Radius Residential Care Limited

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00015)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to a woman while a resident at Radius Elloughton Gardens. Following the woman's admission to Elloughton Gardens, staff did not undertake an interRAI assessment or implement an adequate care plan for food and nutrition, taking into account her dementia. Towards the end of her stay, staff failed to identify and respond to signs of dehydration and deterioration. Sadly, the woman died shortly after her transfer to hospital.

2. The report highlights the importance of adequate care planning and monitoring for patients in rest homes.

Findings

3. The Deputy Commissioner found Radius Residential Care Limited (Radius) in breach of Right 4(1) of the Code. A number of failures in the services provided by Radius were identified, including the failure to undertake adequate care planning for food and nutrition in a timely manner, a failure of multiple staff to identify and respond to signs of dehydration and deterioration, and a failure to undertake a skin scraping for suspected scabies in a timely manner.

Recommendations

4. The Deputy Commissioner recommended that Radius provide a written apology to the woman's family for the breach of the Code.

5. The Deputy Commissioner also recommended that Radius provide an update of its revised policies and procedures, report on the audits undertaken to monitor compliance with its Nutrition and Hydration policy, and use this case to provide continuing education to nursing staff at its facilities.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother, Mrs A, by Radius Residential Care Limited. The following issue was identified for investigation:

   - *Whether Radius Residential Care Limited provided Mrs A with an appropriate standard of care from Month2[1] to Month5 2018 (inclusive).*

7. 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 1–5 to protect privacy.

8. The parties directly involved in the investigation were:

Ms B	Consumer's daughter/complainant
Radius Residential Care Limited	Provider/rest-home service operator

9. Further information was received from:

District Health Board
Registered nurses
Dr C
Dr D

10. Independent expert advice was obtained from Registered Nurse (RN) Rachel Parmee (Appendix A).

Information gathered during investigation

Introduction

11. This report concerns the services provided by Radius Residential Care Limited to Mrs A in 2018, after she was transferred to Radius Elloughton Gardens (Elloughton Gardens).[2]

Background

12. At the time of events, Mrs A was in her eighties and had severe dementia. She had been a resident at a dementia care unit but on 19 Month1 Mrs A had a fall and suffered a fractured neck of femur (NOF)[3] and required admission to hospital. On 23 Month1, she was transferred to another hospital for rehabilitation. On 29 Month1, a decision was made to transfer Mrs A back to rest-home care, as it was felt that she had reached her potential for rehabilitation owing to her dementia.

13. On 11 Month2, Mrs A transferred to Elloughton Gardens.

14. Mrs A had a medical history of atrial fibrillation,[4] chronic heart failure, and urinary tract infections. In 2017, she had fractured her pelvis, which was managed conservatively.

Assessment prior to admission

15. On 28 Month1, prior to Mrs A's transfer to Elloughton Gardens, an interRAI assessment was undertaken. Much of the assessment was not completed because Mrs A was in hospital at the time. The assessment records that Mrs A was "independent with eating and

[2] Elloughton Gardens is owned and operated by Radius Residential Care Ltd (Radius) and contracted by the district health board (DHB) to provide long-term residential, hospital, rest-home, respite, and palliative-care services. Elloughton Gardens can accommodate up to 86 residents.
[3] Hip/top part of the thigh bone (femur).
[4] An irregular heartbeat.

drinking once set up and given prompts", and could mobilise independently but "require[d] steady assistance … to remain safe". It also stated that Mrs A was very easily distracted and would get muddled in conversation and go off on a tangent, and that her "husband report[ed] [that her] mental function ha[d] decreased over the last few months prior to admission [to the dementia care facility]".

16. Mrs A's Needs Assessment and Service Coordination (NASC) "Application for Residential Care" dated 30 Month1 stated that Mrs A had been assessed as requiring "Hospital Care".

17. The DHB's progress notes record: "[Mrs A] can sometimes present resistant and a little agitated toward staff with food, fluid and medication. However, she is easily persuaded." She was noted to require two people to assist her with her general cares, transfers, and walking using a gutter frame. The notes conclude:

> "I do not believe at this time that [Mrs A] requires a Dementia level hospital placement. From her presentation in [the rehabilitation unit] I feel she would be appropriately placed at [hospital-care level]."

18. In response to the provisional opinion, Radius noted that this assessment was based on limited information at the time, and Mrs A was not always easily persuaded to eat and drink.

19. The DHB's "Transfer Notice of Nursing Care" completed at the time of Mrs A's transfer to Elloughton Gardens stated: "[Mrs A] drinks well if fluids in reach and needs assistance with meals."

Admission

20. Mrs A was transferred to Elloughton Gardens on 11 Month2. Her medications at the time included Laxsol and Kiwi Crush for constipation, paracetamol 1g three times a day, oxycodone 2.5mg every two hours when required for pain relief, aspirin 100mg once a day in the morning, quetiapine[5] 25mg once a day at night, allopurinol 100mg once a day in the morning, and metoprolol to treat atrial fibrillation. She was also given the nutritional supplement Ensure Plus 200ml once daily.

21. Mrs A's weight at the time of discharge from hospital was 46.7kg.

Interim care plan

22. On admission, a multidisciplinary assessment was carried out and an interim care plan developed, which noted that Mrs A had weight problems and a poor appetite, and was unable to feed herself. She was noted to have a high risk of falls and to require physical assistance with mobility, although no further detail of her level of assistance was recorded.

23. No specific care plan was recorded relating to Mrs A's food and fluid intake. However, in response to the provisional opinion, Radius noted: "[T]he interim care plan correctly

[5] Used to treat schizophrenia and bipolar disorder.

recorded that [Mrs A] was not able to feed herself and had poor appetite, and it is suggested that Radius properly had regard to those matters from [Mrs A's] admission."

24. An interRAI assessment was not completed within three weeks of Mrs A's admission to Elloughton Gardens, which Radius accepts was "contrary to best practice".

Food and fluid intake

25. Ms B, Mrs A's daughter, told HDC that from Month3 she had concerns that her mother was not being given adequate amounts of fluid. Ms B said that often visitors found her mother thirsty and not having eaten her meals, and that when they assisted her she both ate and drank well.

26. On 5 Month3, Ms B emailed the Facility Manager detailing her concerns about her mother's eating and drinking. In response, the Facility Manager noted that staff assisted Mrs A with her meals, but that sometimes she would not eat and required a lot of prompting, and it could take up to an hour to feed her the main meal. However, he advised Ms B that in response to her concern, a food and fluid chart would be commenced.

27. The chart was commenced on 6 Month3, and recorded Mrs A's food and fluid intake at each meal, as well as routine checks.

28. Radius advised that following the commencement of the food and fluid chart, Mrs A continued to refuse and resist meals and fluid at times. On 9 Month3, Mrs A was noted to have lost weight over the previous month. An incident form was completed for "weight loss of 2.9 kg", and a review by a dietician was arranged.

Dietician

29. On 13 Month3, the dietician noted that Mrs A was refusing meals or eating only a small amount, and documented a plan to encourage Mrs A to eat and drink, give her puréed meals, add butter to her meals and cream to her puddings, give her nutritional drinks, and continue to monitor her weight and food and fluid intake.

30. On 14 Month4, the dietician reviewed Mrs A again and noted that she had lost weight (she weighed 41.4kg) and was still refusing to eat at times, but was enjoying nutritional drinks. Her nutritional drinks were increased to three times daily.

31. The dietician next reviewed Mrs A on 18 Month5. It was noted that her weight had increased slightly (to 43.4kg) and that she was eating and drinking better. The plan documented was to continue to encourage eating and drinking, provide nutritional drinks three times daily, weigh Mrs A monthly, and stop the food and fluid chart.

32. Radius noted that throughout Mrs A's stay she became increasingly resistant to care. Radius stated:

> "Generally, she would only agree to eat ¼ to ½ of her meal, and on occasion she would refuse to eat any of her meal. This was likely due to her worsening dementia and pre-existing conditions (which included difficulty swallowing). As a result of this, and to avoid undernutrition and dehydration, Radius implemented a plan to feed [Mrs A] frequent small meals and fluids, and to weigh her monthly, or more often as indicated. It also developed a food and fluid chart for [Mrs A] to record and monitor her food and fluid intake."

33. Further to this, Radius told HDC:

> "While Radius accepts that it did not have a formal long term care plan in place relating to [Mrs A's] needs in relation to maintaining adequate hydration, it confirms that there was always a plan in place for [Mrs A] relating to her food and fluid intake, and that there was daily reporting in accordance with this plan, for the vast majority of her stay in Elloughton Gardens."

34. There is no documentation relating to whether any additional measures that took into account Mrs A's dementia were taken to encourage her to maintain her food and fluid intake.

Suspicion of scabies

35. In her complaint, Ms B stated that while visiting her mother on 13 Month5, she noticed that her mother was "extremely agitated, scratching her mid to upper body incessantly". She said that she spoke to a nurse and requested that her mother be seen by a doctor, and was told that an appointment would be made for the following Tuesday (18 Month5).

36. On Sunday 15 Month5, the first reference to Mrs A's rash is recorded in the clinical records, with a note that a GP appointment had been scheduled for Tuesday 18 Month5. However, according to the clinical records, on 16 Month5, Mrs A continued to complain of itchiness, and Ms B requested an urgent GP review. The after-hours GP was contacted by telephone and prescribed Pinetarsol,[6] topical hydrocortisone,[7] and promethazine.[8]

37. On 18 Month5, Dr C reviewed Mrs A and documented a "strong suspicion of scabies[9]", and prescribed Lyderm.[10] Dr C also requested a skin scraping in order to confirm the presence of scabies.

Delay in skin scraping

38. A skin scraping to confirm the presence of scabies was not performed until 25 Month5 — a week after Dr C's request. Radius told HDC :

[6] Relieves inflamed and itchy skin.
[7] Steroid cream used to treat itching.
[8] Used to treat allergy symptoms including itching.
[9] A mite that burrows under the skin and causes intense itching.
[10] An insecticide used to treat scabies.

> "Radius accepts that there was a slight delay in arranging for the skin scraping assessment to be carried out. Radius says that there were a number of intervening events that occurred between 18 Month5 (when [Mrs A] was seen by [Dr C) and 25 Month5 (when the skin scraping assessment was carried out). [Mrs A] suffered a number of knocks, which resulted in skin tears, and she also visited [the local public hospital] for a wound on her leg. Also, during this time, there was a staffing shuffle at [Elloughton Gardens] — with [Dr C] going on leave from 20 Month5 to 27 Month5, and [Dr D] taking over his patients."

39. However, while Radius "concedes that the delay in obtaining the skin scraping was unacceptable", it stated that this was a one-off occurrence and it has spoken to the staff involved, who have "given their assurance that it will not happen again".

40. In response to the "information gathered" section of the provisional opinion, Ms B noted that her mother was not transferred to the local public hospital until 5.12pm on 20 Month5, and that prior to her transfer she remained at Elloughton Gardens. Ms B stated: "[T]his would have left ample time for the test to be carried out."

41. The result of the skin scraping showed that Mrs A did not have scabies.

Care between 18–26 Month5

42. Radius advised that because there was a "suspicion" of scabies, Mrs A was nursed, and remained in, her single room from 18 Month5. Radius explained that this was not formal isolation, but as staff were aware that Mrs A might have scabies, precautions were taken when attending to her cares. Radius told HDC that it considers it reasonable for Mrs A to have remained in her single room whilst investigations were being carried out to determine whether she had scabies.

43. Radius said that while being kept in her room, Mrs A continued to be monitored and cared for appropriately. Radius stated:

> "This is confirmed by the progress notes, which record that over this time, [Mrs A] received regular care. The food and fluid intake chart also shows that attempts were made to regularly feed [Mrs A] food and water."

44. In her complaint, Ms B said that on 20 Month5, a family friend visited Mrs A and noted that blood was seeping from below her right leg wound, and that she was breathing erratically and was in obvious discomfort. Ms B said that she spoke to a nurse, who confirmed that there was a 4x4cm laceration on Mrs A's leg. Ms B told HDC that she "insisted" that her mother be taken to hospital, which occurred later that afternoon. Mrs A was returned to Elloughton Gardens at 7.45pm, after her wound had been dressed in hospital.

45. The clinical notes record that at 9.30pm on 22 Month5, Mrs A was having difficulty breathing. Her observations were within normal parameters — BP 110/60mmHg,[11] respiratory rate 20 breaths per minute,[12] and oxygen saturations 95% on room air.[13] She was monitored overnight, and no further concerns were noted.

46. On 23 Month5, Mrs A refused her medications. On 24 and 25 Month5, she refused to eat or drink anything, and accepted only sips of fluid. She was also noted to be itching all over her body.

47. On 25 Month5 at 10.45am, a request for a blood test was faxed to Dr D, who was covering Dr C's practice between 20 and 27 Month5, stating:

> "[N]oticed that both feet are ecchymosis[14] and the tip of her fingers are bluish in colour, bruises to some parts of her body ?suggests to have a blood examination for her. Please advise."

48. At 4.11pm on 25 Month5, the clinical records note that Mrs A continued to itch all over her body and that she had become agitated and uncooperative during her cares, and that the GP had been faxed "regarding her condition", and this "[needed] to [be] follow[ed] up".

49. Dr D confirmed that the blood test was arranged and that this was done the following day, on 26 Month5.

50. At 1.03pm on 26 Month5, it is noted that Mrs A was scratching all over her body and "refused and resisting every cares. Refused to drink and eat".

51. At 5.50pm, it is noted: "[Mrs A] appears unwell. Unable to swallow even drops of water from the sponge and appears she was almost choking." Observations were taken and remained within normal parameters — BP 110/70mmHg, respiration rate 19, heart rate 91 bpm, oxygen saturation 96% on room air, and temperature 36.3°C. Mrs A was noted to appear to be in pain when touched.

52. Dr D told HDC that the laboratory provided the blood test results to the Emergency Department because the results became available after hours. Subsequently, the public hospital contacted Elloughton Gardens to advise that Mrs A's renal function results were abnormal and indicated dehydration and a decline in renal function, and that Mrs A required intravenous fluids. The registered nurse recorded that because Elloughton Gardens could not give an intravenous infusion, Mrs A needed to be transferred to hospital.

53. An ambulance was called at 6.10pm and arrived at 6.22pm.

[11] Normal BP is generally considered to be between 90/60–140/90mmHg.
[12] Normal respiratory rate is 12–20 breaths per minute.
[13] Normal oxygen saturations are 95–100% on room air; 92% or less is considered low.
[14] Discoloration of the skin owing to bleeding under the skin, usually caused by bruising.

Admission to hospital

54. Mrs A arrived at the Emergency Department at 7.05pm. On assessment, she was found to be severely dehydrated. She was diagnosed with acute on chronic renal impairment and also pneumonia. She was admitted under the General Medicine team.

55. On 27 Month5, it was decided to manage Mrs A with comfort cares. Sadly, she died later that evening.

56. A DHB consultant physician/cardiologist reported to the Coroner that on 26 Month5, the medical laboratory contacted an ED physician to advise that Mrs A's serum sodium results had come back "significantly abnormal and elevated at 179mmol/L". The consultant physician/cardiologist stated that "[u]pon reviewing the blood results, the ED physician requested for Mrs A to be brought in to hospital for a formal review".

57. The consultant physician/cardiologist told the Coroner:

> "Upon arrival to hospital, [Mrs A] was reviewed by [the ED physician] who reported that she was a confused, cachectic,[15] elderly lady who was seen moving all four of her limbs. However, she was not following verbal instructions. She appeared severely dehydrated with very dry oral mucous membranes and crusting around both eyes. [The ED physician] also reported that she had visible skin tears over her arms and a stage 1 decubitus sacral ulcer. These lesions were erythematous and warm to touch. Her feet were reported to be dusky, cold and pulseless."

58. In relation to the management of Mrs A's decreased food and fluid intake between 18 and 26 Month5, Radius stated:

> "[F]rom 18 to 26 [Month5], [Mrs A's] food and fluid intake reduced again. [Mrs A] refused to consume most of her food, and only accepted the Ensure powder drinks. Radius confirms that, over this period, it continued to offer [Mrs A] food and fluid regularly in accordance with [Mrs A's] food and fluid plan and Radius' Nutrition and Hydration policy."

59. In addition, Radius stated:

> "Staff are all trained to recognise the signs of dehydration. As [Mrs A] was not able to verbally express her needs and/or feed herself as a result of her dementia, staff were acutely aware of the importance of checking on [Mrs A] regularly and keeping her fluid intake up. … [S]taff attempted to feed [Mrs A] water at every meal, and in between meals."

60. However, there is no documentation relating to any additional measures taken in recognition of Mrs A's dementia.

[15] Physical wasting with extreme loss of weight and muscle mass.

61. Dr C told the Coroner:

> "From my perspective [Mrs A] had advanced/end-stage dementia with a history of heart failure controlled on medication. She was gradually deteriorating with reduced oral intake which is typical of the late stages of Dementia. This often leads to death from dehydration/anorexia with the emphasis on comfort care during the dying process."

Further comment

Ms B

62. Ms B told HDC that she was "deeply shocked and heartbroken" when she saw the "appalling condition" her mother was in by the time she reached the hospital on 26 Month5, having seen her only 10 days previously. Ms B stated:

> "I feel my mother did not receive adequate medical care, fluids and water intake when in isolation for nine days at Radius Elloughton.
>
> Duty of care was clearly not shown by the four nurses while my mother was in isolation, particularly on my mother's last day at Elloughton Gardens."

Radius

63. In relation to maintaining Mrs A's hydration, Radius stated:

> "Radius accepts that [Mrs A's] fluid intake during her stay at [Elloughton Gardens] was variable. The staff have reported that it was extremely difficult to keep [Mrs A's] fluid intake up, as she often refused to sip or swallow fluids. Further, [Elloughton Gardens] does not have the equipment/means to provide intravenous fluid to residents. Radius is confident that it did the best it could in the circumstances to keep [Mrs A's] fluid intake up — which involved attempting to feed [Mrs A] fluid at every meal time, and in between meal times, implementing a food and fluid intake chart, and ensuring that she was regularly reviewed by a dietician."

64. Radius also stated:

> "With the benefit of hindsight, Radius now accepts that it should have held a multidisciplinary team review with [Mrs A's] family and GP in Month5 when it was evident that [Mrs A's] health was deteriorating. Radius confirms that, at this meeting, the attending parties would have discussed [Mrs A's] changing health status, her medical needs, and her resistance to consuming food and fluids, and would have put in place a detailed care plan for [Mrs A] moving forward.
>
> Having had an opportunity to reflect on the case, Radius now accepts that it should have recognized that [Mrs A] was approaching a palliative care phase in Month5. Radius confirms that, had a multidisciplinary team review taken place, it is likely that it would have developed a palliative care plan for [Mrs A]. It is likely that this plan would

> have set out that providing comfort cares at Elloughton Gardens was preferable to hospital admission."

65. However, Radius believes that Mrs A was provided with an appropriate level of care while at Elloughton Gardens. Radius stated:

> "Radius denies that [Mrs A] did not receive the requisite level of care during her stay at [Elloughton Gardens]. Radius refers to the progress notes and clinical notes in support which show that between 15 [Month5] and 26 [Month5], appropriate nursing action was taken."

66. Radius concluded:

> "Radius takes the care of all residents very seriously, and was upset to discover that [Mrs A's] family were unhappy with the level of care provided to [Mrs A] at [Elloughton Gardens]. While Radius feels saddened for [Mrs A's] family, it remains of the view that the care and services it provided to [Mrs A] was reasonable and appropriate."

Changes made by Radius

67. Radius stated that it has reflected on the adequacy of its policies and practices, and "accepts that its note-taking and documentation practices need tightening, and also that it should have falls risk management in place for its residents".

68. Radius said that it is undertaking a "robust review" of its internal policies and practices "to ensure it has all appropriate policies and plans in place and that care delivery is provided in accordance with Radius' policies, procedures and guidelines and to ensure that Radius' systems are utilised and well embedded".

69. Radius advised that it now "ensures that its long term care plans always include details relating to a range of areas, including diet and nutrition". Radius stated:

> "[Radius has] tightened its documentation processes to ensure that all documentation is completed fully, accurately and in a timely manner. This is reflected in the orientation and ongoing training/education staff receive at Radius. Radius' compliance with its documentation processes is regularly reviewed through its internal audit process."

Radius's policies

70. The Radius Nutrition and Hydration policy (March 2018) states:

> "Providing clients with optimal nutritional care is an integral part of their treatment, and provision of appropriate food and fluids to meet their needs is essential to maximise individual health outcomes.
>
> …

> We have a responsibility for ensuring that appropriate systems and processes are in place to ensure that all clients have access to food and hydration appropriate to their needs."

71. The policy lists "some of the warning signs of dehydration", including:

> "Client drinks less than 6 cups of fluid per day or needs help drinking or swallowing …
>
> Client has dry mouth or cracked lips
>
> Dark urine
>
> Client experiences an increased number of falls and recurrent infections
>
> All clients who demonstrate clinical signs of dehydration or [who] are at risk of dehydration must be commenced on a fluid balance chart, medical officer notified and hydration assessment completed each duty by clinical staff."

72. The Radius Assessment, Care Planning & Review policy (March 2018) states: "Assessment, care planning and review/evaluation processes will form the basis for all healthcare delivery to all clients within Radius Residential Care facilities."

73. Under "Assessment", the policy states: "Within three weeks of admission the full multidisciplinary client assessment is to be completed using InterRai."

74. Under "Care Planning", the policy states:

> "On completion of the assessment phase and within three weeks of admission a long term care plan which addresses client centred needs and goals is to be developed in collaboration with the client, family/whānau and the multidisciplinary team."

Response to provisional opinion

Radius

75. Radius's response to the provisional opinion has been incorporated into the "information gathered" section of this report where appropriate.

76. In addition, Radius submitted that Elloughton Gardens has since undergone certification and surveillance audits that have identified no issues in relation to its systems, processes, policies, and procedures, or the training of staff to use those systems and processes. Radius submitted that these audit findings do not reflect a culture of poor care.

77. Radius also submitted that the nursing competencies to ensure adequate nutrition and hydration, and undertake assessment of Mrs A "were not complex or difficult". It stated:

> "Radius considers that the [Deputy Commissioner's opinion] should emphasise the role of the nursing staff in terms of the expected competencies of such nurses rather than solely attributing this to an alleged culture of poor care."

Ms B

78. Ms B was provided with a copy of the "information gathered" section of the provisional opinion. Her response has been incorporated into the report where appropriate.

Opinion: Radius Residential Care Limited — breach

Introduction

79. Radius had an organisational duty to provide Mrs A services with reasonable care and skill and to comply with the Code of Health and Disability Services Consumers' Rights (the Code). This included responsibility for the actions of its staff.

80. During her stay at Elloughton Gardens, there were a number of deficiencies in the services provided to Mrs A, which meant that the care she received fell below acceptable standards. While the individual nurses involved in Mrs A's care hold a degree of responsibility, given the number of staff involved in caring for Mrs A, as discussed below, I consider that Radius holds primary responsibility for these failures at a systems level.

Care planning

81. The Radius Assessment, Care Planning & Review policy (March 2018) states: "Assessment, care planning and review/evaluation processes will form the basis for all healthcare delivery to all clients within Radius Residential Care facilities."

82. Under "Assessment", the policy states: "Within three weeks of admission the full multidisciplinary client assessment is to be completed using InterRAI."

83. Under "Care Planning", the policy states:

> "On completion of the assessment phase and within three weeks of admission a long term care plan which addresses client centred needs and goals is to be developed in collaboration with the client, family/whānau and the multidisciplinary team."

84. The Radius Nutrition and Hydration policy (March 2018) states:

> "Providing clients with optimal nutritional care is an integral part of their treatment, and provision of appropriate food and fluids to meet their needs is essential to maximise individual health outcomes.
>
> …

> We have a responsibility for ensuring that appropriate systems and processes are in place to ensure that all clients have access to food and hydration appropriate to their needs."

85. Mrs A deteriorated during her stay at Elloughton Gardens. Mrs A's deterioration was not unexpected owing to her severe dementia. However, I have a number of concerns about the way this was managed and responded to by staff.

86. Prior to Mrs A's admission to Elloughton Gardens she was assessed as "independent with eating and drinking once set up and given prompts".[16] She was noted at times to be "resistant and a little agitated toward staff with food, fluid and medication", but easily persuaded.[17]

87. At the time of admission to Elloughton Gardens, on 11 Month2, an interim care plan was developed, which recorded that Mrs A had weight problems and a poor appetite, and was unable to feed herself. I note that in response to the provisional opinion Radius submitted that the above assessment was based on a limited amount of information, and that Mrs A was not always easily persuaded to eat and drink.

88. In relation to its management of Mrs A's food and fluid intake, Radius told HDC:

> "While Radius accepts that it did not have a formal long term care plan in place relating to [Mrs A's] needs in relation to maintaining adequate hydration, it confirms that there was always a plan in place for [Mrs A] relating to her food and fluid intake, and that there was daily reporting in accordance with this plan, for the vast majority of her stay in Elloughton Gardens."

89. However, there is no documented plan regarding ensuring that Mrs A maintained adequate food and fluid intake.

90. My expert advisor, RN Parmee, stated:

> "Accepted practice would have been to develop a care plan on admission to [Elloughton Gardens] which included the need to maintain [Mrs A's] fluid intake with measures such as ensuring fluid was available to her and that in recognition of her dementia was encouraged/reminded to drink regularly (as part of every interaction with staff). … Given [Mrs A's] severe dementia it may be assumed that she was not always able to initiate drinking of fluid independently and would therefore require caregivers to provide prompts as well as accessibility to fluids."

91. RN Parmee also raised concern that an accurate interRAI assessment was not completed within three weeks of Mrs A's admission. RN Parmee advised that had an interRAI

[16] interRAI assessment, dated 28 Month1.
[17] DHB progress notes.

assessment been completed, a number of areas, including communication, nutrition, and falls, would have contributed to the resulting long-term care plan.

92. I accept RN Parmee's advice. Although I accept that a multidisciplinary assessment was undertaken at the time of Mrs A's admission, and Mrs A's eating and weight issues identified, no specific care plan, including a review/evaluation process, was developed in relation to maintaining her food and fluid intake at that time. I am also concerned about the failure to undertake an interRAI assessment within the required timeframe. As noted by RN Parmee:

> "Assessment leads to a structured and documented care plan which identifies client centred needs and appropriate evidence-based care/interventions with evaluation/ review describing the achievement of goals to these needs."

93. In my view, this was not done in a timely manner following Mrs A's admission.

94. I am also mindful of very similar observations being communicated by Mrs A's GP in his statement to the Coroner, where he referred to Mrs A as "gradually deteriorating with reduced oral intake which is typical of the late stages of Dementia". This reinforces the significance of nutrition for Mrs A, a frail woman with advanced dementia.

95. Following Mrs A's admission, Ms B raised concerns about her mother's food and fluid intake. Ms B stated that on a number of occasions visitors noted that when her mother was offered drinks by them, often she was thirsty.

96. In response to Ms B's concerns, the Facility Manager noted that while staff did help Mrs A with her meals, she could take a long time to feed, and a food and fluid chart was commenced on 6 Month3. On 9 Month3, an incident form was completed for "weight loss of 2.9 kg", and a referral to a dietician was made.

97. Staff continued to record Mrs A's daily food and fluid intake, and the dietician reviewed her on three occasions.

98. Radius told HDC:

> "Generally, [Mrs A] would only agree to eat ¼ to ½ of her meal, and on occasion she would refuse to eat any of her meal. This was likely due to her worsening dementia and pre-existing conditions (which included difficulty swallowing). As a result of this, and to avoid undernutrition and dehydration, Radius implemented a plan to feed [Mrs A] frequent small meals and fluids, and to weigh her monthly, or more often as indicated. It also developed a food and fluid chart for [Mrs A] to record and monitor her food and fluid intake."

99. In response to this, RN Parmee commented:

> "This implies that she had made an informed decision to eat a certain amount and puts the onus on her rather than recognising the effects of her dementia and deteriorating condition."

100. RN Parmee also noted that there is no reference in the clinical records to Mrs A having difficulty swallowing. RN Parmee advised:

> "The expected standard is that there is a comprehensive care plan available to inform care staff of interventions required to meet resident needs and daily reporting on the implementation of this plan [and] policy is adhered to and that there is adequate documentation of evidence to support this. This would then provide evidence and assurance that policy requirements were being met."

101. RN Parmee noted the strategies used by Ms B to encourage her mother to eat and drink. RN Parmee stated:

> "There does not appear to be any evidence in care plans or progress notes that principles of care of people with dementia were being used, particularly in terms of administering food and fluids."

102. I accept this advice. While a food and fluid chart was commenced after Ms B raised concerns, there is no evidence of the information having been monitored and responded to.

Response to deterioration

103. From 18 Month5, Mrs A was nursed in her room because of the possibility that she might have scabies. During this time, Mrs A's food and fluid intake decreased.

104. Radius stated:

> "[F]rom 18 to 26 [Month5], [Mrs A's] food and fluid intake reduced again. [Mrs A] refused to consume most of her food, and only accepted the Ensure powder drinks. Radius confirms that, over this period, it continued to offer [Mrs A] food and fluid regularly in accordance with [Mrs A's] food and fluid plan and Radius' Nutrition and Hydration policy."

105. Radius's Nutrition and Hydration policy (March 2018) lists "some of the warning signs of dehydration", including:

> "Client drinks less than 6 cups of fluid per day or needs help drinking or swallowing …
>
> Client has dry mouth or cracked lips
>
> Dark urine
>
> Client experiences an increased number of falls and recurrent infections

> All clients who demonstrate clinical signs of dehydration or [who] are at risk of dehydration must be commenced on a fluid balance chart, medical officer notified and hydration assessment completed each duty by clinical staff."

106. RN Parmee advised that in her opinion, Mrs A was exhibiting all of the listed signs of dehydration. RN Parmee stated: "It was also clear that her health status had changed significantly during this time giving a clear signal that palliative care was indicated."

107. Despite this, no further action was taken, including referring Mrs A for clinical review or undertaking additional monitoring. It was not until 25 Month5 that a referral was made to the GP and a blood test was ordered.

108. RN Parmee stated:

> "While the food and fluid chart continued during the time that [Mrs A] was in isolation and deteriorating, there is no evidence that the information recorded was acted on through a review of interventions and care planning."

109. RN Parmee noted Radius's acknowledgement that a multidisciplinary team meeting should have been arranged, and that had that occurred, a palliative care plan would likely have been put in place. However, RN Parmee stated:

> "I do not accept that this excuses the lack of assessment and planning of [Mrs A's] care. There were very clear signs that [Mrs A] was dehydrated and that her health was deteriorating between 18th and 26th [Month5] which should have been acted on rather than simply recorded."

110. RN Parmee noted the Nursing Council of New Zealand *Competencies for registered nurses* Domain one, two, and four, and stated:

> "In my opinion there was a failure to meet these competencies through lack of response to clear signals that [Mrs A] was in a state of dehydration and deterioration. The response should have taken place and triggered the need for a multidisciplinary team meeting rather than a multidisciplinary team meeting triggering a response."

111. I accept this advice. It is extremely concerning and disappointing that the group was convened only in response to Mrs A's significant demise, and not in anticipation of it. I note RN Parmee's view that the failure to manage Mrs A's fluid intake from 18 Month5 would be considered a severe departure from accepted standards.

Management of suspected scabies

112. There was an eight-day delay in a skin scraping being performed to investigate the presence of scabies — from 18 Month5 when Dr C requested it, until 25 Month5 when it was undertaken — during which time Mrs A remained in precautionary isolation in her room.

113. Radius explained that the delay was caused by "a number of intervening events that occurred", including Mrs A suffering some skin tears — one of which required her to go to hospital — and Dr C going on leave.

114. RN Parmee advised:

> "This delay was particularly significant as [Mrs A] suffered from dementia and would have had limited understanding of the isolation process and was prevented from attending her usual social events. This situation would have been distressing for any resident but magnified for a person with dementia and may have contributed to a decline in her health status."

115. Further to this, RN Parmee does not accept that any of the "intervening events", as set out by Radius, would have precluded a skin scraping — a "relatively simple procedure that a Registered Nurse could complete" — being obtained.

116. RN Parmee advised that for any condition that requires isolation, the accepted standard of practice would be to obtain a diagnosis as soon as possible. RN Parmee considers that the failure to do so in this case was a "severe departure" from accepted practice. I accept RN Parmee's advice.

117. I note that Radius "concedes that the delay in obtaining the skin scraping for suspicion of scabies was unacceptable", but stated that it was a one-off occurrence and that it has spoken to the staff involved, who have "given their assurance that it will not happen again".

Conclusion

118. I have a number of concerns about the care provided to Mrs A while at Elloughton Gardens. As noted above, Mrs A's deterioration was not unexpected, owing to her severe dementia, of which dehydration is a common feature, and she was reliant on staff to identify this and to implement appropriate care, in agreement with the family.

119. I note RN Parmee's view:

> "Registered Nurses were practising in a culture whereby they were not meeting the Nursing Council competencies for the RN scope of practice in terms of responding to information provided from monitoring processes (such as food and fluid charts) and completing required assessments and care planning. Caregivers did not appear to be using strategies consistent with caring for a person with dementia."

120. It was the responsibility of Radius to have in place adequate systems to ensure that staff provided Mrs A with care of an appropriate standard and that complied with the Code. In my view, a number of aspects of the care provided to Mrs A were deficient, and the failures of multiple nursing staff involved in Mrs A's care demonstrate a pattern of suboptimal care. In particular:

a) The failure to undertake an interRAI assessment within three weeks of admission in accordance with policy.

b) The failure of staff to implement an adequate care plan for food and nutrition, taking into account [Mrs A's] dementia.

c) The failure of multiple staff to identify and respond to signs of dehydration and deterioration between 18 and 25 Month5.

d) The failure to undertake a skin scraping in a timely manner.

121. Overall, as set out above, I consider that the care provided to Mrs A by Radius, as the service operator, was inadequate. Accordingly, I find that Radius failed to provide services to Mrs A with reasonable care and skill, and breached Right 4(1) of the Code.[18]

Recommendations

122. I recommend that within three months of the date of this report, Radius:

a) Provide a written apology to Mrs A's family 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 to the family.

b) Provide HDC with an update on the outcome of the review of its policies and practices, including details of what changes, if any, have been made, and how it has monitored the effectiveness of these changes.

c) Provide HDC with a copy of its updated long-term care plan policy and related template, in particular the sections relating to diet and nutrition.

d) Provide HDC with a copy of its updated palliative care policy and related planning templates, in particular the sections relating to circumstances where a multidisciplinary team review, including both the consumer's GP and family, should take place.

e) Report to HDC on the audits it has undertaken to monitor compliance with its Nutrition and Hydration policy, including any actions taken in response to any issues identified.

f) Provide HDC with a copy of the orientation manual relating to documentation.

g) Provide HDC with a copy of its last two internal audits relating to documentation and, where issues have been identified from the audits, provide a report on any remedial actions undertaken.

Points (b) to (g) should be provided to HDC within three months of the date of this report.

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

123. I also recommend that Radius use an anonymised version of this report as a case study to provide continuing education to nursing staff at its facilities, and confirm to HDC that this has been done within six months of the date of this report.

Follow-up actions

124. A copy of this report with details identifying the parties removed, except Radius Residential Care Limited and the expert who advised on this case, will be sent to the district health board, and it will be advised of the name of Radius Residential Care Limited (trading as Elloughton Gardens).

125. A copy of this report with details identifying the parties removed, except Radius Residential Care Limited (trading as Elloughton Gardens) and the expert who advised on this case, will be sent to the Nursing Council of New Zealand, the Health Quality & Safety Commission, and the Ministry of Health (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 Radius Elloughton Gardens (Radius) to [Mrs A] between 11 [Month2] and 26 [Month5]. 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 co-ordinating 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 Radius was reasonable in the circumstances and why, with comment on:

1. The appropriateness of the steps taken to manage [Mrs A's] fluid intake
2. 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 22 December 2018
2. Radius' response dated 15 March 2019
3. Clinical records from Radius covering the period 11 [Month2] to 26 [Month5]
4. Letter from [Consultant Cardiologist] at the DHB dated 23 October 2018
5. Clinical records from the DHB covering the period 26 [Month5] to 27 [Month5]

5. Background

[Mrs A] was admitted to Radius on 11 [Month2] for dementia care. On 26 [Month5] she appeared unwell and her blood tests for renal function were abnormal. [Mrs A] was transferred to [hospital] and upon admission was found to be severely dehydrated.

Review of Documents

6. The appropriateness of the steps taken to manage [Mrs A's] fluid intake

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

It is stated in the documentation provided on [Mrs A's] admission to REG that [Mrs A] suffered from severe dementia but did not require a Dementia Level Hospital placement, therefore it was considered appropriate to transfer her from D3 [dementia care] to the Hospital Level care which could be provided at REG. She was described as settled and interacting pleasantly. It also stated that [Mrs A] can sometimes present as resistant and a little agitated toward staff with food, fluid and medication, however she is easily persuaded and therefore appropriately placed in Hospital level care.

In [the DHB's] Transfer Notice of Nursing Care, it states that [Mrs A] 'drinks well if fluids in reach and needs assistance with meals.'

An InterRAI assessment form was completed and dated 28th [Month1] by [the] Quality Manager. The form was completed while [Mrs A] was in hospital recovering from a fractured hip. Much of the form is completed with the statement 'currently in hospital with fractured hip'. It states that she was 'independent with eating and drinking once set up and given prompts'.

Further assessments (Multidisciplinary assessment) and an interim care plan completed on 11th and 12th [Month2] state that [Mrs A] had weight problems (underweight and frail) and was unable to feed herself. It also states that she was easily distracted and forgets to eat and needs assistance to eat and drink.

The InterRAI assessment was not completed under the conditions required for completion of the assessment. The assessment should follow 3 days of observation and interaction with the client in order to accurately complete each section of the assessment including interviews with staff caring for the client, particularly where the client is unable to give answers due to disability such as dementia in [Mrs A's] case.

There is clearly a discrepancy between the [Month1] and [Month2] assessments in terms of [Mrs A's] ability to meet her nutritional needs.

Accepted practice would have been to develop a care plan on admission to REG which included the need to maintain [Mrs A's] fluid intake with measures such as ensuring fluid was available to her and that in recognition of her dementia was encouraged/reminded to drink regularly (as part of every interaction with staff). The statement by [Mrs A's] daughter indicates that [Mrs A] readily took drinks from friends, relatives and other residents when offered and was often thirsty. Given [Mrs A's] severe dementia it may be assumed that she was not always able to initiate drinking of fluid independently and would therefore require caregivers to provide prompts as well as accessibility to fluids.

It is noted in the response on behalf of REG that [Mrs A] was becoming increasingly resistant to assistance with cares including eating and drinking and that a food and fluid chart was implemented to record food and fluid intake with recordings made. Records for [Month3] and [Month4] were included in the documentation provided. In total there were 8 refusals recorded in [Month3] and 2 in [Month4] when recordings were being made up to 6 times a day. The food and fluid chart was stopped on the advice of the dietitian on 18th [Month5] as [Mrs A's] nutritional status had improved with this intervention. It can be assumed that the need to record [Mrs A's] fluid intake also acted as a prompt for caregivers to offer fluids and supplements regularly with the result in [Mrs A's] weight and hydration.

On the same day that the food and fluid chart was stopped [Mrs A] was placed in informal isolation as a precaution for suspected Scabies. The response provided on behalf of REG states that [Mrs A] was not put in 'formal isolation' on suspicion of scabies as hers was an isolated case rather than part of an outbreak. However, [Mrs A] was isolated to her room and 'staff took precautions' when attending to her cares. The nature of these precautions is not stated in the response or in the short-term care plans and progress notes provided. It may be assumed that these precautions could have included reduced contact and therefore reduced encouragement of fluids and monitoring of [Mrs A's] hydration status and general condition. The records of [Mrs A's] daily care from 18th to 26th [Month5] provide the following information related to her food and fluid intake:

18th [Month5]	Ate and drank moderately
	Dietician stopped food and fluid chart
	Ate and drank fairly

19th [Month5]	Eating and drinking less Ate and drank less	
20th [Month5]	Eating and drinking less	
21st [Month5]	Ate moderately Drinking well	
22nd [Month5]	Eating and drinking well Monitored every now and then Drank 2 cups water and ensure Eating and drinking well with good appetite 9.30pm — Difficulty breathing — obs taken	
23rd [Month5]	Refused meds Drank Ensure. Still in isolation	
24th [Month5]	Refused eating. No concerns	
25th [Month5]	4 pm. 8.23 pm 10.57	Refused to eat anything Ate and drank poorly Gave her sips of fluids
26th [Month5]	1.03pm 10.27 pm 10.37 pm	Refused to eat and drink Eat and drink at teatime Unable to swallow even drops of water from the sponge and appears she almost choking

It appears, from this information that [Mrs A] was eating and drinking 'less' for the 2 days following cessation of her food and fluid chart. She then had 2 days where she was eating and drinking well and then refused to eat and drank very little for the following 4 days.

The notes for the 26th [Month5] are particularly concerning with records made 10 minutes apart which are completely contradictory (see highlighted section).

The note dated 23rd [Month5] states that she is still in isolation even though the statement on behalf of Radius Elloughton Gardens states that she was never in formal isolation.

Apart from the entry on 22nd [Month5] which states the amount of fluid taken there is no evidence of the amount of fluid taken. Terms such as moderate, less and poorly do not give accurate indication of the level of [Mrs A's] fluid intake. It is concerning that the term 'less' is used in the 2 days following cessation of the fluid chart. This should have been a trigger that closer monitoring needed to be put back in place.

The documentation provided signals at least 7 days of inadequate fluid intake resulting in the signs and symptoms [Mrs A] presented within the Emergency Department at [the] Hospital consistent with severe dehydration including:

> ‘sodium results significantly abnormal and elevated at 179 mmol/L consistent with acute on chronic renal failure … appeared severely dehydrated with very dry oral mucous membranes and crusting around both eyes’ (ref Letter [consultant physician/cardiologist] dated [2018])

This finding appears consistent with the family’s assertion that [Mrs A’s] fluid intake was not monitored adequately.

In the response on behalf of REG it is stated that Radius staff are all trained to recognise signs of dehydration and acutely aware of the importance of checking on [Mrs A] regularly and keeping her fluid intake up.

The Radius Care Nutrition and Hydration policy states the following

> *9.2 … where requested or indicated food and fluid intake need to be recorded daily by care staff on the daily food and fluid monitoring form.*
>
> *9.4 The warning signs of dehydration to be observed:*
>
> *Client drinks less than 6 cups of fluid per day or needs help drinking*
>
> *Client has dry mouth or cracked lips*
>
> *Dark urine*
>
> *All clients who demonstrate clinical signs of dehydration … must be commenced on a fluid balance chart, medical officer notified, and hydration assessment completed each duty by clinical staff.*

On admission to [hospital] on the 26th [Month5], [Mrs A] was exhibiting each of these signs of dehydration. Her fluid balance was not monitored or reported daily during the 9 days following cessation of the food and fluid chart. It was not until the 25th of [Month5] that a blood test was ordered by [Dr D] to assess renal function. I am unable to locate a record of the circumstances which prompted this order.

The response also refers to the food and fluid charts as evidence that [Mrs A’s] hydration status was being addressed and monitored. As mentioned above the food and fluid chart had been discontinued on the day [Mrs A] was placed in informal isolation for suspected scabies so does not provide evidence of maintenance of her hydration during the 9-day period prior to her hospitalisation.

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

I believe there to have been a severe departure from the accepted standard of care. It appears, in the absence of adequate documentation and the status of [Mrs A] on admission to [hospital], that she was not cared for during the 9 days prior to [Mrs A’s] admission to [hospital], in accordance with the Nutrition and Hydration Policy.

There is no formal careplan available which sets out [Mrs A's] needs in relation to maintaining adequate hydration such as her severe dementia necessitating regular encouragement to drink.

The expected standard is that there is a comprehensive careplan available to inform care staff of interventions required to meet resident needs and daily reporting on the implementation of this plan. Policy is adhered to and that there is adequate documentation of evidence to support this. This would then provide evidence and assurance that policy requirements were being met.

c. How would it be viewed by your peers?

My peers in education and practice would agree with this finding.

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

I believe there needs to be a review of care planning and documentation in the Facility with attention to the adequacy of daily reporting of patient status. The rationale for this recommendation is discussed below.

Along with this there needs to be review of staff understanding of the rationale behind the Nutrition and Hydration policy and the impact of severe dementia on resident's decision making and ability to initiate self-care.

e. Any other matters that I consider warrant comment.

I would like also to comment on the implementation of the Assessment, Care plans and Review Policy at REG. This has relevance to other areas covered in the response on behalf of Radius Elloughton Gardens (REG), the management of [Mrs A's] skin irritation, her fall and subsequent wounds. I believe the management and documentation of these have relevance in the lead up to [Mrs A's] hospitalisation on the 26th [Month5].

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

The policy states that *assessment, care planning and review/evaluation processes will form the basis for all healthcare delivery to all clients within Radius Care facilities*. Assessment leads to a structured and documented careplan which identifies client centred needs and appropriate evidence-based care/interventions with evaluation/ review describing the achievement of goals related to these needs.

The expected standard is that within three weeks of admission a full multidisciplinary assessment is to be completed along with an accurate InterRAI assessment using the required method of data collection. The InterRAI assessment was inaccurate and did not follow accepted practice. There is no evidence that a careplan appropriate to [Mrs A's] needs was developed from the information gathered in the multidisciplinary assessment. Of importance in relation to this case is the need for an appropriate care

plan linked to the assessments listed under *5.1.4 including communication assessment, skin assessment/Pressure Risk assessment, pain assessment, mini nutritional assessment and falls risk assessment.* Each of these areas were problematic for [Mrs A] and would have been triggered in an accurate InterRAI assessment and contributed to the resulting long term careplan.

There is an interim careplan but no evidence of a long-term care plan. In fact, the response on REG's behalf notes:

> 'Radius has confirmed that its long-term care plans relate only to leisure and pastoral care and are therefore not relevant to this case. It also notes that it does not have a falls risk management plan for its residents.'

These statements are in direct contradiction to the Assessment, Care Planning and Review Policy and the Falls Prevention Policy.

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 expected standard of care. The lack of adherence to policies in terms of assessment and care planning, along with inadequate records of care provided, particularly following the suspicion of scabies and cessation of the food and fluid chart, mean that there is inadequate evidence of the care provided to [Mrs A] in the last 9 days she was at REG.

I am led to the conclusion that inadequate care was provided during the 9-day period leading up to [Mrs A's] hospitalisation, particularly in terms of meeting her hydration requirements.

c. How would it be viewed by my peers?

My peers in education and practice would, I believe, agree with this conclusion.

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

As stated above Implementation of policies particularly in relation to accurate assessment, care-planning and comprehensive documentation is required."

RN Parmee provided the following further advice:

"Thank you for the opportunity to provide further advice on this case for which I provided initial advice on 3rd December 2019.

I am asked to review new information provided by [Ms B] and Radius Elloughton Gardens (Radius) and to advise:

1. Whether the new information causes me change or add to my initial advice

2. Whether the new information raises any issues
3. Where I have identified departures from the standard of care or accepted practice, either in my initial report or this report, whether these departures are attributable to systemic factors, individual error, or a combination of both

I have been provided with the following documents:

1. [Ms B's] letter of complaint dated 22nd December 2018
2. Radius's response dated 15th March 2019.
3. A copy of my expert advice dated 3rd December 2019
4. [Ms B's] letter to HDC dated 14 January 2020
5. Radius's letter to HDC dated 17 February 2020
6. Various records, policies.

Review of documents.

1. Whether the new information causes me change or add to my initial advice

My initial advice focussed on the appropriateness of the steps taken to manage [Mrs A's] fluid intake and the implementation of the Assessment, Care plans and Review Policy at REG.

1. The appropriateness of the steps taken to manage [Mrs A's] fluid intake.

In their response REG make the following points:

1. 'During her stay at REG [Mrs A] became increasingly resistant to her cares including assistance with eating and drinking … she would only agree to eat ¼ to ½ of her meal … This was likely due to her worsening dementia and pre-existing conditions (which included a difficulty with swallowing).' They go on to mention the measures put in place to avoid undernutrition and dehydration including the food and fluid chart. A copy of the food and fluid chart was supplied, which confirms that the food and fluid chart was continued during the time that [Mrs A] was in isolation (18th to 26th [Month5]).

2. Radius states that there should have been a multidisciplinary review including [Mrs A's] family and GP at the time that it was evident that [Mrs A's] health was deteriorating. They also reflect that at this time a palliative care plan would likely have been put in place.

Given this new information I now accept that a food and fluid chart was maintained during the time that [Mrs A] was in isolation and that this corresponded with entries in the progress notes. I also accept that the note made at 10.27 on 26th [Month5] was retrospective and that made at 10.37 was current.

However, I do not accept that the term 'agree to eat ¼ to ½ her meal' can be applied to a resident with severe dementia. This implies that she had made an informed decision to eat a certain amount and puts the onus on her rather than recognising the

effects of her dementia and deteriorating condition. I was unable to find any reference in her medical, nursing or dietitian records that [Mrs A] had difficulty swallowing. In fact, her interim care plan (dated 11th [Month2]) states that she has no chewing or swallowing difficulties (p 3).

In her report (dated 14th January 2020) [Ms B] stated that friends and relatives found [Mrs A] thirsty and very willing to drink when offered fluids. [Ms B] also noted that her mother was not placed at a table with people who required assistance with eating and drinking. She mentioned that she used the strategy of leaving her mother for a few minutes and then coming back if her mother was disinterested in food and fluids. The latter is a well-used strategy in the care of people with dementia. There does not appear to be any evidence in care plans or progress notes that principles of care of people with dementia were being used, particularly in terms of administering food and fluids.

While the food and fluid chart continued during the time that [Mrs A] was in isolation and deteriorating, there is no evidence that the information recorded was acted on through a review of interventions and care planning. While a multidisciplinary team meeting would have drawn closer attention and examination of [Mrs A's] deteriorating health and that a palliative care plan was indicated, I do not accept that this excuses the lack of assessment and planning of [Mrs A's] care. This should have happened as part of the day to day care provided to [Mrs A]. There were very clear signs that [Mrs A] was dehydrated and that her health was deteriorating between the 18th and 26th of [Month5] which should have been acted on rather than simply recorded. The Radius Care Nutrition and Hydration policy identifies the signs of dehydration, all of which [Mrs A] was exhibiting. It was also clear that her health status had changed significantly during this time giving a clear signal that palliative care was indicated.

The Nursing Council of New Zealand competencies for Registered Nurses include

> *Domain one: Professional responsibility*
>
> *This domain contains competencies that relate to professional, legal and ethical responsibilities and cultural safety. These include being able to demonstrate knowledge and judgement and being accountable for own actions and decisions, while promoting an environment that maximises health consumer safety, independence, quality of life and health.*
>
> *Domain two: Management of nursing care*
>
> *This domain contains competencies related to assessment and managing health consumer care, which is responsive to the consumers' needs, and which is supported by nursing knowledge and evidence-based research.*

Domain four: Interprofessional health care & quality improvement

This domain contains competencies to demonstrate that, as a member of the health care team, the nurse evaluates the effectiveness of care and promotes a nursing perspective

In my opinion there was a failure to meet these competencies through lack of response to clear signals that [Mrs A] was in a state of dehydration and deterioration. The response should have taken place and triggered the need for a multidisciplinary team meeting rather than a multidisciplinary team meeting triggering a response.

I maintain my initial opinion that there was a severe departure from the expected standard of care in terms of the management of [Mrs A's] fluid intake.

2. The implementation of the Assessment, Care plans and Review Policy at REG

In their response REG state that there was an interim care plan in place for [Mrs A] and not a long-term care plan based on an InterRAI assessment carried out within 3 weeks of admission. I accept that a multidisciplinary assessment was completed on admission. While training and tightening of documentation processes has taken place as a result of this complaint, I maintain my initial opinion that there was a severe departure from the expected standard of care. I believe this departure contributed to lack of appropriate intervention discussed above.

2. Whether the new information raises any issues

1. Management of suspected Scabies infection.

In her report dated 14th January 2020, [Ms B] raises concerns about the response from REG in relation to the timeliness of the skin scraping to diagnose scabies and the definition of the isolation [Mrs A] was in between 18th and 26th [Month5].

REG state that the delay in arranging the skin scraping was due to a number of intervening events including [Mrs A] suffering a number of knocks resulting in skin tear, a visit to the Emergency Department at [the public hospital] for a wound on her leg and a change in staffing at the medical centre.

This delay resulted in [Mrs A] being isolated unnecessarily for 9 days. This is particularly significant as [Mrs A] suffered from dementia and would have had limited understanding of the isolation process and was prevented from attending her usual social events. This situation would have been distressing for any resident but magnified for a person with dementia and may have contributed to a decline in her health status.

I agree with [Ms B] that none of the 'intervening events' preclude a skin scraping being obtained. Obtaining a skin scraping is a relatively simple procedure that a Registered Nurse could complete and process with a faxed lab form from the Medical Practice.

I therefore consider these events to be a severe departure from the expected standard which would be to obtain a diagnosis as soon as possible for any condition that necessitates isolation.

1. **Where I have identified departures from the standard of care or accepted practice, either in my initial report or this report, whether these departures are attributable to systemic factors, individual error, or a combination of both**

The departures that I have identified in this report and maintained from my initial report are, I believe, contributable to systemic factors and individual error.

As I have stated Registered Nurses were practising in a culture whereby they were not meeting the Nursing Council competencies for the RN scope of practice in terms of responding to information provided from monitoring processes (such as food and fluid charts) and completing required assessments and care planning. Caregivers did not appear to be using strategies consistent with caring for a person with dementia.

I acknowledge that REG has put appropriate staff education in place and has reviewed its assessment and documentation processes in response to this case.

Please do not hesitate to contact me if further advice is required."