CHT Healthcare Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 19HDC00763)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to an elderly man in the last ten months of his life — in particular, the management of his unintended weight loss, his nutritional care planning, and the monitoring of his food and fluid intake. The report also addresses the lack of communication with his EPOA.

2. This case highlights the importance of delivering the fundamentals of care to vulnerable consumers, such as weight monitoring, food and fluid monitoring, and keeping accurate, up-to-date care plans. It also emphasises the importance of critical thinking, adherence to internal policies, and communication with the EPOA at critical decision points.

Findings

3. The Deputy Commissioner considered that care provided was poor, and found the rest home in breach of Right 4(1) of the Code. Further, the lack of engagement with the man's EPOA at critical decision points meant that the EPOA, as the legal representative, was not made aware of her father's altering state of health, including his blood test results, and was not given the opportunity to participate in decisions relating to her father's care. As such, the Deputy Commissioner found the rest home in breach of Right 6(1) of the Code.

Recommendations

4. The Deputy Commissioner recommended that the rest home provide a written apology to the family and undertake an audit to confirm that the "Weight Loss Procedure" is being complied with; provide training to all nursing staff on care planning, weight loss monitoring, and food and fluid intake; share this investigation as an anonymous case study with all CHT Healthcare Trust care staff (healthcare assistants and registered nurses); and consider whether its two-yearly mandatory training for registered nurses on the Nursing Clinical Procedures should occur more frequently.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided by CHT Healthcare Trust. The following issue was identified for investigation:

- *Whether CHT Healthcare Trust provided Mr A with an appropriate standard of care between Month1[1] and Month10 (inclusive).*

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

[1] Relevant months are referred to as Months 1–10 to protect privacy.

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7. The parties directly involved in the investigation were:

Ms B	Complainant
CHT Healthcare Trust	Provider

8. Further information was received from a medical centre.

9. Independent expert advice was obtained from Registered Nurse (RN) Sheryl Lilly (Appendix A).

Information gathered during investigation

Background

10. Mr A (aged in his nineties at the time of events) had been a resident at the rest home for three years. Mr A had dementia and required hospital-level care.

11. Mr A's condition started to deteriorate from Month1 2018. In Month8, he was diagnosed with likely bowel cancer. Sadly, he passed away on 2 Month10. His daughter, Ms B, made a complaint to HDC about the care he received from the rest home during this time.

12. This report concerns the care provided to Mr A regarding the management of his unintended weight loss, his nutritional care planning, the monitoring of his food and fluid intake, and the communication with Ms B.

Care planning Month1

13. On 23 Month1, Mr A had a six-monthly resident assessment (an interRAI[2] assessment) at the rest home. The "Undernutrition" portion of the care plan states: "[Mr A] cannot see clearly the food in front of him due to eyesight problem." The relevant interventions listed for Mr A were: "Ensure adequate, nutritious diet", "Weigh every month", and "Monitor when eating/drinking".

14. The "Dehydration" portion of Mr A's care plan states an intervention for his dehydration as: "Note and report how much of the meal/fluids has been consumed."

15. Neither of the above-mentioned sections acknowledged that Mr A had dementia.

Monitoring of weight loss

16. At the time of the interRAI in Month1, Mr A weighed 71.7kg.

17. The "Nursing Clinical Procedures" from the rest home outline clinical indicators that are to be monitored on a monthly basis, including weight loss. The Procedures state that weight loss that occurs for two months in a row, weight loss of 5% of body weight in one month, or

[2] A clinical assessment of an older person's ability and care needs.

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weight loss of 10% of body weight in six months should trigger the completion of a weight loss report, and should be reported to the Unit Manager and recorded in the Client Management System.

18. On the weight chart that was completed each month, it states:

“**Instructions:**

1. [Registered Nurse] to write appropriate scale in left-hand column.
2. Weight to be graphed and written along lower section each month.
3. Weight loss of 5% in 1 month or 10% in 6 months must be recorded in a Weight Loss Report.
4. 2 consecutive episodes of weight loss must be recorded in a Weight Loss Report.”

19. As per the “Nursing Clinical Procedure” and his care plan, Mr A’s weight was recorded each month, and was documented in his medical notes as follows:

Date	Weight	Decrease kg
Month1	71.7 kg	Not documented
Month2	71.7 kg	Not documented
Month3	69.9 kg	Not documented
Month4	69.4 kg	Not documented
Month5	65.9 kg	Not documented
Month6	63.6 kg	Not documented
Month7	59.4 kg	“63.6 kgs”
Month8	59.8 kg	“^ 0.4 kg”

20. In Month4, Mr A had lost weight for two consecutive months. In Month5, Mr A had lost 3.5kg — 5% of his body weight in one month — and he had lost weight for three consecutive months. In Month6, Mr A had lost weight for four consecutive months. According to the Nursing Clinical Procedures, a weight loss report should have been completed at these times, but this did not occur. Mr A’s family were not informed of the weight loss.

21. In Month7, Mr A had lost 4.2kg — 6.6% of his body weight in one month. A weight loss report was completed on 31 Month7. The date on which Mr A was weighed in Month7 is

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unclear from the documentation, and it is also unclear whether the weight loss report was initiated as a result of him being weighed.

22. The rest home told HDC that healthcare assistants (HCAs) are responsible for weighing the residents and passing on the information to the registered nurse. The nurse then enters the information into VCare[3] and is responsible for identifying weight loss.

23. The rest home said that a number of healthcare assistants were involved in weighing Mr A between Month1 and Month10, and it is difficult to provide the exact number. The rest home stated that the registered nurses are responsible for following up on weigh-in results and taking actions as appropriate.

24. The rest home said that unfortunately, staff did not take steps to address Mr A's weight loss when it became evident during their monthly checks. It stated that this was contrary to expected practice and the written policy in place at the time.

25. The rest home told HDC that its registered nurses were required to, and did, attend two-yearly training in relation to the Nursing Clinical Procedures, which included nutrition, hydration, and weight loss.

Monitoring of food and fluid intake

26. Mr A's care plans from Month1 and Month8 noted that his food and fluid intake should be monitored and documented. However, between Month1 and Month8, Mr A's food and fluid intake was documented inconsistently. Documentation of his food intake varied from being recorded in the morning and evening, being documented in either the morning or the afternoon only, or not documented at all.

27. On the majority of occasions on which food and fluid intake was documented by the healthcare assistants, it was recorded as "eating and drinking well" or "ate ½/all/most of meal".

28. Following the commencement of food and fluid charts in Month8, monitoring became more consistent.

Care planning Month8

29. Following a general practitioner (GP) review, on 7 Month8 Mr A was prescribed a nutritional supplement (Ensure x1 per day).

30. Mr A had a second six-monthly interRAI undertaken on 8 Month8. The assessing nurse noted that Mr A had lost weight. He was placed on the Replenish, Energy and Protein (REAP) programme[4] and referred for dietician and GP review. Mr A's care plan was altered to include the addition of "On REAP programme" and "Encourage extra snacks/supplements". No other changes to the "Undernutrition" portion of the care plan were made. A food and

[3] Vcare is software used in an aged-care setting.
[4] A weight management programme that focuses on unintended weight loss.

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fluid intake chart was put in place, and senior care staff were asked to assist Mr A with eating.

31. On 15 Month8, Mr A's Ensure prescription was altered to 2x per day following a dietician review.

Communication

32. Ms B held Mr A's activated enduring power of attorney (EPOA).[5] However, Ms B told HDC that she was not receiving adequate updates from the rest home. The rest home acknowledged that it had not been keeping Ms B adequately informed about Mr A's care. The rest home explained that Ms B's brother lived locally and visited on a daily basis, and, as a result, staff tended to keep him more informed about Mr A. In response to the "information gathered" section of the provisional report, Ms B told HDC that her brother did not relay information to her.

33. The rest home said that when Ms B raised concerns with the Unit Manager and the local district health board (DHB) in Month8, a communication plan was put in place, and weekly updates occurred until Mr A's death.

Blood test form

34. On 30 Month1, Mr A's blood test results showed that he had iron deficiency anaemia. He was prescribed an oral iron supplement, and was to have a repeat blood test in three months' time. However, this information was not communicated to Ms B.

35. Mr A's GP ordered the repeat blood test on 16 Month4. A staff member was given the blood test form to action. However, the rest home said that a staff member placed the form into Mr A's file, rather than onto the relevant clipboard to be actioned. There was a four-month delay in Mr A receiving this blood test.

36. In Month8, Ms B made multiple requests for her father to have a repeat blood test and was told that the rest home's policy was that blood tests were taken only once per year. The rest home has confirmed that this information was incorrect.

37. The rest home said that once it was identified that Mr A's blood test was overdue, the Unit Manager attempted to take blood. However, Mr A's veins caused difficulty, and a medical laboratory was asked to undertake the test. The blood test took place on 22 Month8.

Subsequent events

38. Following Mr A's weight loss intervention between Month7 and Month9, he gained 2.7kg.

39. Mr A's blood test results from 22 Month8 showed progressive iron deficiency anaemia and a raised cancer marker.[6] A diagnosis of likely bowel cancer was made and discussed with Ms

[5] An EPOA is a legal document that sets out who can take care of a person's personal or financial matters if the person is unable to.

[6] Carcinoembryonic antigen (CEA).

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B. It was agreed that Mr A would receive palliative care. Sadly, Mr A died on the evening of 2 Month10.

Further information

Ms B

40. Ms B told HDC that Mr A's deterioration in the last eight months of his life was significant, and she feels that the lack of action and basic care provided to him may have been a contributing factor to his death.

Rest home

Care planning

41. The rest home told HDC that assigned primary nurses for each resident have the responsibility for ensuring that the care plans for their residents are adequate for the individual resident's needs.

42. The rest home acknowledged that the level of detail in Mr A's care plan could have been improved. It said that internal audits are completed to monitor the level of detail in care plans to provide feedback to staff and raise corrective actions if required. The rest home said that CHT Healthcare Trust conducts refresher training for registered nurses as a result of a corrective action around lack of care plan detail.

43. The rest home told HDC that training for registered nurses in relation to care planning occurs as part of their orientation, and they also have annual refresher training. The rest home said that the topic of care planning is also discussed regularly at nurses' meetings.

44. The rest home acknowledged that care plans are the accepted form of communication between professionals. However, it said that because residents' daily needs can change depending on their health status, often day-to-day communication amongst care staff is the more accurate way to capture the needs of residents on any particular day.

Nutritional intake

45. The rest home told HDC that staff provided assistance to Mr A at every meal, and generally he ate well, but at times he refused to eat his whole meal. The rest home said that this was evident over the last months of Mr A's life, in which he required more assistance to eat his meals. The rest home stated that at times, Mr A would express that he did not want any more food, and staff would respect this decision.

46. In response to the "information gathered" section of the provisional report, Ms B told HDC that her father did not receive assistance with every meal, and, when she visited him, often his untouched meals were removed on her arrival. Ms B said that she was told by other residents that Mr A was not receiving assistance with feeding. Ms B stated that usually her father would eat all food that he was offered, but he would need to be prompted to eat or reminded that the food was there, as he had very poor eyesight. Ms B is concerned that a contributing factor to her father's weight loss was that he did not receive assistance to eat.

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<u>Policies</u>

47. The rest home told HDC that as a result of this complaint, it identified that its policies for weight loss, nutrition, and hydration were too dependent on a manual assessment of weight loss meeting the mandated criteria of 5% in one month, or 10% in six months. Consequently, a new weight loss policy and checklist was put in place.

<u>Overall responsibility</u>

48. The rest home told HDC that its Clinical Coordinator and Unit Manager had overall responsibility of the nurses who provided services to Mr A.

Responses to provisional opinion

Rest home

49. The rest home was given an opportunity to respond to the provisional opinion, and confirmed that it had no further comments. The rest home outlined the changes it has made since these events (see paragraph 78 below).

Ms B

50. Ms B's comments on the "information gathered" section of the provisional report have been incorporated into this report where relevant.

Opinion: CHT Healthcare Trust — breach

Introduction

51. This report highlights the importance of aged-care facilities delivering the fundamentals of care to vulnerable consumers, such as weight, food, and fluid monitoring.

52. In order to assess the care provided to Mr A, I obtained independent expert advice from a registered nurse, RN Sheryl Lilly.

Weight loss management

Planning

53. Mr A had dementia, which can cause confusion, and he experienced a loss of appetite and an increased lack of insight. These can all contribute to unintended weight loss. This was not addressed in Mr A's care plans.

54. Mr A's care plan from Month1 states that food and fluid intake should be monitored. However, there is little documentation to indicate that this was occurring in a structured and consistent manner between Month1 and Month8.

55. As RN Lilly noted, there is no evidence that in either Month1 or Month8, Mr A's diagnosis of dementia was considered when the rest home was planning interventions to ensure that he was receiving adequate nutrition. In addition, both of Mr A's care plans stated that staff were to monitor his food and fluid intake, but RN Lilly noted that the appropriate

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documentation was not arranged to enable staff to do so objectively and consistently. RN Lilly also observed that the interventions outlined in Mr A's care plan were not altered sufficiently to respond to his needs relating to unintended weight loss.

56. RN Lilly noted that there is regular mention in the progress notes of the need for Mr A to have assistance with finishing meals, and there is some reference to how much he was eating. RN Lilly advised that these comments should have prompted the need for a specific plan to be written to manage Mr A's weight loss. However, this did not occur.

Monitoring

57. RN Lilly noted that there is no supporting documentation to show that Mr A's eating and drinking were monitored, apart from comments in the progress notes that inconsistently recorded "eating and drinking well" or "ate only half his meal". RN Lilly advised that "it can be very difficult to monitor a person's eating in such a subjective manner with no baseline information or ongoing comparative data from day to day".

58. Between Month2 and Month7, it was documented that Mr A was losing weight each month. In this time, Mr A lost 12.3kg. However, across a six-month period, no action was taken by staff to respond to Mr A's significant weight loss. The rest home told HDC that a number of staff were involved in weighing Mr A.

59. During Mr A's interRAI review in Month8, it was noted that he had lost over 10% of his body weight in the previous six months. Mr A was placed onto the REAP programme, and dietician and GP reviews were requested, but his care plan was not altered to reflect weight loss management.

Evaluation

60. RN Lilly observed that Mr A's weight chart clearly indicated steady weight loss, but there is no evidence of immediate interventions, ie, a short-term care plan that reflected the goals, interventions, and evaluations of recognising and then dealing with Mr A's unintentional weight loss.

61. RN Lilly stated:

> "There is an expectation that nurses 'use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care'. I find little evidence of this in CHT documentation regarding [Mr A's] continued weight loss. My peers would expect to see documentation around daily food and fluid intake, weekly weighs, instructions around increased snacks and fortified food …
>
> It was not until the required six monthly interRAI assessment in [Month8] was carried out that proactive action was taken in the form of GP and dietician input."

62. RN Lilly advised that in Month8 when it was identified that Mr A had been losing weight, it appears that no changes were made to his care plan apart from placing him on the REAP programme. RN Lilly said that the accepted practice would be to make changes to the care plan to reflect the management of the weight loss, not just the monitoring of it.

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63. RN Lilly advised that in light of staff not complying with written instructions around weight loss management, the lack of proactive interventions, and the failure to meet the Health and Disability Services Standards,[7] she considers there to have been a moderate departure from accepted practice. RN Lilly also considers the slow response to Mr A's weight loss to have been a moderate departure from accepted practice.

64. I accept RN Lilly's advice. In addition, the lack of critical thinking by staff and consideration of other reasons for Mr A's deteriorating health is concerning. Mr A's subsequent bowel cancer diagnosis suggests that other factors may well have been at play and may have contributed to his loss of appetite and weight loss.

Conclusions — weight loss management

65. Effective care planning for aged-care residents is vital to capture the needs of the residents and ensure that appropriate person-centred services are provided. However, the nurses involved in Mr A's care failed to ensure that his care plans were fully reflective of his needs. The rest home told HDC that it was the responsibility of Mr A's assigned primary nurse to ensure that his care plans met his needs, and that the Clinical Coordinator and Unit Manager had overall responsibility of the nurses. While I am concerned about the lack of oversight of Mr A's care plans, I am also of the view that it is the responsibility of all staff involved in a resident's day-to-day care to be observant and alert to subtle, or not so subtle, signs of deterioration in the resident's general condition, and be ready to escalate matters of concern.

66. Between Month1 and Month8, Mr A's food and fluid intake was not monitored adequately. This should have been done in a robust manner, using objective measures to document his intake. Despite the poor monitoring, issues with Mr A's eating were mentioned regularly in his documentation. However, the issues were not escalated, and no action was taken to address his poor intake. This suggests that staff consistently and repeatedly failed to appreciate the deficiencies in Mr A's food and fluid intake between Month1 and Month8. This is concerning, particularly given that his diagnosis of dementia placed him at an increased risk of unintended weight loss.

67. In addition to inadequate care planning and monitoring of Mr A's food and fluid intake, it is clear that there was a lack of critical thinking, and the various staff at the rest home repeatedly failed to recognise the significance of Mr A's weight loss, which was documented each month. This is evident by the failure of staff to take adequate steps to address it. By not taking any action, staff also failed to adhere to organisational policies in relation to weight loss.

68. The rest home has acknowledged that the policies it had in place for weight loss, nutrition, and hydration were too dependent on a manual assessment meeting mandated criteria. Notwithstanding this, had the nurses critically engaged with the documented downward

[7] The relevant Standards (administered by the Ministry of Health) set out the steps providers need to take to ensure that they are providing safe, quality services. The Standards also outline what people can expect from the services they receive.

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trend in Mr A's weight loss and also followed the "Nursing Clinical Procedure", a weight loss report would have been completed several months earlier, which would have initiated the appropriate steps that needed to occur, including providing Mr A with the nutritional supplements he needed, and prompted further assessment of his condition more generally. I consider it more likely than not that staff were not familiar with their obligations in relation to weight loss, and did not appreciate the importance of monitoring weight. In my view, it is the responsibility of the rest home to ensure that its staff are aware of their obligations, and are providing services consistent with accepted practice.

Blood test form

69. In Month4, Mr A's GP requested a blood test and provided the form to rest home staff. However, the form was filed incorrectly and was not actioned.

70. RN Lilly noted that the process of placing the blood test form onto the clipboard for actioning was not followed. However, she said that she would have expected the GP to have had a system in place for follow-up of test results. RN Lilly considers the misfiling of the blood test form to be a minor departure from accepted practice.

71. I am concerned that other than placing a blood test form onto a clipboard for action, there was no other mechanism to ensure that test results were followed up in a timely manner. Had there been, it is likely that staff would have identified that Mr A's blood test form had not been actioned much earlier. However, I acknowledge RN Lilly's comments about the collaboration between aged-care facilities and GPs to ensure the timely management of test requests and results.

Communication

72. Ms B held Mr A's activated EPOA, and was therefore the person legally entitled to be given information about Mr A's care and give consent on his behalf to health services.[8] She should have been provided with updates, involved in medical decisions, and advised of any changes in Mr A's condition or test results. Ms B was not informed that Mr A's blood test in Month1 showed that he had iron deficiency anaemia. The rest home has acknowledged that prior to Ms B's complaint to the rest home and the DHB, its communication with her was not adequate. The rest home said that Ms B's brother lived locally and visited daily, so staff tended to keep him informed about Mr A instead of Ms B.

73. An EPOA is activated when an individual no longer has capacity to make decisions for themselves, as had occurred with Mr A. When competent, Mr A had made the decision for Ms B to represent his health and welfare interests when he was no longer competent. It was the responsibility of the rest home to ensure that Ms B was provided with information that a reasonable consumer, in Mr A's circumstances, would expect to receive.

[8] Clause 4 of the Code of Health and Disability Services Consumers' Rights defines "consumer" as including, for the purposes of Rights 5, 6, 7(1), 7(7), 7(10), and 10, a person entitled to give consent on behalf of that consumer.

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74. It is vitally important that all providers, and particularly aged-care facilities, engage with the individual who holds an activated EPOA, as this is the person legally entitled to make decisions on behalf of the person who lacks competence. I appreciate that the lack of information and communication caused avoidable distress to Ms B, at an already difficult time.

Conclusion

75. In summary, between Month1 and Month7, the rest home failed to provide services to Mr A with reasonable care and skill, as follows:

- Mr A's care plans between Month1 and Month8 were inadequate, as they did not take into account his diagnosis of dementia, which can contribute to unintended weight loss.
- At the time of care planning, no documentation was arranged to enable objective, consistent, and adequate monitoring of Mr A's eating and drinking.
- Staff failed to monitor Mr A's food and fluid intake adequately.
- Staff failed to recognise the significance of Mr A's weight loss when weighing him each month.
- Nursing staff repeatedly failed to adhere to the "Nursing Clinical Procedures".
- There was a significant delay in a weight loss report being initiated for Mr A.
- Once weight loss was identified, Mr A's care plan was not altered to reflect the management of his weight loss.
- Management of Mr A's blood test request form was inadequate.

76. As a result of the above, Mr A's deteriorating condition was not identified and managed in a timely manner in the months leading up to his death. The above identified deficiencies are reflective of a lack of critical thinking with multiple staff members failing to provide basic care to Mr A on many occasions. Despite receiving two-yearly training, the nurses involved in Mr A's weigh-ins failed to think critically and adhere to the internal policies in place at the rest home. This appears to indicate a lack of understanding of rest home policies and nursing responsibilities. Ultimately, the rest home is responsible for ensuring that its clinical staff are aware of, and are complying with, its policies. The care provided to Mr A shows a pattern of poor care operating at the time of the events, which I attribute to the rest home. Accordingly, I find the rest home in breach of Right 4(1)[9] of the Code of Health and Disability Services Consumers' Rights (the Code).

77. Further the lack of engagement with Mr A's EPOA at critical decision points meant that Ms B, as Mr A's legal representative, was not provided with information that she would expect to receive. Ms B was not made aware of her father's altering state of health, including his blood test results in Month1, and was not given the opportunity to participate in decisions

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

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relating to her father's care. Accordingly, I find the rest home in breach of Right 6(1)[10] of the Code.

Changes made

78. In Month8, Ms B raised her concerns directly with the rest home. Following a review of the circumstances, the rest home advised that the following corrective actions were undertaken:

- Alerts on the quality system are now in place to flag weight loss.
- A weight loss procedure was developed, which outlines clear steps to be taken in relation to unintended weight loss. Staff were educated on this policy, and it was discussed at a staff meeting.
- The electronic client management system was updated to include triggers that will automatically identify weight loss of 5% in one month or 10% in six months. The Clinical Coordinator is to run a report at the end of each month to identify residents who have had weight loss, and the Clinical Coordinator identifies any interventions required with GPs, dieticians, families, the Unit Manager, and nursing staff.
- Allocated primary nurses for each resident check the weight loss charts on their residents' files regularly and action any concerns. This is overseen by the Clinical Coordinator.
- Weight loss management training is scheduled for all staff, and will be held four times a year. The first training session was scheduled for January 2021.
- Nutrition and hydration training has been provided to staff and added to the online training programme that staff complete as part of their regular mandatory training.
- All staff were requested to complete a course on "Hydration and Nutrition: Managing weight to promote health", by December 2021. Regular fortnightly meetings are to be held with nursing staff. Care planning is discussed at every registered nurses meeting, and the importance of personalising care plans for residents is emphasised. Care planning training for all nursing staff was scheduled for 2022.
- Ongoing training on communication will occur with staff.
- On every GP round, the Clinical Coordinator collects the blood forms from the GP and immediately places them on the appropriate board for action. In the absence of the Clinical Coordinator, the registered nurse does the same.
- All clinical appointments/blood tests due/follow-up tests are put into the registered nurses diary to be followed up.

[10] Right 6(1) states: "Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive …"

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- The primary nurse is required to check their residents' files regularly to ensure that all aspects of their residents' care are being followed up.

Recommendations

79. With consideration of the changes already made, I recommend that the rest home:

a) Provide Mr A's family with a written apology for the breaches 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 to Ms B.

b) Undertake an audit of a sample of 40 residents' weight records to confirm that the "Weight Loss Procedure" is being complied with. Where there has not been 100% compliance, CHT should consider what further remedial actions are required. Evidence of the audit, its outcome, and any additional remedial actions are to be provided to HDC within four months of the date of this report.

c) Provide evidence of training that has been provided to staff in the last 12 months on care planning, weight loss monitoring, and food and fluid intake. Evidence of this is to be provided to HDC within three months of the date of this report.

d) Share this investigation as an anonymous case study with all CHT Healthcare Trust care staff (healthcare assistants and registered nurses) and provide evidence to HDC that this has occurred within six months of the date of this report.

e) Consider whether its two-yearly mandatory training for registered nurses on the Nursing Clinical Procedures should occur more frequently, and provide HDC with evidence of this and the outcome of this consideration, within three months of the date of this report.

Follow-up actions

80. A copy of this report with details identifying the parties removed, except CHT Healthcare Trust and the expert who advised on this case, will be sent to the district health board, the New Zealand Aged Care Association, the Nursing Council of New Zealand, and HealthCERT.

81. A copy of this report with details identifying the parties removed, except CHT Healthcare Trust and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following expert advice was obtained from RN Sheryl Lilly:

"**1. Disclaimer**

I, Sheryl Lilly, have been asked to provide an opinion to the Commissioner on case number C19HDC00763 and I have read and agree to follow the Commissioner's guidelines for Independent Advisors. I have no known personal or professional conflict in this case.

2. Expert's Background

I have been a New Zealand Registered nurse for thirty years with a background in clinical care and aged care nursing management. I am an owner and General Manager of two small rest homes and a Head and Spinal Injury Rehabilitation unit. I am also a Career Force assessor.

3. Instructions from the Commissioner

I have been asked to review the documentation sent to me and provide an opinion of the care provided to [Mr A] by staff at [the rest home] from [Month1] to [Month10], whether the care was reasonable in the circumstances and why.

In particular please comment on:

1. The management of [Mr A's] gradual weight loss from [Month1] onwards, including any issues regarding the identification and response to the weight loss.
2. The adequacy of the response by CHT staff from [Month4] onwards, regarding [Mr A's] requirement for assistance with eating and drinking and not always finishing his meals.
3. The management of [Mr A's] blood test form in [Month4].
4. The adequacy of the communication from CHT to [Ms B].
5. The adequacy of policies and procedures around weight loss, nutrition, and hydration in place at the time of the events.
6. Any other issues you identify during this period of care.

4. Factual summary

A complaint has been raised around the care provided to [Mr A], by the GP and the staff at CHT [the rest home].

Expert Review

The management of [Mr A's] gradual weight loss from [Month1] onwards, including any issues regarding the identification and response to the weight loss.

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[Mr A's] initial weight in [Month1] was 71.7 kgs, there was already a slight weight loss over the previous 6 months of approximately 3 kgs.

There was then a steady decline over the next six months to 59.4kg. This decline was recorded on the weight chart each month, and within those six months, particularly over [Month4], [Month5] and [Month6] the progress notes referred to his difficulty with his meals, not seeing his food and needing assistance with eating his meals. His Care plan dated [Month1] stated under the heading of undernutrition '[Mr A] cannot see clearly the food in front of him due to eyesight problem' and the interventions were, among other instructions, 'weigh every month' and 'monitor when eating/drinking'.

There is evidence of monthly weighs and regular mention of the need for assistance with [Mr A's] meals to help him finish them and some reference to how much he was eating, all of this in his progress notes although this was inconsistent.

These comments should have prompted the need for a specific plan being written to manage [Mr A's] weight loss, this would have been best practice.

The weight loss report is a great assessment/planning tool but there is no evidence of evaluations or outcomes of the interventions over the subsequent period until his passing.

[Mr A] was also diagnosed with Dementia. As dementia progresses, confusion, loss of appetite, and increase in lack of insight can also contribute to unintentional weight loss and this would have needed to be taken into consideration during the planning, his careplan did not appear to take this into account.

Considering that [Mr A's] Weight chart clearly indicated a steady weight loss, there is no evidence of immediate interventions, ie, a short term care plan that reflects the goals, interventions and evaluations of recognising and then dealing with [Mr A's] unintentional weight loss. There is an expectation that nurses 'Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.' I find little evidence of this in CHT documentation regarding [Mr A's] continued weight loss. My peers would expect to see documentation around daily food and fluid intake, weekly weighs, instructions around increased snacks and fortified food. All of which are indicated in the REAP programme that he was started on but I see no documentation of these interventions being carried out.

It was not until the required six monthly interRAI assessment in [Month8] was carried out that proactive action was taken in the form of GP and Dietician input. However, there is no evidence of any changes in the careplan apart from being on the REAP programme; the accepted practice would be changes in the careplan to reflect the management of the weight loss not just the monitoring of it.

Although [Mr A] did not quite meet the benchmark of a 5% loss in consecutive months, I note that the CHT weight chart indicates that if there are two consecutive months with

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weight loss this is to be reported on a weight loss report; this was not done until 31 [Month7].

Taking into account all of my above comments, the fact that CHT staff were in breach of their written instructions around weight loss and the lack of proactive interventions, and the failure to meet the Health And Disability Service Provision Requirements I consider there has been a moderate departure from accepted practice.

The adequacy of the response by CHT staff from [Month4] onwards, regarding [Mr A's] requirement for assistance with eating and drinking and not always finishing his meals

There are many occasions in the progress notes that indicate [Mr A] was having difficulty with managing his meals. The Unit Manager states that a decision was made for senior staff to feed [Mr A] to better manage his refusal to eat. That decision was not made until after the interRAI assessment in [Month8]. I consider it should have been made much sooner, along with a plan to deal with the continued weight loss. Monitoring weight loss as instructed in the care plan is only a partial response to the weight loss issue. There is an expectation that the registered nurse in charge would establish an action plan around this and then continue to monitor the outcome and adjust the plan accordingly. The VCare plan only instructs to monitor eating and drinking, with no supporting documentation to evidence this apart from comments in the progress notes that inconsistently recorded 'eating and drinking well' or 'ate only half his meal'; it can be very difficult to monitor a person's eating in such a subjective manner with no baseline information or ongoing comparative data from day to day. This brief instruction was left unchanged even after the [Month8] interRAI assessment alerted the scribe to the unintentional weight loss.

A weight loss report was only done after the [Month8] interRAI assessment; this was a breach of their weight loss procedure, as it should have been done when the first weight loss was recorded twice in a row in the [four months prior to these events]. Despite the fact that a referral for a dietician was done, a GP review was asked for and [Mr A] put on the REAP programme, I am critical of the slow response to the weight loss and consider this a moderate departure from accepted practice.

There is evidence that there has been a change in policy around weight loss recognition with a clear pathway to addressing the problem in an acceptable time frame. There would be a benefit to adding into that pathway supporting documentation that should be completed that evidences clear instructions to other staff. I have not used VCare but it appears to have generic interventions by way of drop box; the problem was identified in the [Month1] Vcare plan as an eyesight problem that prevented [Mr A] from eating, but the interventions did not address this. There does not seem to be any reference to [Mr A's] dementia and how that may have affected his under nutrition.

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The management of [Mr A's] blood test form in [Month4]

[Mr A's] blood form due in [Month4] was accidently filed instead of being actioned and was missed. There was a system in place that was not followed, and this has been addressed.

Talking to my peers, standard practice around blood forms varies from facility to facility; we would expect the GP of the facility to have their own system in place that double checked that the bloods were taken. It was an unfortunate mistake to happen, and I consider it a minor departure.

The adequacy of the communication from CHT to [Ms B]

On reviewing the progress notes, there appears to be little communication with [Ms B] the EPOA.

The progress notes show a family stamp indicating when there has been family communication when the EPOA was spoken to. Reading through the progress notes, there is reference to, but no stamp, when [Mr A's] son visited regularly and I can only presume he was kept up to date on daily issues; unfortunately he may not have been keeping [Ms B] up to date. It was only when [Ms B] complained to [the DHB] that a plan of weekly communication with [Ms B] was established and followed.

It is standard practice to communicate predominantly with the EPOA, usually around GP visits, unwellness or any incidents. Families can sometimes prefer a different family member or a regular visiting family member to be the main contact for communication with the facility. This should be clearly indicated in the person's care plan to avoid any misunderstandings.

The communication with [Mr A's] family was probably adequate until there became an issue, which is often the case. However, once CHT became aware of the complaint to [the DHB], they responded appropriately and improved their communication with the EPOA. I would consider this a minor departure.

There is always room for improvement in communication and although difficult, ideally managers should be contacting families monthly to communicate good news as much as issue-based news. This would go a long way towards building positive relationships with families and in turn would help future facility/family communication in stressful times.

The adequacy of the policies and procedures around weight loss, nutrition, and hydration in place at the time of the events.

There did not appear to be a specific weight loss policy during this event, however there is reference to weight loss in the nursing clinical procedures that clearly states the pathway to be followed when weight loss occurs.

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There is reference to seeking Dietician input for unplanned weight loss. There is also reference to when to report weight loss on the weight loss chart. These policies are adequate, however, the procedures after recognising the weight loss seem to be absent and as I have mentioned above a clear clinical pathway of interventions would be beneficial. With that in mind, I consider the policies to meet accepted standards.

Other issues

While reading the documentation provided to me, I found that [Mr A's] careplan was, in my opinion, sparse. It was very objective with many repetitive generic phrases under each heading that were not person centred. As a nurse I could not get a good 'picture' of [Mr A] and his needs. Careplans are the accepted form of communication between professionals looking after their clients, and they should provide a clear picture of the person, their goals and interventions to meet those goals. The Vcare document appears to be overly broad and not particularly specific to the client.

Sheryl Lilly RN"

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