ms F telephoned Ms B to inform her of the situation.

Later that evening Ms B visited her mother and found that she had deteriorated badly since her last visit two days earlier. Ms B had not been contacted by staff at Summerset Trentham. She recalls that the family "thought that something would have been done [over the weekend] and that she would have received medication".

Ms B found the nurse manager, Ms C, and told her that her mother needed antibiotics immediately, and reminded Ms C that her mother had had pneumonia at the public hospital. Ms B asked whether Summerset Trentham had any medication on the premises. Ms C informed her that they did, but that it could not be administered as there had been no reply to faxes sent to the doctor.

Despite her illness, Mrs A's fluid intake on Monday was noted to be "good", with an input of 850mls before 7pm and 1350mls total. IDC output of 750mls was also documented in the fluid balance chart. Evening staff documented in the progress notes that they "pushed fluids", although some documented input, such as "drank 200ml", does not correspond with entries in the hydration chart.

Re-admission to the public hospital
Dr D's prescription was administered to Mrs A from Summerset Trentham's own supply at around 6.30pm, and care staff updated Ms B on her mother's condition.

Mrs A deteriorated rapidly and was transferred back to the public hospital by ambulance shortly before midnight.

Ms B was contacted by Summerset prior to the transfer and met her mother at the hospital in the early hours of Tuesday. She recalls that her mother was in severe pain, and her urine was "dark brown". Over four to five hours, Ms B fed her mother four cups of water, noting that she was "very dehydrated".

Mrs A was admitted to hospital, and administered antibiotics. However, she did not recover, and died a few days later. The cause of death was recorded as dehydration and respiratory arrest, bibasal pneumonia and advanced dementia.

Subsequent actions

Summerset Care investigation and improvements
After receiving Ms B's letter of complaint, Summerset Care conducted its own investigation into the allegations. It accepts that there were deficiencies in compliance with internal policies and documentation, in particular:

> "[T]hat there are missing entries in the hydration chart on [Tuesday], that the entries on [Wednesday] are not as clear as they might have been, that entries on [Thursday] total 550mls, that there are significant issues with the single entry on [Saturday] for 100mls and that entries on [Sunday] are unclear ... neither the hydration chart nor [Mrs A's] progress notes refer to a review of [Mrs A's] fluid intake or to any decision on whether or not to administer a saline bag overnight."

However, Summerset Care submitted:

> "Nursing staff assure us that, despite the clear shortcomings in the maintenance of the hydration chart, fluids were administered in accordance with the clinician's instructions."

As a result of its internal investigation, Summerset Care has made the following improvements at Summerset Trentham:

1. Conducted in-service training on:
    a. Long- and short-term care plan development and management
    b. Admission procedures
    c. Initial care and support planning
    d. Professional standards of practice including the Code of Conduct for nurses
    e. Medication administration
    f. Subcutaneous administration procedure and unwell or injured resident procedure.
2. The following policies and procedures have been reviewed and updated:
    a. Fluid balance charting
    b. Advance directives

c. Subcutaneous hydration

d. Clinical handover

e. Medication

f. Informed consent

g. Nutrition

h. Management of unwell residents

i. District health board discharge summary.

3. All registered nurses (including agency nurses) have completed drug competency tests.

4. 24 staff members are completing the National Certificate in "Support of the Older Person".

5. Two caregivers and one registered nurse are undertaking a palliative care course. Further staff enrolment is planned.

6. Staffing levels have been increased. Caregiver staffing has risen from 1:7 to 1:5.

7. Additional permanent staff have been recruited to fill vacant positions previously filled by agency staff. Summerset is now fully staffed.

8. An automated robotic system has been introduced for medication administration, to reduce the chance of medication errors occurring.

9. A training programme for staff on obtaining informed consent has been developed, and commenced from December 2009.

Ministry of Health audit

On 19 November 2008, HealthCERT conducted an unannounced inspection of Summerset Trentham, after receiving complaints about the care provided to residents.

The audit found a number of service areas where corrective action was required to comply with Health and Disability Sector Standards. An implementation plan was required to be submitted to the Director-General of Health within one month of the inspection report being received by Summerset Care Ltd.

Areas that required action included: removing means of taking short-cuts that could endanger resident safety; reviewing policies and procedures and incident reporting particularly to ensure adequate detail to identify residents at risk of relapsing after illness; documenting unplanned hospital admissions on incident forms; ensuring complaints are managed as per Summerset policy; ensuring that families are engaged in decision-making, and that communication with them is documented; ensuring regular review of resident progress notes and indicators of well-being (eg, weight) and implementing short-term care plans where necessary; ensuring frequent assessment, monitoring and observation of unwell residents; and ensuring that the storage and administration of medicines complies with legislation, regulations and guidelines.

In February 2009, Summerset Care Ltd submitted an implementation plan to address the shortcomings identified by the HealthCERT audit. On 10 April 2009, the Ministry of Health advised that Summerset Trentham had attained many of the Health and Disability Sector Standards, and it would continue to liaise with the Summerset Area Manager until all sector standards were met.

In June 2009, Summerset submitted a progress report to HealthCERT. It was accepted with no request for additional changes.

Apology
Ms B advised that Summerset approached her to meet to discuss her complaint. A meeting at Ms B's home took place on 1 December 2009. During the meeting Summerset Care's CEO advised Ms B that "Summerset accepts that the care provided to [Mrs A] fell below the standards we set ourselves". The CEO also apologised to Ms B. In a letter to Ms B dated 4 December 2009, the CEO reiterated Summerset's apology and outlined the actions taken to improve its services.

Ms B advised HDC that the apology came too late, and she remains concerned "that the lack of care and consideration by Summerset and its staff toward her mother" resulted in her family "losing their mother (and grandmother), so soon".

Relevant standards

Summerset 'Fluid Balance Charting Procedure':

"— Volumes and time of recording are recorded in the appropriate squares immediately after measuring

— Other staff should be aware of the need to monitor the resident's intake and output.

— Lifestyle Plan should provide up to date details of his/her fluid requirements

— Intake and output columns:

…

- Record fluids as they are given…"

Summerset 'Resident's Records and Information Policy':

"… Nursing documentation

... [A]n accurate medical record must be maintained to facilitate efficient and effective resident care and evaluation.

…

> The resident's progress notes and health problems are to be concisely and accurately recorded to ensure all relevant members of the health care team are kept informed and of a high standard…
> …
> Progress notes:
>
> Progress notes are to be completed for every resident by the caregiver for every shift.
> …
> Other records relevant to the resident such as [hydration charts] are to be completed at the end of each shift and kept in the resident's file."

Summerset 'Informed Consent Policy' states:

> "Residents/family/whanau are to be kept fully informed of their rights and their health condition.
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> Three essential elements for informed consent are:
>
> - Effective communication and documentation of meetings/discussions in the medical notes between all parties;
> - The provision of all necessary information that is easily understood to the resident/family or welfare guardian about options risks and benefits;
> - The residents/welfare guardian gives voluntary and informed consent."

Opinion: Breach — Summerset Care Ltd

Standard of care
Mrs A was a frail elderly woman, recovering from a long hospital stay, when she came to Summerset Trentham. Her medical history and current need for active hydration management was explicitly stated in the discharge summary from the public hospital.

Nursing and care staff had strict medical instructions from the public hospital and the rest home's contracted GP, Dr D, that Mrs A's oral fluid intake needed to be carefully monitored, and that she required 1000mls of subcutaneous fluids if she had not consumed 800mls before 7pm. The prescribed management and treatment plan was clear, and yet it was not followed by staff. My expert, Wendy Rowe, advised:

> "Subcutaneous fluids should have been given each day following the day of admission. There were a number of [registered nurses] who could have made this decision."

With the exception of her last day, Mrs A's oral intake recorded in the fluid balance sheet was inadequate, yet she was never administered subcutaneous fluids. The hydration chart was never reviewed in the progress notes and, although staff were aware that Mrs A's oral intake was insufficient and that she should be administered subcutaneous fluids, they never took steps to provide additional hydration, as per the prescribed treatment plan. Ms Rowe advised:

> "The tasks that the staff were unable to perform were of a very basic nature and did not require advanced knowledge and skills. There was no need for the staff to make a decision about how to manage [Mrs A's] hydration status as this had already been clearly documented by the medical practitioner. What they failed to do was carry out a prescribed treatment plan. This repeatedly put [Mrs A] at risk of dehydration and led to a slow but significant decline in her general status."

Despite Ms B raising concerns about her mother on Friday and Saturday, and specifically requesting that she be seen within 48 hours by a general practitioner, Mrs A did not receive a medical assessment until she became gravely ill on Monday and was admitted to hospital. Both Ms B and Ms F had noticed visible deterioration in Mrs A's condition and brought their concerns to the attention of Summerset Trentham staff. Ms Rowe advised that Mrs A's deterioration should have been acted on more promptly:

> "[Mrs A's] needs were high and complex and she required close monitoring. With the addition of appropriate fluids she may not have deteriorated as quickly as she did. This may have given the nursing staff more time to establish whether her deterioration was due to her age and complex medical history or her recent chest infection and dehydration. There is no clear evidence that suggests that [Mrs A] was well hydrated or that she had been closely monitored by the registered nurses within this facility."

In previous cases HDC has noted the importance of DHBs having systems to help staff identify and respond to patients who become physiologically unstable.[3] The same is true for rest homes providing hospital level care. The key requirements are to recognise when a patient is deteriorating and respond promptly and appropriately.

Given Mrs A's recent hospitalisation and her recognised status as a high risk patient, the nursing staff had an inappropriately high threshold for seeking medical intervention outside of the weekly visits of Dr D. It is concerning that Summerset Trentham did not have a clear system in place for ensuring that a doctor be called to assess a vulnerable patient when her daughter and a friend, both of whom were familiar with Mrs A's health, had expressed significant concern about her condition and requested a medical assessment. Coupled with the deficiencies in monitoring her condition, this resulted in Mrs A not receiving the services she needed at Summerset Trentham.

[3] Case 05HDC11908 at pages 48–50; case 06HDC19538 at page 8; case 07HDC21742 at pages 13–14; case 08HDC03994 at pages 10 and 11, case 08HDC17125 at pages 23–24.

Nor was Mrs A's IDC appropriately managed. Her IDC output was recorded only once per 24 hours in her hydration chart. Ms Rowe advised that "IDCs should be emptied once per shift to indicate urinary flow and signs of retention".

Documentation
Mrs A's care and support plan did not note any instructions relating to fluid management, and the hydration chart and progress notes were not accurately completed by staff.

Although staff have assured Summerset Care management that Mrs A was adequately hydrated, this is hard to believe without adequate and accurate documentation to support their claim. Ms Rowe commented:

> "If the progress notes and care and support plan had clearly demonstrated the care being provided for [Mrs A], the lack of accurate hydration chart would not have been such a big issue. Unfortunately none of this documentation is completed to a reasonable standard."

The failure to accurately document Mrs A's input and output was in breach of the Summerset 'Fluid Balance Charting Procedure' and 'Resident's Records and Information policy'.

Staff failed to document in the progress notes conversations with Ms B on Friday and Saturday, during which she raised concerns about her mother's condition and ability to take oral medications. Ms B's request that her mother be promptly evaluated by a doctor was similarly not recorded. Summerset Care accepts that there "should have been" a record of Ms B's discussions with staff.

Information provided to welfare guardian Ms B
Ms B had been appointed Mrs A's welfare guardian and property manager from September 2007. Summerset was made aware of her appointment when Mrs A was admitted. Clause 4 of the Code of Health and Disability Services Consumers' Rights (the Code) states that for the purpose of Right 6, "consumer" includes a person entitled to give consent on behalf of that consumer. This includes a welfare guardian.

Ms B was not contacted by the Summerset Trentham staff to tell her about her mother's deteriorating condition until she had become very ill on Monday evening. Despite being sufficiently concerned to contact Dr D that afternoon, staff did not immediately alert Ms B about the change in her mother's condition. Staff should have involved Ms B in decisions about her mother's care in accordance with Summerset's informed consent policy and Right 6(1) of the Code.[4]

[4] Right 6(1) of the Code states:
(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including —
(a) An explanation of his or her condition …

Conclusion

The risk of Mrs A dehydrating was clearly identified in her hospital discharge notes, and clear instructions had been recorded about how to minimise this. Despite this, staff caring for Mrs A at Summerset Trentham failed to comply with those directions, and the rest home's policies.

It is of considerable concern that, despite the clear direction in her discharge summary, care plan and, repeatedly, in her notes, Mrs A's fluid chart was not correctly filled out, her catheter was not monitored properly, and she was not administered subcutaneous fluids despite repeatedly reaching the point at which it was directed that they be administered.

Summerset Trentham submitted that this was an exceptional case. However, I note that a disturbing culture of non-compliance with clear internal policies and procedures is evidenced in several recent HDC reports involving various rest homes.[5] All rest homes need to take steps to ensure compliance with internal documents and directions that regulate residents' care.

Care plans, policies and other documentation should not be generated solely to fulfil auditing requirements. They should form the basis of regular care and ongoing staff training. Through its failure to adequately educate and supervise its staff, Summerset Trentham failed to care properly for Mrs A when she was at her most vulnerable.

By failing to provide an adequate standard of care to Mrs A, consistent with her needs and in compliance with Summerset Trentham's policies, and for failing to maintain adequate documentation and obtain medical intervention in a timely manner, Summerset Care Limited breached Rights 4(1), (2) and (3) of the Code.[6]

By failing to appropriately update Ms B on Mrs A's condition, Summerset Care breached Right 6(1) of the Code.

Opinion: Breach — Ms C

As nurse manager, Ms C had overall responsibility for managing care staff and ensuring that residents were provided with an adequate standard of care. Her clinical responsibility included ensuring that Summerset Trentham policies were followed, and documentation relating to residents was properly completed by staff. Ms Rowe advised:

[5] See cases 07HDC16959 and 08HDC17105.

[6] Right 4 of the Code states that:

(1) Every consumer has the right to have services provided with reasonable care and skill.

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

> "The Nurse Manager has overall responsibility for patient care delivery ... During [Mrs A's] admission it seems that no one took responsibility to monitor her general condition (that included her hydration status) or to adequately assess her condition and then act when it was obvious she was becoming dehydrated and required re-assessment by a medical practitioner."

Ms C's job description included an expectation she would "ensure that [residents] are contented, their issues are listened to and addressed ...". It is very clear that Mrs A was not contented, and the issues raised by her welfare guardian were neither listened to nor addressed.

Ms C must accept responsibility for her own failings and those of her staff. Throughout her seven-day stay at Summerset Trentham, Mrs A was not provided with adequate care, and the documentation of her care was haphazard and incomplete. On Monday, Ms C herself failed to document a discussion with Ms B, during which she agreed that Mrs A required antibiotics. She also told Ms B that no reply had been received from the doctor, despite a faxed prescription for antibiotics having arrived around four hours earlier.

Ms C did not provide Ms B (Mrs A's welfare guardian) with sufficient updates about her mother's condition, and she gave an inaccurate answer to Ms B's questions about the involvement of the doctor on Monday.

In these circumstances Ms C breached Rights 4(1), (2) and (3) and Rights 6(1) and 6(3) of the Code.[7]

Recommendations

I recommend that Summerset Care Ltd:

- Undertake training of staff in obtaining informed consent to treatment, with particular focus on obtaining consent from welfare guardians and persons holding Enduring Power of Attorney for a resident. Evidence that such training has been completed is to be provided to HDC by **15 February 2010**.

I recommend that Ms C:

- Apologise to Ms B for her breaches of the Code. A copy of the letter of apology is to be sent to me to forward to Ms B by **15 February 2010**.

[7] Right 6(3) of the Code states:
(3) Every consumer has the right to honest and accurate answers to questions relating to services …

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand.

- A copy of this report with details identifying the parties removed, except the names of the expert who advised on this case and Summerset Care Ltd and Summerset Trentham, will be sent to HealthCERT (Ministry of Health), the District Health Board, and the Retirement Villages Association of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A

Independent advice to Commissioner

The following expert advice was obtained from Wendy Rowe:

[Please note that in the interests of readability, page and appendix references to information supplied to Ms Rowe by HDC have been removed]

> "I have been asked to provide an opinion to the Commissioner on case number 08/04291. I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I am a registered nurse with 24 years of nursing experience. I spent the first 15 years of my career working in a hospital in a variety of settings, mainly medical and rehabilitation. I then worked for seven years in the private sector primarily in the aged care areas. My last job was as a senior Academic staff member at a polytechnic. I now work full time as a Clinical Nurse Manager of a convalescent care facility that is owned by a DHB, which includes hospital level care, slow stream rehabilitation, palliative care and GP admissions. I have a Bachelor of Nursing, a Master of Arts and a Certificate in Adult Teaching and Education. I am currently completing a postgraduate certificate in Adult and Older Adult at Massey University.
>
> **Purpose:**
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> To provide independent expert advice about whether Summerset Trentham and Nurse Manager [Ms C] provided an appropriate standard of care to [Mrs A].
>
> **Background:**
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> [Mrs A] was an 85 year old lady, who had been living at home with significant support from her church, family and carers.
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> [In mid-2008], [Mrs A] was admitted to [the public hospital] following a fall, and was admitted for four weeks. During this time, she developed pneumonia and was successfully treated with antibiotics. She was also assessed as requiring full time hospital care.
>
> [A month later], [Mrs A] was discharged to Summerset Trentham home and hospital, in a stable condition. Her discharge summary stated:
>
> > *Caregivers please note — [Mrs A's] fluid intake needs to be carefully managed or she will dehydrate: please maintain a daily intake chart. If her oral intake by 7pm is less than 800ml she will require a 1000ml bag of normal saline sub-cut overnight.*

Summerset Trentham's GP, Dr D, noted the discharge instructions in her notes and a hydration chart was commenced. However, [Mrs A's] oral intake was not documented accurately and subcutaneous fluids were never administered.

On [Monday], during a visit from a friend, [Mrs A] was noted to be coughing up 'purulent blood-tinged sputum' and [Dr D] was faxed for an antibiotic prescription. Antibiotics were administered in the early evening, but [Mrs A] deteriorated rapidly, and she was transferred back to [the public hospital] via ambulance shortly before midnight.

[Mrs A] did not recover, and passed away [a few days later]. The cause of death was recorded as dehydration and respiratory arrest, bibasal pneumonia and advanced dementia.

[Mrs A's] daughter (EPOA and welfare guardian), [Ms B], complained to HDC on 16 December 2008. She believes that her mother was not provided with appropriate care and that her death was hastened by lack of care.

Compliant:

The Commissioner is investigating the following issues:

- *Whether Summerset Care Ltd, Trentham provided health care of an appropriate standard to [Mrs A] [over a period of a week in mid-2008].*
- *Whether Summerset Care Ltd, Trentham communicated appropriately with [Mrs A's] welfare guardian, Ms B, [over a period of a week in mid-2008].*
- *Whether Nurse Manager [Ms C] provided health care of an appropriate standard to [Mrs A] [over a period of a week in mid-2008].*
- *Whether Nurse Manager [Ms C] communicated appropriately with [Mrs A's] welfare guardian, Ms B, [over a period of a week in mid-2008].*

Supporting Information:

Letter of complaint from [a barrister] on behalf of [Ms B]. Notification of investigation letters of 3 April 2009, to Summerset Care Limited and Nurse Manager [Ms C] Information from Summerset Care Limited

[Mrs A's] progress notes Please note that Nurse Manager [Ms C] has failed to respond to HDC's letters, or attempts to contact her.

Expert Advice Required:

1. Please comment generally on the standard of care provided to [Mrs A] by:

a) Summerset Care Limited

- **Initial care and support plan** completed is comprehensive indicates need to monitor output, does not include instructions pertaining to monitoring of input and does not discuss doctor's orders for additional fluids
- **Doctor's entries indicate** if input is less than 800 mls at 7 p.m. to administer 1000 mls of subcutaneous Normal Saline 12 hours overnight. This was not actioned by any of the registered nursing staff during [Mrs A's] admission
- **Progress notes** indicate patient is prone to dehydration and requires accurate fluid balance chart which was not completed consistently throughout her admission
- **Hydration chart**
- *indicates 800 mls intake required daily, although there is no timeframe noted on chart*
- ***Day one [Tuesday]:*** *incomplete hydration chart due to first day in facility, with no output noted*
- ***Day two [Wednesday]:*** *indicates adequate input and output achieved, however at 3 pm only 680 mls had been given and last entry is not timed. No p.m. entry in progress notes indicating when this fluid was given, therefore at 7 p.m. not able to make decision about fluids, assume last 250mls given some time in p.m. shift. Therefore unable to be certain of adequate fluids at 7 p.m., possibility of insufficient input and need to give fluids*
- ***Day three: [Thursday]:*** *insufficient input and output*
- ***Day four [Friday]:*** *insufficient input at 7 p.m. and output only 7.30 p.m.*
- ***Day five [Saturday]:*** *insufficient input and no output recorded*
- ***Day Six: [Sunday]:*** *insufficient input at last entry 2.30 p.m., next entry at 7.30 p.m., and output 500mls at 2.30 p.m. only*
- ***Day seven: [Monday]****: insufficient input at 7 p.m. with last entry at 1435 indicating only 725 mls, next entry at 7.30 p.m.*
- Taking into consideration the first day there was not the opportunity to complete a hydration chart accurately, every other day based on the hydration chart there is evidence to show that on each day additional fluids in the form of normal saline subcutaneously should have been given
- Output has also only been recorded once per 24 hours, which indicates the staff were only emptying the IDC once. Best practice indicates IDCs should be emptied once per shift to indicate urinary flow and signs of retention

- **Progress notes**
- On admission indicates need to push fluids and to keep hydration chart due to dehydration
- No review of hydration chart in progress notes. Night staff indicate that the hydration chart needs to be completed accurately, but do not indicate they gave additional fluids when the chart clearly showed inadequate input for the 24 hours ([Wednesday])
- Indicates weight and urine spec required but no evidence of either of these things being completed
- Evidence of IDC draining well on [Wednesday] with no amount recorded on hydration chart
- [Thursday] reports food and fluids intake good although inadequate amounts reached on hydration chart
- [Saturday] night staff indicate she will be forced to have subcutaneous fluids, although they do not initiate them at the time, when it is clear the adequate amount has not been reached on the hydration chart

b) Nurse Manager [Ms C]
   - As Nurse Manager did not give any evidence it is hard to establish what was going on for her at the time
   - Nurse Managers are responsible for the overall level of care delivered by the staff to the patients
   - This includes adequate completion of all documentation pertaining to patients (the hydration chart, initial care and support plan, and progress notes). In this case there is evidence to show that the documentation is inadequate and reflects the level of competency of the staff under the Nurse Manager's responsibility.

2. Please comment generally on the adequacy of information provided to [Mrs A's] Welfare Guardian, [Ms B] by:

a) Summerset Care Limited
   - The staff did not record any conversations with [Ms B] on [Friday and Saturday] in the progress notes. This does not fit with their policies and procedures as indicated by [the CEO]
   - There is no evidence that [Mrs A] had difficulty swallowing her medications as stated by the RN and her daughter
   - There is also evidence of the RN working on [Monday] contacting the daughter to indicate that she was being transferred to hospital
   - Information given to staff members by Ms B should have been documented in the progress notes

b) Nurse Manager [Ms C]

- As already stated it is the Nurse Manager's responsibility to ensure that their staff follow the facility's policies and procedures
- There is evidence that the Nurse Manager spoke to the family but this is not documented anywhere in the progress notes

3. Was [Mrs A's] fluid intake managed appropriately?

- **No.** Subcutaneous fluids should have been given each day following the day of admission. There were a number of RNs who could have made this decision, firstly at 7pm as prescribed by the medical practitioner, then at the commencement of the night shift when the night RN discovered the hydration chart indicated inadequate fluid intakes

4. Was [Mrs A's] overall condition adequately monitored by nursing and care staff?

- **No.** The care staff were unable to complete an accurate hydration chart, document in the progress notes on a regular basis and/or accurately describe events as per the care and support plan. Nursing staff should have ensured accurate records of events as they occurred
- Assessment of her hydration status was not completed by the RN on duty in the p.m. shift at 7pm when the decision to give extra fluids needed to be made
- Antibiotics were also prescribed for [Mrs A] at 2.30pm on [Monday] and administered from stock medication at 6pm. These may have been more effective if given earlier?

5. Was [Mrs A] provided with adequate medical care?

- I will not comment on the medical care provided

6. Should [Mrs A's] deterioration have been acted on more promptly?

- **Yes.** [Mrs A's] needs were high and complex and she required close monitoring. With the addition of appropriate fluids she may not have deteriorated as quickly as she did. This may have given the nursing staff more time to establish whether her deterioration was due to her age and complex medical history or her recent chest infection and dehydration. There is no clear evidence that suggests that [Mrs A] was well hydrated or that she had been closely monitored by the registered nurses within this facility

Additional comments:

The Nurse Manager has overall responsibility for patient care delivery. Each registered nurse is also responsible for managing the patients on a shift by shift basis. During [Mrs A's] admission it seems no one took responsibility to monitor her general condition (that included her hydration status) or to adequately assess her condition and then act when it was obvious she was becoming dehydrated and required re-assessment by a medical practitioner. The tasks that the staff were unable to perform were of a very basic nature and did not require advanced knowledge or skills. There was no need for the staff to make a decision about how to manage the patient's hydration status as this had already been clearly documented by the medical practitioner. What they failed to do was carry out this prescribed treatment plan. This repeatedly put [Mrs A] at risk of dehydration and led to a slow but significant decline in her general status.

If the progress notes and care and support plan had clearly demonstrated the care being provided for [Mrs A], the lack of an accurate hydration chart would not have been such a big issue. Unfortunately none of this documentation is completed to a reasonable standard. There is evidence to suggest that the Management staff have taken steps to improve the staff's understanding of policies and procedures following this incident. In my opinion the providers' peers would view the conduct with moderate disapproval."