Health New Zealand|Te Whatu Ora Counties Manukau

A Report by the

Aged Care Commissioner

(Case 20HDC00692)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to Health NZ Counties Manukau's management of Mr A during his admission between Month1[1] to Month3 2020, in particular his falls management and care planning.

Findings

2. The Aged Care Commissioner found that timely interventions were not always provided to reduce the risk of Mr A's falls, and there was a lack of consistency and quality in his care planning. The Aged Care Commissioner acknowledged the challenges Health NZ Counties Manukau was facing due to the COVID-19 pandemic but noted that this did not exclude it from fulfilling its duties under the Code, and accordingly, the Aged Care Commissioner found that Health NZ Counties Manukau breached Right 4(1) of the Code.

3. In addition, the Aged Care Commissioner was concerned about the standard of documentation in relation to Mr A's bed positioning and food charts and emphasised the importance of clear and objective documentation to inform decision-making and show that an agreed plan of care was being implemented. Furthermore, the Aged Care Commissioner considered that the issues around Mr A's oral care should have been communicated to the family at an earlier stage to formulate a more appropriate plan around sustainable oral care.

Recommendations

4. The Aged Care Commissioner recommended that Health NZ Counties Manukau provide an apology to Mr A's family for the deficiencies in care; update the falls policy to include a post-falls pathway; provide education/training to staff on pressure-injury and Waterlow assessments; and use this case for education/training on the importance of clear and objective documentation. In addition, the Aged Care Commissioner recommended that Health NZ Counties Manukau provide HDC with an update on the quality improvement project to mitigate falls and the project to revise the current plan of care.

Complaint and investigation

5. The Health and Disability Commissioner (HDC) received a complaint from Mr B about the services provided to his late father, Mr A, by Counties Manukau District Health Board (now Health New Zealand|Te Whatu Ora (Health NZ) Counties Manukau).[2] The following issue was identified for investigation:

[1] Relevant months are referred to as Month1–Month3 to protect privacy.

[2] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now called

- *Whether Counties Manukau District Health Board provided Mr A with an appropriate standard of care in Month1–Month3 2020 (inclusive).*

6. This report is the opinion of Aged Care Commissioner Carolyn Cooper and is made in accordance with the power delegated to her by the Commissioner.

7. The parties directly involved in the investigation were:

Mr A	Consumer
Mr B	Complainant/consumer's son
Health NZ Counties Manukau	Provider

8. Independent clinical advice was obtained from an older persons health and rehabilitation nurse, Registered Nurse (RN) Richard Scrase (Appendix A).

Information gathered during investigation

Background

9. Mr A (aged 88 years at the time of events) was admitted to Middlemore Hospital (Health NZ Counties Manukau) in Month1[3] (initially under Ward 1), with a 10-day history of lethargy, decline in mental function, and shortness of breath.

10. Following a chest X-ray, Mr A was diagnosed with left-sided empyema[4] and a left-sided trapped lung.[5] Aspirated cultures showed extended spectrum beta-lactamase (ESBL) *Escherichia coli* (E. coli).[6] He was transferred to a different ward (Ward 2) on 30 Month1, under the care of the Respiratory team. A chest drain was inserted, and he was treated with oral antibiotics and then subsequently with a course of intravenous (IV) antibiotics via a peripherally inserted central catheter (PICC) line.

11. Mr A remained on Ward 2 until 8 Month2, when he was transferred to a rehabilitation ward due to serious deconditioning.[7] While in the rehabilitation ward, Mr A showed re-accumulation of fluid in his lungs, and he required another chest drain. Due to increased clinical care needs, Mr A was transferred back to Ward 2 on 19 Month2.

Health New Zealand|Te Whatu Ora). All references in this report to Counties Manukau DHB now refer to Health NZ Counties Manukau.

[3] Mr A was admitted during the COVID-19 pandemic, when New Zealand was placed under COVID-19 Alert Level 4.

[4] A collection of pus in the space between the lung and the inner surface of the chest wall (pleural space).

[5] The lung cannot expand because of a remote inflammatory condition.

[6] E. coli is a bacterium. ESBL is an enzyme that makes the bacteria harder to treat with antibiotics.

[7] Deconditioning is the decline in physical function of the body as a result of physical inactivity and/or bedrest or an extremely sedentary lifestyle.

12. It was recognised early that Mr A had significant comorbidities, including a fall-induced haemothorax (a collection of blood in the chest) and a cognitive impairment.[8] Mr A was also at risk of delirium[9] and falls. He had four falls during his hospital admission, and he was allocated a one-to-one care partner because of his fluctuating delirium and high falls risk.

13. Despite drainage and treatment of his empyema, Mr A continued to deteriorate. He required oxygen for comfort but did not appear to be in any pain. Sadly, Mr A passed away in Month4 at 4pm in the presence of his son, Mr B. The cause of death documented in the hospital records was 'chronic left sided empyema, due to chronic left sided trapped lung'. I take this opportunity to extend my sincere condolences to Mr A's family and friends.

14. This report discusses the care provided to Mr A by Health NZ Counties Manukau. In particular, it considers the concerns Mr B raised about the management of Mr A's falls, and Mr A's 24-hour watch, care planning, bed positioning, nutrition and diet, and personal cares.

Delirium management

15. Daily care plans showed that in addition to his cognitive impairment, Mr A was at risk of delirium throughout most of his admission. In response to the provisional opinion, Mr B stated that Mr A's delirium was 'out of character', and on admission, Mr A was 'still engaging in conversation as he normally would', but three weeks later, his mental state had deteriorated severely.

16. Health NZ stated that 'it is very common for older patients who already have a degree of cognitive impairment to suffer delirium which [in Mr A's case would have] fluctuate[d] according to his fatigue and [chest] infection'.

Confusion Assessment Method (CAM) assessments

17. A CAM assessment is a tool for detecting delirium. A score of 0 indicates low risk, whereas a progressively higher score indicates increasing risk. It is noted on the CAM assessment that if a patient scores 1 or more, the assessment is to be repeated each shift, and a CAM care plan is to be completed.

18. Daily CAM assessments were completed between Month1 and Month2. Predominantly Mr A was assessed as low risk (scoring 0). It appears that no formal CAM assessments were undertaken between 1 and 28 Month2, but clinical entries during this time document the following scores:

- Day 1: CAM 0
- Day 3: CAM 1

[8] On 4 November 2019, Mr B had a Blind Montreal Cognitive Assessment (MoCA) score of 15/30 (moderate), deeming him mentally incapable. Mr B was his activated Enduring Power of Attorney.

[9] Delirium is an altered state of consciousness that can develop over hours or days. It results in confused thinking and a lack of awareness of the person's surroundings.

- Day 4: CAM = 1 moderate confusion
- Day 5: CAM — 2–3; CAM = 1 due to disorientation, rechecked and CAM — 1; CAM 1–2
- During 11 and 18 Month2, daily clinical entries documented Mr A's CAM score between 1–2
- 23 Month2: CAM 2 due to hallucination & acute confusion

19. Between 28 Month2 and 9 Month4, CAM assessments for Mr A were completed daily rather than on every shift (except on 28 Month3), with fluctuating scores of 0–4.

20. A CAM care plan for Mr A was not completed until 28 Month2, despite clinical notes showing that between 5 and 23 Month2 his CAM score fluctuated between 0 and 3.

21. Furthermore, the CAM assessment was not always repeated each shift when possible delirium was identified (scoring 1 or more on the assessment):

- On 13 Month3 at 6.44am, Mr A scored 4 on his CAM assessment, but no further assessment was completed until 6.41am on 14 Month3.
- On 22 Month3 at 8.58am, Mr A scored 2, but the next CAM assessment was not completed until 6.37am on 23 Month3, when again he scored 2.
- On 26 Month3 at 12.16pm, Mr A scored 3 on his CAM assessment, but his next assessment was not completed until 5.04pm on 27 Month3.
- On 27 Month3 at 10.34pm, Mr A scored 2, but the next assessment was not completed until 7.24am on 29 Month3, when he scored 4.

Medication for sleep cycles

22. Mr A was noted to be 'sleeping on and off', and on 8 Month3 a 'very small dose of quetiapine'[10] (12.5mg) was trialled to help Mr A with his nocturnal agitation, sleep, and ongoing confusion. It was noted that Mr A had refused the quetiapine on the night of 10 Month3, but that when he had taken it on 8 and 9 Month3, he slept better. Mr A was also charted 2mg of melatonin[11] on 11 Month3.

23. On 13 Month3 Mr A was '[a]gitated [and] very disorientated'. The quetiapine was stopped, and he was started on 5mg temazepam.[12] However, on 24 Month3 a decision was made to stop all unnecessary medication.

Care partner

24. Health NZ's 'Determining the need for Care Partners for patients with Behaviours of Concern' guideline states that when a patient requires a high level of observation,[13] a care

[10] Quetiapine is an antipsychotic medication used to treat certain mental/mood disorders.
[11] Melatonin helps to regulate night and day cycles or sleep-wake cycles.
[12] Temazepam is a medication generally used to treat severe or debilitating insomnia.
[13] This is based on a comprehensive assessment of a patient's clinical, cognitive, and mental health conditions, including behaviours of concern such as a high falls risk or being at risk of delirium.

partner will be allocated. The level of observation can either be time specific (15-minute checks) or constant visual (one-to-one, 24-hour watch).

25. Mr A received a care partner[14] because of his cognitive impairment, fluctuating delirium, and high falls risk. The care partner assisted him with personal cares, mobility, and eating and drinking. Health NZ told HDC that the need for a care partner is reviewed according to the patient's condition, and Mr A varied between requiring 15-minute checks and a one-to-one care partner. This is discussed in further detail below.

Falls management and 24-hour watch

26. Mr A experienced four falls during his time in hospital, one in Ward 1 and three in Ward 2. Mr B is particularly concerned that Mr A had two falls in one night on 29 Month2, having been left alone in the toilet when he was supposed to have a one-to-one care partner supervising him. These falls are discussed in detail below.

27. Health NZ stated that it regards patient falls as a serious matter. It said that although it has a number of safeguards and checks in place to prevent falls, unfortunately falls sometimes occur and may not be able to be prevented. Health NZ noted that '[h]uman factors such as patient impulsiveness and deteriorating condition or cognition' were contributing factors in Mr A's case.

28. Health NZ's 'Management and Prevention of Patient Falls' policy states:

> 'All patients in the care of Counties Manukau Health (CM Health) are assessed for risk of falls within 6 hours of admission, to outline the appropriate actions to be taken to minimise the risk of fall and the activities required following a fall.'

29. Health NZ's 'Patient Falls — The Immediate Management' guideline identifies actions that must be taken following a patient fall within a hospital environment. In particular, the guideline notes:

- 'Address any immediate safety issues. Falls prevention strategies must be implemented to prevent recurrent falls.'
- 'Consider delirium screen if recent onset of confusion.'
- 'Re-assess patient's falls risk score on ABC & MORSE Falls Assessment.[15]'
- 'Complete incident form on the Incident Reporting System, investigate and detail the likely reason the patient fell.'
- 'Complete the Post Fall checklist … Update plan of care.'

[14] A healthcare assistant (HCA).

[15] A tool used to assess a person's likelihood of falling based on the person's previous history of falls, diagnosis, current use of ambulatory aids, gait, mental status, and medication use. A score of 0–24 indicates low risk, whereas a progressively higher score indicates increasing risk levels.

30. Health NZ stated that appropriate interventions were in place at the time of Mr A's falls, and all Mr A's falls were managed appropriately according to the above guideline. This included a post-fall sticker, a post-fall checklist and an incident report, and a review and close of incident by the respective Charge Nurse Manager (CNM). Health NZ said that all intervention and recourses available during a night shift were utilised by the staff.

Morse Fall Scale (MSE) assessments

31. MSE assessments were completed regularly between 26 Month1 and 3 Month4, identifying Mr A as a high falls risk throughout his admission. On 26 Month1, his falls assessment score was 35 (high risk). MSE care plans were also completed regularly during this time. In addition, often Mr A's daily care plans identified the need for assistance with mobility, including the use of a walking frame.

Events surrounding fall one while on rehabilitation ward

32. Mr A was admitted to the rehabilitation ward on 8 Month2 for 'rehab post ESBL L) empyema'. He was assessed as a high falls risk (scoring 40 on his falls assessment) and provided with a walking frame. An Invisa-beam[16] was already in place. From 8 Month2 onwards, 15-minute patient checks were completed.

33. Clinical notes between 13 and 15 Month2 suggest an increase in Mr A's delirium. On 15 Month2, Mr A was seen by an occupational therapist/physiotherapist (OT/PT), who highlighted Mr A's reluctance to mobilise. The therapist noted: '[U]nable to mobilise pt. Pt remains RIB [resting in bed].'

Fall one — 15 Month2

34. Mr A's first fall occurred on 15 Month2 at 11.30pm and was witnessed. An incident form was completed, which stated that with the assistance of a registered nurse, Mr A attempted to walk to the toilet but did not follow instructions and left his walking frame too early to reach the toilet rails (approximately one metre away). As a result, he lost balance and fell on his right-hand side, landing on his hip and arm. Confusion and/or disorientation was also documented as a contributing factor. Mr A was noted to have been wearing 'firm supportive footwear' at the time of the incident.

35. The incident was reported to the on-call night house officer, who reviewed Mr A and noted that he had not sustained any injuries from the fall. The Severity Assessment Code[17] (SAC) for the incident was scored as 4 (minor). Health NZ stated that after this fall, a one-to-one care partner was appointed because of Mr A's fluctuating cognition.

Events surrounding falls two and three while on Ward 2

36. Mr A was transferred back to Ward 2 on 19 Month2 for ongoing care. The discharge plan from the rehabilitation ward stated: 'Please provide care partner for assistance.' Health NZ stated that a healthcare assistant was deployed to Ward 2 as the care partner on this

[16] A device that uses invisible infrared beams to monitor the bed or chair of people at risk of falling. If the patient starts to move from the bed or chair, the invisible beam is broken and the alarm triggered.
[17] A Severity Assessment Code is used to determine the appropriate action to take on an incident.

transfer, to enable Mr A to settle into a new environment. Clinical notes between 19 and 28 Month2 show that the one-to-one care partner was still in place.

37. Health NZ stated that staff complete a risk assessment every time a patient is moved to a new ward, and Mr A's risk assessment was completed upon transfer. However, both the falls assessment and care plan were not completed until 23 Month2 (four days after the transfer). The falls assessment showed an increase in risk (a score of 95) and noted that Mr A should not be left alone in the bathroom.

38. On 27 Month2, it was documented in the clinical notes that Mr A 'landed on x1 knee [with 2 assist]' while transferring back into bed with his walking frame. Mr A denied any pain. The patient observation form on 27 Month2 documents Mr A as settled, with no agitation and impulsiveness from 3pm to midnight.

39. On 28 Month2, Mr A scored 1 on his CAM assessment, identifying him as being at risk of delirium. He was reviewed by an OT/PT, who documented:

> '[Patient] significantly improved over the weekend … however underlying [cognitive] impairment evident … pt very impulsive, OT/PT needed to give verbal instructions to remind pt to take his time pt mobile 15m: [walking frame and 1 assist], unsteady gait pt [independently] sat back in chair.'

40. A chest X-ray later that day showed re-accumulation of fluid in the lung, and a family meeting was held. The need for palliative care in the community was discussed with Mr B. Clinical notes show that Mr B agreed with private hospital placement, and referrals were made to the palliative care team and the Needs Assessment and Service Co-ordination (NASC) for input.

41. Intentional rounding every 15–30 minutes commenced on 28 Month2.[18] The patient observation form from 28 Month2 (between 7am–3pm) shows that Mr A was checked every 15–30 minutes. The form was not completed from 3pm–11pm, but no concerns were highlighted.

Falls two and three — 29 Month2

42. On 29 Month2, Mr A experienced two unwitnessed falls (falls two and three). The first fall (fall two) on 29 Month2 occurred at 12.35am. Clinical notes show that a registered nurse had assisted Mr A to the bathroom, sat him on the toilet and then alerted the healthcare assistant out in the corridor to watch him in the bathroom. The healthcare assistant went to the bathroom and found Mr A sitting on the floor and helped him back to bed. It was documented that Mr A reported falling on his buttocks while attempting to rise from the toilet.

[18] It is not clear from the clinical notes when exactly, or why, the one-to-one care partner (referred to in paragraph 36) ceased prior to this.

43. Following this, the on-call night house officer assessed Mr A and noted no apparent injuries. The house officer requested hourly rounding, which was documented on the post-fall checklist. Health NZ told HDC that although hourly rounding was instructed, nursing staff undertook 30-minute rounding, as Mr A did not use the call-bell. Clinical notes from 6am on 29 Month2 documented that '[i]ntentional rounding was done [every] 30mins'. In response to the provisional opinion, Health NZ confirmed that half-hourly rounding was undertaken following fall two.

44. The second fall (fall three) on 29 Month2 occurred at 4am. Clinical notes document that Mr A had walked himself to the toilet unassisted, only to be found by staff sitting on the bathroom floor when the bell rang for assistance. Mr A was assisted back to bed and was reviewed by the house officer, who noted that Mr A had a minor skin tear on his right hand, which was cleaned and dressed.

45. Health NZ stated that following fall three, a care partner (for 15-minute checks) was ordered, as Mr A was noted to have on-and-off confusion due to his cognitive impairment. However, as the fall occurred during the night shift, a care partner could not be provided by the Duty Manager until the morning shift, although clinical notes show that a healthcare assistant watched Mr A until the care partner arrived.

46. Both falls were documented on one incident form. The incident form recorded that in both instances, assistance/supervision was not requested, and confusion and/or disorientation was a contributing factor. It does not appear that Mr A was wearing non-slip socks during either fall. The SAC was scored at 4 (minor) and further falls prevention interventions were implemented, including non-slip socks and a night light, and placing the bed in a low position.

47. The CAM assessment on the morning of 30 Month2 indicated that Mr A developed a mild to moderate delirium in the 24 hours after the fall, scoring a level 3. This was reassessed in the afternoon and had dropped to a score of 1.

48. On 30 Month2 Mr A was reviewed by an OT/PT, who noted: '[L]ikely will always need assistance at all times as high falls risk.' The 15-minute checks were 'terminate[d]' and a one-to-one care partner put in place, as Mr A was considered unsafe to be alone.

Decision to withdraw one-to-one care

49. On 1 Month3, following a discussion between Mr B and a NASC staff member, it was agreed that Mr A would be weaned off the one-to-one care partner with 'strict 15 minutely observations' in order to progress the discharge process and placement into palliative care. The NASC staff member noted:

> 'Son had chosen 2 potential facilities but neither have beds available as of today. Client has care partner which seems appropriate given his recent fall but [it] will be difficult to get acceptance to a facility when falls risk is so high as they won't provide 1:1 care.'

50. Health NZ stated that when patients are bound for placements after discharge, the staff use clinical judgement and start to wean one-to-one care partners to 15-minute checks to assist the patient to be independent, because there are no one-to-one care partners at placements. Clinical notes state: '[Mr B] is aware this may lead to ↑ falls risk but believes/ agrees it to be an appropriate decision.'

51. On 11 Month3 a bed became available in a residential care facility, and from the morning of 12 Month3 Mr A was moved to 15-minute checks for the next 36 hours, as per a consultant psychiatrist's suggestion. However, the one-to-one care partner was reinstated in the evening because Mr A kept trying to get out of bed by himself.

52. Mr A was seen by a 'Behaviors of Concern' specialist nurse on 18 Month3 regarding the need for on-going one-on-one observation. During this review it was noted that his delirium had 'resolved' but he was still at high risk of falls. The specialist nurse suggested:

> 'Continue 15/60 minute checks to assist with cares as required. Trial 1hourly Intentional Rounding from tomorrow (AM). Reassess times of the day that the patient becomes more impulsive then request care partner to carry out 15/60 minute visuals around that high risk time. Patient doesn't require a care partner during all shifts.'

53. On 19 Month3, it was documented that Mr B had expressed interest in transferring Mr A to the rehabilitation ward to help him to get stronger on his feet, as this would allow him to go to the toilet. The following day, an OT/PT assessed Mr A and noted that due to his fluctuating condition and lack of formal rehabilitation goals, he was not considered appropriate for inpatient rehabilitation.

Events surrounding fall four while on Ward 2

54. At 1.30pm on 20 Month3, clinical notes show that Mr A was 'tolerating' 15-minute checks. However, the 15-minute Checks Form (dated 20 to 21 Month3) highlights that Mr A was awake much of the night and became particularly unsettled around 5am on 21 Month3, when it was noted that he was hallucinating. Again, a one-to-one care partner was put in place. Mr A's CAM assessment dated 21 Month3 showed him to be at risk of delirium (a score of 2).

55. Clinical notes document that Mr A was unsteady on his feet during the afternoon and evening of 21 Month3. It was noted at 8.20pm that he tried to get out of bed himself. No falls assessment or care plan was completed on 21 Month3, before or after his fourth fall, and he was not reassessed until 26 Month3.

Fourth fall — 21 Month3

56. At 10.25pm on 21 Month3 Mr A experienced a further unwitnessed fall (fall four). Health NZ told HDC that a healthcare assistant checked on Mr A and, after leaving the room, heard a bang. Staff found Mr A sitting on the floor and assisted him to bed. He was reviewed by the on-call night house officer, who noted no injuries.

57. The post-falls checklist completed at 11.20pm shows that 15-minute checks commenced after 9pm. It is noted that a post-fall sticker was not included in the clinical notes on this occasion, and a falls incident form has not been provided to HDC, although clinical notes on 22 Month3 document that one was lodged. Therefore, it cannot be determined why the fall was thought to have occurred and what interventions were implemented following the fall, although Health NZ stated that '[a]ll reported fall injuries were classified as minor (SAC 4)'.

58. Following the fourth fall, Mr A was managed on the ward with a one-to-one care partner because of his fluctuating delirium and high risk of falls. On 2 Month3, one-to-one care was removed and 15-minute checks were put in place.

Care planning

59. Health NZ's 'Fundamentals of Care Standards' policy, dated February 2019, states: '[A]ll patients have a documented plan of care.'[19]

Daily care plans and goals

60. Mr A had daily care plans ('Daily Assessment and Plan of Care') completed throughout his admission. These documented a daily goal and identified patient safety risks, such as pressure injuries, delirium, and high falls risks.

61. Mr A's daily goals during Month1 to Month3 (inclusive) varied on a day-to-day basis. It is noted that six of Mr A's daily goals relate to personal care (for example, showering or shaving), seven are 'to be comfortable', eight are 'to get better', and 14 of Mr A's daily care plans do not have a goal documented. The daily care plans did not always state whether or not each daily goal had been achieved.

<u>Mobility and assistance</u>

62. Mr A's daily care plans often identified the need for assistance with mobility, although the type of need (eg, to go to the bathroom) was not always specified. In particular, 13 of Mr A's daily care plans refer to the need for assistance with mobility but do not provide any further information. Sixteen of Mr A's daily care plans document that he needed a walking frame in addition to assistance. The number of people he required for assistance fluctuated throughout Month1 to Month3.

63. On 29 and 30 Month1 Mr A's daily care plan documented that he was 'independent' with mobility. He was again noted as 'independent' on 7 Month2, but he required 'supervision' and a 'Gutter frame'. On both 22 and 26 Month2 Mr A was marked as 'bed bound'.

64. Between Month1 and Month3 (inclusive), only two daily care plans provided further detail as to what mobility assistance was required. On 1 Month2 Mr A's daily care plan stated that he needed one person to transfer from his bed to the chair, and on 27 Month3 it is documented that he needed two people to assist him to transfer from his bed to the chair.

[19] Care Standard 2: Clinical Monitoring and Management, Best Practice Standard 4, Best Practice Indicator a.

65. Health NZ stated that nursing documentation shows the number of times Mr A was mobilised during the shift, which would have lowered his risk of a pressure injury. The clinical notes also show that Mr A was turned in bed.

Bowel assessment charts

66. Mr A's bowel assessment chart shows that his bowel movements were monitored regularly between 26 Month1 and 9 Month4. Over this 76-day period, he evacuated his bowels only 25 times, suggesting that he had difficulty opening his bowels.

67. On 3 Month2 Mr A was reviewed by a dietician, who noted that his bowels had not opened for six days and that his medications included laxatives, although the clinical entry shows '[zero] given'. Mr A's bowel assessment chart shows that he had only one bowel motion in the first 15 days of his admission (on 4 Month2).

68. Mr A's bowel assessment charts show that laxatives were given regularly between 15 and 24 Month2, and again after 22 Month3. Clinical notes show that laxatives were sometimes withheld when Mr A had already had a bowel motion and, at times, Mr A refused laxatives and 'stated he is taking them as needed' (clinical entry dated 26 Month2).

Pressure injury assessments

69. Health NZ's 'Management and Prevention of [Counties Manukau] Health acquired Pressure Injuries (Adult)' policy, dated 1 November 2021,[20] states:

> 'For patients who are identified as having a Pressure Injury on admission or acquire one during a hospital admission, staff must … manage the pressure injury as per bundle of care[21] identified through the Waterlow Risk Assessment.[22]
>
> …
>
> Dependent on Bundle of Care interventions require[d], the Pressure Relieving Equipment Decision Tree should guide staff to ensure patients are placed on the correct equipment. This needs to be reviewed each time there is a change in the patient's risk assessment score.'

70. Health NZ stated that at no time did Mr A develop a pressure injury during his hospital admission, and appropriate assessments and interventions were put in place following a risk assessment.

[20] This policy is outside the scope of investigation, given that it came into force after the events, but it is included for further information.
[21] A bundle of care is a set of interventions that, when used together, significantly improve patient outcomes.
[22] A Waterlow assessment is a risk assessment tool that aids the early identification of patients at risk of developing pressure injuries. A score of 0–10 indicates no risk, whereas a progressively higher score indicates increasing risk levels. Factors that influence a Waterlow score include weight loss, decreased appetite, and tissue malnutrition.

71. Mr A's clinical records show a fluctuating assessment of him being at risk of pressure injuries, although he was not assessed as at risk on admission to hospital, as documented by his daily care plan dated 26 Month1.

72. Pressure injury care plans and Waterlow assessments were completed regularly during Mr A's hospital admission and, although not always completed on the same day, were consistent in the assessment of risk. Mr A's daily care plans, however, did not always parallel the assessment of risk noted on the pressure injury care plan and/or Waterlow assessment.[23]

73. Mr A's bundles of care were changed depending on his Waterlow Score, and he was provided with appropriate pressure-relieving mattresses as his pressure injury risk and mobility changed.

74. Health NZ stated that 'it is expected that each [Waterlow] assessment would be slightly different as a patient's condition may or may not change at the time of assessment'. However, it is noted that there were inconsistencies in the assessments as to whether Mr A had lost weight[24] and whether he had single or multiple organ failure.[25]

75. As part of the pressure injury assessment, 'a full visual inspection of the patient's skin integrity' was required.[26] Health NZ told HDC that Mr A's skin was monitored continually while he was in hospital, and his clinical notes reflect this, with regular skin checks documented. In addition, Mr A had skin integrity assessments on 31 Month1 and 19 Month2, which showed no pressure injuries present.

Bed positioning

76. Mr B is concerned that although Mr A could not be laid flat on his back due to his chest infection, he found his father unattended, lying on his back with full delirium. Mr B stated that staff were unaware that his father needed to be sitting up for meals. He said that family members had to request oxygen, as they found Mr A's breathing to be laboured and wheezy.

Care plan considerations

77. On 14 Month2, a telephone meeting was held with Mr B to discuss concerns about Mr A's care. The clinical notes from the meeting contain no mention of the angle of Mr A's bed;

[23] For example, Mr B's Waterlow assessment and/or pressure injury care plan assessed him as 'at risk' on 28 Month1, 30 Month1, 4 Month2, 5 Month2, 8 Month2, and 18 Month2; however, his daily care plans for the corresponding days show him as 'not at risk'.

[24] For example, Mr B's Waterlow assessment dated 25 Month2 documented that he had not lost weight in the last 3–6 months. However, his assessment dated 28 Month2 documented his weight loss as 'unsure', and the assessment dated 25 Month3 noted a 1.5kg weight loss in the last 3–6 months.

[25] For example, Mr B's Waterlow assessment dated 22 Month3 notes 'single organ failure' under 'tissue malnutrition'. On 25 Month3 it was documented that he had 'multiple organ failure', and then 'single organ failure' again on 8 Month4.

[26] As outlined in Health NZ's 'Adult Pressure Injury Waterlow risk assessment' policy dated 20 March 2019.

however, clinical notes from a family meeting with a dietician on 15 Month2 show that Mr A 'need[ed] to be sat up for meals'.

78. On 15 Month2, care plan considerations for Mr A stated: '**DON'T** lay [Mr A] flat in bed. His bed head should be raised at least 30 degrees while he is sleeping.' The considerations also stated: 'Please encourage [Mr A] to sit out of bed during meals as this is good for his chest.'

79. Health NZ stated that this document was drafted following discussion with Mr B, who had raised several concerns about cares during a family meeting. One of his concerns regarded Mr A lying flat. Health NZ stated:

> '[Mr B] felt his father was uncomfortable when the bed was completely flat. His current acute condition with on-going fluid congestion would have contributed to [Mr A] feeling breathless, however his clinical observations showed no decrease in oxygen saturation levels or increased respiratory effort. As the breathlessness was concerning to [Mr B] it was decided that [Mr A] would be placed at a 30-degree angle to assist with his shortness of breath.'

80. Health NZ said that the care plan considerations were designed only as a reference for staff, especially healthcare assistants, to enhance care. Health NZ stated: '[W]hile this document provided prompts for staff its design was not intended to be used as a formal care plan.' Health NZ told HDC that a copy of the care plan considerations was placed on [Mr A's] wall and at the front of his chart.

Care provided on rehabilitation ward

81. Health NZ stated that while in the rehabilitation ward, Mr A was encouraged to sit out of bed for his meals and then returned to bed, lying at 30 degrees when he was tired, as written in the care plan considerations. Health NZ told HDC that the Charge Nurse Manager recalls coming onto the ward on the morning shift and, as part of the visual checks of patients, noting that Mr A's head of the bed was sitting at the correct angle, and at no time was Mr A seen lying flat.

82. There is limited documentation in the clinical notes pertaining to the angle of Mr A's bed.[27] Furthermore, none of Mr A's daily care plans during his admission in the rehabilitation ward document the need for Mr A to be placed at a 30-degree angle to assist with his shortness of breath. Health NZ told HDC that it is not common practice to document specific elevation of the head of the bed unless specifically requested by medical staff.

[27] For example:
- 1 Month2 (OT/PT review): 'Pt received lying in bed, HOB [head of bed] 60°.'
- 9 Month2 (OT/PT review): 'Bed mobility — lie → sit [independent] with head of bed elevated ~ 45°.'
- 10 Month2: 'Lying 45° in bed.'
- 18 Month2: '[I]n bed looking settled [with] head of bed slightly elevated.'
- 18 Month2: 'Received pt on bed looking comfortable and settled [at] head of bed elevated at least 30–45°.'
- 19 Month2: 'Received pt on bed, asleep, on 40°.'

83. Regular entries in the clinical notes reflect staff awareness that Mr A was to be encouraged to sit out of bed during meals.

Care provided on Ward 2

84. Health NZ told HDC that when Mr A was transferred to Ward 2 on 19 Month2 following the insertion of a chest drain, a copy of the care plan considerations was supplied to the Charge Nurse Manager of Ward 2 to ensure continuity of care.

85. Health NZ stated that as Ward 2 is a respiratory ward, most staff are trained to care for respiratory patients and, as such, understand that many respiratory patients are short of breath and prefer the head of the bed to be raised. Staff are also aware that patients need to sit up to cough out secretions.

86. Health NZ said that clinical records refer to Mr A having slept comfortably, but do not document position angles routinely, as noted in paragraph 82 above. Only two entries in the clinical notes during his admission on Ward 2 document the angle of the bed.

87. Health NZ stated that staff encouraged Mr A to sit in the chair for meals, but often he felt tired when unwell, so he was put back to bed. The clinical records reflect this, showing regular entries of staff encouraging Mr A to sit in the chair for meals.

Oxygen saturation levels and Early Warning Scores

88. There are regular references in the clinical notes to the Early Warning Score (EWS)[28] during Mr A's admission on the rehabilitation ward, which largely was recorded as being 0–1 (low). In addition, Mr A's oxygen saturation levels were monitored regularly, and he was noted as stable until 18 Month2, when it was documented that there 'appear[ed] to be a re-accumulation of fluid causing symptomatic breathlessness'.

89. Between 19 and 27 Month2, no shortness of breath or respiratory distress was noted. Mr A scored low on his EWS, although it was noted on one occasion (23 Month2) that his oxygen saturation levels were low as he was sliding down the bed, but they returned to normal once he was repositioned. On 20 Month2 Mr A was put on high-flow oxygen to help produce phlegm for a sputum sample,[29] not because he needed oxygen.

90. On 28 Month2, clinical notes show that Mr A felt a bit short of breath. His chest X-ray showed re-accumulation of fluid in the lung, although it was agreed with Mr B that no

[28] The New Zealand Early Warning Score (NZEWS) helps to detect clinical deterioration in acutely hospitalised adult patients and is calculated from routine vital sign measurements. The score increases as vital signs become increasingly abnormal and triggers an escalating clinical response to manage a patient's deterioration. An EWS of 1–5 is considered low risk, and the escalation pathway may involve actions such as increasing vital sign frequency and discussion with a senior nurse. An EWS of 6–7 is medium risk, with actions such as vital signs to be monitored every 30 minutes and a house officer review within 30 minutes. An EWS of 8–9 is high risk, with actions such as vital signs to be monitored every 15 minutes and discussion with a senior medical officer. An EWS of 10+ corresponds to an immediately life-threatening critical illness, and actions may involve a rapid response call and managing the life-threatening issues.

[29] Sputum is thick mucus made in the lungs. A sputum culture helps to diagnose infections of the lungs or airways.

further chest drains would be inserted. Mr A was given oxygen to help with his breathlessness if needed.

91. On 6 Month3 it was noted that Mr A had an EWS of 8 (high) at the beginning of the shift. He was given oxygen and noted no shortness of breath later. On 13 Month3, Mr A's EWS was 6, but no chest pain or shortness of breath was noted.

92. On the afternoon of 25 Month3, Mr A had an EWS of 10 and was given oxygen. His EWS dropped to 1 overnight but again rose to 10 on the morning of 26 Month3. Clinical notes state: 'Breathing irregular at present. Possible small pauses.'

93. On 26 Month3, a house officer explained to Mr B that Mr A's breathing was deteriorating and his body appeared to be shutting down, and he would likely pass away within days or hours. On 27 Month3, Mr A was placed on comfort cares.[30]

Nutritional plan and dietary management

94. Mr B stated that the hospital was starving his father of food and liquid. He told HDC that staff would put the food tray on the ward and walk off, only to come back later and find that Mr A had not eaten his meal, but no one questioned why his trays were untouched and just removed them. Mr B said that staff did not realise that his father could not feed himself and that he needed help to drink. He told HDC that there was 'no water or liquid on [the] ward'.

95. Mr B stated that because of this, his father suffered severe weight loss. Mr B feels that staff lied to him about what his father was eating and drinking and that the food diary was not kept up to date properly with the date, time, and amounts of food. He also said that the nutritional meal plan was not in line with what was discussed, as no supplements were given, apart from a 'protein milkshake'.

96. Health NZ told HDC that while it acknowledges the concerns raised by Mr A's family regarding poor nutritional intake, it does not accept that there was any deficit providing adequate care for Mr A's dietary requirements and does not agree that Mr A was not provided with adequate water. Health NZ stated:

> 'While the Red Tray[31] assistance was provided during protected mealtimes, it was not always possible to encourage [Mr A] to eat and drink at times as sometimes he refused.'

97. Health NZ said that it is very difficult to optimise oral intake in patients with delirium, and although staff may encourage oral intake, under no circumstances can staff force a patient to eat. Furthermore, Health NZ stated that there is nothing more from a dietetic perspective

[30] Comfort care is a form of medical care that focuses on relieving symptoms and optimising comfort as a patient undergoes the dying process.
[31] A 'Red Tray' system alerts nursing staff and healthcare assistants that potentially a patient has a nutritional deficit and/or inability to feed themselves and will require assistance.

that could have been done to increase Mr A's oral intake, and nor is there any indication that he became malnourished during his hospital stay.

Care provided in Ward 2

98. Mr A's admission summary, dated 26 Month1, shows that he presented with 'lethargy and anorexia' and was dehydrated. It was noted that he had had poor oral intake for 10 days prior to his admission and had been taking Nepro[32] supplements twice a day.

99. Health NZ stated that during his stay in Ward 2, it was noted that Mr A was able to feed himself without assistance, although staff delivered his meal tray and set it up for him.

100. On 1 Month2 clinical notes show that Mr A was 'eating minimal, drinking well' and a food chart was commenced to monitor his food intake. Health NZ told HDC that Mr A was started on Nepro twice a day, which is the highest calorie supplement that can be provided for patients with renal impairment and is a 200ml bottle that provided him with 800 calories and 400ml of fluid.

101. On 3 Month2 Mr A was reviewed by a dietician, who documented that Mr A had inadequate oral intake related to a decreased appetite, possibly due to his empyema. Mr B was advised by the dietician that staff were 'unable to force feed [a] patient and [their] best option [was] to optimise his oral intake'. The plan was to encourage small frequent meals, continue with Nepro supplements, and in addition trial Renilon[33] twice a day. Monitoring of Mr A's weight, oral intake, and bowel charts was also commenced.

102. On 8 Month2 Mr A was reviewed again by the dietician, who noted that he was eating a third to half his meals on average, but that he was drinking his supplement drinks. Clinical notes show that while on Ward 2, Mr A was being encouraged at least daily to both eat and drink, although at times Mr A refused to eat.[34]

Care provided in rehabilitation ward

103. On admission to the rehabilitation ward on 8 Month2, Mr A's daily care plan noted a decrease in oral intake and stated that the aim was to encourage 1.5 litres of fluid per day. Health NZ said that during the rehabilitation ward admission, Mr A's oral intake was monitored by the dietician and the rehabilitation assistant, rather than the nursing team.

104. An 'e-Nutritional Screening Assessment' was completed on 9 Month2 by the rehabilitation assistant, who deemed Mr A at low risk of having dietary deficit. Health NZ stated that despite the low-risk outcome, Mr A was reassessed by the dietician as a low to moderate

[32] An energy-dense nutritional supplement for use as a sole source of nutrition or as a nutritional supplement.
[33] Nutritional supplement drink for patients with renal disease.
[34] For example:
- 2 Month2: '[E]ncouraged pt to drink fluids … pt reluctant to eat.'
- 4 Month2: '[D]rinking high protein drinks. Didn't eat lunch.'
- 5 Month2: '[C]linically dehydrated but overall improved … encourage oral fluids as pt forgetful.'
- 7 Month2: 'Pt encouraged to eat main meal … but pt refused.'

nutritional risk, due to fluid overload.[35] The dietician documented that Mr A had an inadequate oral intake related to his acute illness and recommended a 'soft mechanical diet',[36] with extra snacks. Mr A was again placed on a Red Tray system and Neprol (200ml twice daily) was continued, although the Renilon drinks were stopped.

(10–13 Month2)

105. Mr B told HDC that staff admitted that they forgot to feed Mr A over a public holiday weekend and that no food or liquid was provided. Mr B also said that his father's dentures were lost but not reported to him until he arrived on the ward after the weekend.

106. On admission to the rehabilitation ward, Mr A was noted to have dentures. Clinical notes on 10 Month2 state: 'Pt. stated [losing] his dentures, looked but couldn't find.' Health NZ told HDC that Mr B was contacted by nursing staff on 10 Month2 regarding Mr A's loss of dentures; however, clinical notes suggest that this information was not relayed to Mr B until 13 Month2.

107. Health NZ apologised for the loss of Mr A's dentures and stated that it takes the loss of such items very seriously. Health NZ also expressed disappointment that the reporting of the loss was delayed, and a refund of $1000 was made to Mr A's family.

108. Health NZ told HDC that on 10 Month2 a house officer contacted Mr B in response to his request for fluids to be charted for Mr A and advised Mr B that Mr A was well hydrated and did not need IV fluid replacement at this time.

109. On 11 Month2 Mr A was reviewed by a geriatrician, who informed Mr A that his family were concerned about his poor oral intake and explained the importance of eating and drinking for recovery. The geriatrician recommended that Mr A's breakfast tray be simplified, that he restart Renilon in addition to the Neprol, and that he be 'give[n] instruction that he need[ed] to eat & drink'. However, at both lunch and dinner that day, it was noted that Mr A refused to eat and he drank minimally, despite encouragement and having the food tray simplified.

110. Health NZ stated that on 12 Month2, the geriatrician directed staff to ensure that Mr A sat upright during meals and to encourage small amounts of food more frequently, as Mr A did not appear to want to eat normal quantities three times daily. Despite these interventions,

[35] If not enough fluids or water are consumed, the body becomes dehydrated and may also have difficulty getting rid of fluids. As a result, excess fluid builds up in the body.
[36] A soft mechanical diet consists of any foods that can be blended, mashed, puréed, or chopped.

clinical notes from 12 Month2 show that Mr A still refused meals and fluids, [37] and IV/subcutaneous[38] fluids were charted for hydration (500ml).

111. Clinical notes show that Mr A's eating and drinking continued to be minimal on 13 Month2, despite staff encouragement. Mr B was allowed to visit Mr A for a short period of time on the afternoon of 13 Month2, as a one-off visitation.[39]

Care plan considerations

112. On 15 Month2 Mr A was reviewed by a dietician, with Mr A's family present. Extra supplements between meals were requested by the family, but it was explained that Mr A was already on a very high dose.[40] It was decided that Mr A's meal summary would be adjusted to reflect his preferences, and extra juice would be given mid-morning, and it was suggested that the family bring in a water bottle as it was easier for Mr A to manage. The dietician again recommended a soft mechanical diet because Mr A's dentures had been lost and he was struggling with hard food. In response to the provisional opinion, Mr B disputed that fruit juice was given and told HDC that the water bottle he brought in for Mr A went missing.

113. Health NZ told HDC that Mr A had difficulty opening his supplements and he required prompting to finish meals or supplements, and he would stop eating if he felt rushed by staff. In response to the provisional opinion, Mr B noted an incident where Mr A became agitated and refused to eat any more after a nurse 'was trying to "force" [him] to hurry with his lunch'.

114. Health NZ stated that the care plan considerations drafted on 15 Month2 were intended to rectify these barriers and guide staff in their care, and were effective in addressing the nutritional concerns both staff and family had observed and assessed. The care plan considerations state:

> '**ALL** food and **ALL** fluid intake must be documented … Allow [Mr A] to try/practi[s]e opening his drinks (Nepro), if he cannot offer assistance … Set up his meals and offer 1 item at a time otherwise it is too overwhelming … He will often need prompting, say

[37] For example:
- 'Poor eating and drinking … pt not eating well … is on red tray. Giving small & frequent food … encourage food & fluid intake, small & frequent diet.'
- 'Patient refused lunch … Encourage [with] drink supplement. Completed 1 bottle. Continue to encourage.'
- 'Offered food & drink but still refusing.'
- 'Pt refused dinner. Offered fluids at 1530 Pt refused, stated he will have it when he … feels like it. Again offered fluids @ 1630, pt refused. Pt only had jelly at dinner time. Had a cup of tea around 1800 hours … Pt doesn't want any interruption and refusing nursing care, stated he wants to sleep … Enc[ourage] small frequent meals … Sit upright for meals.'
- 'Sat upright for dinner, however pt refused to eat any dinner, tried to feed but Pt strongly refused.'

[38] Under the skin.

[39] Health NZ had a 'no visitors' policy in place due to the COVID-19 lockdown.

[40] At this time, Mr A was on 125ml of Renilon twice a day (500 calories) and 220ml of Nepro twice a day (792 calories).

politely that it is time to have a drink or time to eat … Don't rush, let [Mr A] take his time.'

115. Clinical notes show that staff were following the care plan considerations by sitting Mr A upright for meals, offering foods one at a time, and encouraging him to eat and drink. At 11.00am on 17 Month2 it is documented that Mr A's fluid intake was 650ml. The plan was for '1000ml fluid overnight through PICC' if he did not reach 1.2 litres of oral fluids. At 9.30pm, subcutaneous fluids were withheld 'as patient has achieved over 1.2L as per doctor notes'.

Care provided after returning to Ward 2

116. The discharge plan from the rehabilitation ward states:

> 'Please provide care partner for assistance and prompting with meals, and accurate food diary recording … Continue nutritional supplements between meals instead of at mealtimes … Aim 1.5L fluids per days.'

117. On 21 Month2 Mr A was reviewed by the dietician, who noted that he was on a soft mechanical diet to assist with chewing, and renal supplement drinks were continued to provide extra energy and protein.

118. On 22 Month2 a family meeting was held with Mr B. Mr B was told that his father had lost interest in eating and had minimal oral intake, despite having nutritional supplements. It was explained that nasogastric tube feeding[41] was not appropriate given his father's delirium, as he would likely pull out the tubes and would find the process of placing them traumatic, and the focus was on keeping Mr A hydrated and monitoring his electrolyte levels.

119. On 23 Month2 Mr B spoke with the dietician, who reiterated that Mr A would not benefit from a nasogastric feeding tube, and it was agreed that Mr A be allowed to eat and drink 'as desired [without] force feeding' but with assistance and 'gentle encouragement' from the care partner. Clinical notes show that Mr A was offered food and fluid every 30 minutes to one hour, but he refused most of the time and became angry if the care partner persisted. In the evening, it was documented that Mr A was struggling to swallow, and 80ml per hour of IV fluids was charted.

120. The following day, 24 Month2, Mr A was assessed by a speech language therapist, who noted his poor appetite and oral intake and that he appeared to be 'holding food in [his] mouth' and taking some time to swallow. It was decided that because of his level of delirium, he could not be assessed for swallowing, although there was a risk of 'silent aspiration[42]'.

[41] A soft flexible tube inserted through the nose into the stomach, frequently used for administering nutritional supplements.
[42] The accidental inhalation of food, liquid or other material into the windpipe without being aware of it.

Staff did not feel that Mr A should be made 'nil by mouth',[43] but it was agreed to downgrade to a puréed diet, with directions that he be upright and fully assisted with food and fluids, and to ensure that he was given small mouthfuls at a slow pace.

121. Clinical notes between 25 and 30 Month2 show that Mr A's eating had improved. He was reviewed by a dietician and the speech language therapist on 30 Month2. They noted that Mr A still needed assistance with eating and drinking, although his swallowing had improved. It was recommended that he have 'thin fluids' and a 'minced + moist diet'.

122. Clinical notes show that Mr A was eating and drinking adequately between 1 and 10 Month3,[44] and on 11 Month3 it was agreed to trial a 'soft diet', as Mr A was 'fed up' with the puréed diet.

123. On 18 Month3 a Behaviours of Concern specialist nurse documented: 'Can independently feed self, just minimal assistance with setting up meal tray.' However, it was noted that Mr A appeared 'mildly dry'. Staff were to encourage small sips of water each time they checked on Mr A, but with a restriction of 1 litre per day.

124. From 24 Month3, clinical notes show that Mr A was again refusing to eat, and on 26 Month3 Mr B was advised that his father's body was shutting down. A decision was made to 'stop unnecessary meds' and to allow 'oral intake as pt wishes'.

Weight chart

125. Mr A was weighed regularly between 1 and 17 Month2. On 1 Month2 Mr A's weight was 91.1kg, and on 9 Month2 (when he was admitted to the rehabilitation ward), he weighed 93kg (a weight gain of 1.9kg). During his stay in the rehabilitation ward, his weight increased steadily, and on 17 Month2 he weighed 94.25kg.

Food and fluid charts

126. A food chart to monitor Mr A's food and fluid intake was commenced on 1 Month2 while he was in Ward 2, and food charts continued throughout his admission. Mostly they were completed, although several were incomplete, with a lack of documentation noted on 14 occasions.[45] In response to the provisional opinion, Mr B stated that until he complained about Mr A not receiving sufficient food and fluid (after the holiday weekend), 'nobody was formally monitoring his intake', and he noted that food charts were not filled in properly.

127. Health NZ told HDC that Mr A's food chart was completed by the care partner and, according to the food chart, Mr A had variable eating patterns, but overall he ate minimally. His intake of supplement drinks was also variable. Mr A ate foods such as tinned fruit, yoghurt, toast,

[43] To be given no food, fluid, or medications by mouth.

[44] For example:

- 1 Month3: 'E + D well.'
- 2 Month3: 'E+ D ok.'
- 8 Month3: 'Pt had good food & fluid intake for breakfast.'
- 10 Month3: 'E & D well.'

[45] In particular: 3, 4, 6, 7 and 25–29 Month2; 3, 11, 12, 19 and 21 Month3.

soups, mashed potatoes, jelly and ice-cream, nutritional supplements, and fluids (hot drinks and water).

128. On admission to the rehabilitation ward on 8 Month2, a fluid chart was commenced with the aim to encourage 1.5 litres of fluid per day. Fluid balance charts were completed for the period 8–19 Month2, as well as on 23 Month2 and 7 Month3. On two specific occasions (8 and 9 Month2), Mr A's fluid balance charts showed that the target of 1.5 litres was not met. IV fluids were documented on seven of the fluid balance charts.

129. Health NZ acknowledged that at times the documentation of Mr A's dietary and fluid management was not clear or complete. Health NZ told HDC that on review of the clinical records, dietary and fluid management information could be identified in several other areas, such as patient observation forms, daily care plans, fluid balance charts, and nursing notes.

Personal cares

130. Mr B stated that Health NZ showed poor hygiene practices while Mr A was in hospital. Mr B said that the family had to request that Mr A be showered, shaved, and have his hair brushed, and no moisturiser was applied to Mr A's arms and legs, despite his skin showing signs of dryness.

131. Mr B told HDC that the family had to keep asking the hospital to check that Mr A was warm enough and to put blankets on him, but on numerous occasions, they found him cold and with only one blanket on. In particular, on 26 Month3, the family found Mr A in a chair 'with his feet so cold they were purple' and still in his night diaper. Mr B also stated that the nurses were not brushing Mr A's teeth, and the family were concerned about oral thrush.

132. Health NZ stated that Mr A was provided with all the necessary personal cares, including showers, washes, toileting, and mouth care. Health NZ said that it was known that Mr A preferred his personal cares to be completed by a male staff member, and this was met whenever possible. Health NZ told HDC that Mr A was showered every couple of days when he had a chest drain in place; however, on a few shifts, Mr A refused washes or showers. Health NZ apologised that a daily shave was not always completed and if they did not meet Mr B's expectations.

Showering and shaving

133. On admission to hospital, it was noted that Mr A 'usually need[ed] prompting for showering and dressing' and, as stated in paragraph 61, some of Mr A's daily goals related to personal care.[46]

134. On 28 Month1, Mr A's family called requesting he be showered. This was documented as an 'achieved' goal for that day, and clinical notes show that Mr A was given regular showers

[46] Goals related to personal care were documented on 28 Month1, 29 Month1, 3 Month2, 4 Month2, 7 Month2, and 21 Month2.

and washes after this date. It is noted that there were 11 days (out of his 76-day hospital admission) where reference to a shower or wash was not documented in the clinical notes. There is evidence that Health NZ was aware that Mr A preferred a male staff member to assist with his personal cares, but male staff were not always available.

135. Out of the six daily goals that related to personal care, one was documented as 'not achieved' (3 Month2: 'to have a shave') and one was documented as 'achieved' (4 Month2: 'to shower + shave') when it was not, as the clinical notes indicate that Mr A declined a wash on that occasion. Mr A also declined the offer of a shower on other occasions.[47] There are limited clinical notes regarding Mr A being shaved during his admission, although it is noted on occasion that Mr A declined to be shaved.[48]

Skin care

136. As discussed in paragraph 75 above, Mr A's clinical notes show that his skin was monitored regularly while he was in hospital, although there is limited documentation specifically relating to his skin being moisturised.

Oral care

137. There is only one reference to oral cares having been completed between 26 Month1 and 10 Month2, which was on 4 Month2: '[O]ral care done.'

138. On 14 Month2 Mr A was reviewed by a geriatrician, who noted '[p]oor dentition on bottom'. Oral cares were completed by the healthcare assistant on 15 Month2.

139. On 17 Month2, Mr A was reviewed by a senior medical officer, who documented that although Mr A had no oral thrush, poor dentition was again noted. The plan was for 'mouth cares'.

140. As noted in paragraph 106, unfortunately Mr A's dentures were lost around 10 Month2, and on 19 Month2 a dentist came to fit him with another set of dentures. It is documented that Mr A did not complain of a sore mouth, although Bonjela[49] was charted.

141. On 24 Month2, Mr B expressed concern about Mr A's oral health. The clinical notes state: 'Son unhappy re care — states mouth "a state".' At 2.04pm, a registered nurse documented:

[47] For example:
- 29 Month1: '[D]eclined shower.'
- 30 Month1: '[D]id not want to have a shower due to wanting to get [chest drain insertion] done first.'
- 4 Month2: 'Declined wash.'
- 12 Month2: 'Refused wash & shower' (2pm). At 2.35pm: '[H]ad shower.'
- 14 Month2: 'Had wash — refused to have shower.'
- 24 Month2: 'Pt was uncooperative and aggressive while washing the pt.'

[48] For example:
- 8 Month2: 'Offered help with shave but pt said he can do it himself.'
- 24 Month2: 'Pt was uncooperative and aggressive while … shaving.'
- 8 Month3: 'Pt refused shaving this PM.'

[49] A gel used to treat mouth ulcers and ease discomfort.

'Mouth cares done and mouth appeared really crusty and dirty. Nil thrush noted.' At 2.47pm, Mr A's family called the Charge Nurse Manager concerned about oral thrush. The Charge Nurse Manager advised that staff had checked Mr A's mouth and no thrush had been noticed, although regular mouth care was encouraged.

142. Between 25 and 30 Month2 there are daily references to oral care having been completed, and again between 6 and 9 Month3. At 5pm on 13 Month3 it is noted that staff '[t]ried to do oral cares patient waved nurse care partner aways and said to "bucker off"'. Oral cares were completed at 10pm that day and staff were encouraged to continue this. Clinical notes show that Mr A's oral cares were completed daily between 14 and 15 Month3, and between 19 and 31 Month3.

Toileting

143. With respect to toileting, clinical notes consistently referred to Mr A being toileted, and that he varied between being continent and incontinent. Mr A had a healthcare assistant, alongside the nurses, to assist him with toileting, and on admission to the rehabilitation ward on 8 Month2 it was noted that he was using a portable urinal bottle.

144. On the occasions when he was incontinent, documentation shows that the nurses were constantly checking and changing Mr A's continence product, as well as his bed sheets and clothes.

Bedding and blankets

145. Clinical notes show that Mr A was frequently given extra blankets, although it was noted that on occasion, Mr A tried to remove his blankets.[50]

146. On 26 Month3, Mr A's temperature was noted to be 34.1°C. Extra blankets were applied, and his temperature increased to 35.1°C. A registered nurse rechecked Mr A and noted that his temperature had reduced again to 33.2°C after sitting out on the chair for lunch. He was transferred back to bed and a Bair Hugger[51] was put on him, after which his temperature rose to 34.4°C. Clinical notes show that the Bair Hugger was used daily from this date.

Further information

147. Health NZ provided sincere condolences to Mr A's family for the loss of Mr A and apologised for the distress caused to both Mr A and Mr B as a result of this experience. Health NZ stated that it is mindful that all patients are vulnerable when in its care and takes this responsibility seriously. However, Health NZ believes that the clinical team provided appropriate and professional care to Mr A at all times.

[50] For example:
- 24 Month2: 'Sometimes Pt tried to take off sheets/blankets from him.'
- 25 Month3: 'Gets agitated [with] blankets on.'

[51] A forced-air warming blanket that brings heat close to the patient's body to help increase blood flow.

148. Mr A was admitted during the COVID-19 pandemic. Health NZ told HDC that initially Mr A was thought to have COVID-19 because of his respiratory symptoms and fever. While this was excluded later, it did result in him being isolated (droplet and contact isolation). Once the E. coli bacteria was determined to be multi-resistant, he was kept in contact isolation to avoid spread to other patients. Health NZ stated that confusion worsens in hospital as a result of dislocation from a person's usual environment, and Mr A's cognitive impairment was also made worse by his infection.

149. Health NZ said that services during Mr A's admission were greatly affected by the COVID-19 pandemic. Health NZ told HDC that the extra burden within health care of staff redeployment into widescale COVID-19 swabbing, patient and visitor screening, and Managed Isolation Quarantine (MIQ) needs drew a number of senior nursing staff out of DHBs and into these services. Health NZ stated that this affected the skill mix in some areas and resulted in a further stretch of healthcare staff.

Responses to provisional opinion

Mr B

150. Mr B was given an opportunity to respond to the information gathered during this investigation. Mr B's comments have been incorporated into this report where relevant and appropriate.

151. In addition, Mr B stated that his father 'deteriorated' while under the care of Health NZ Counties Manukau. He reiterated that Mr A was supposed to be on 24-hour watch, but staff were not supervising him properly, and Mr A sustained injuries from a fall staff were unaware had occurred. Furthermore, Mr B maintained that Mr A was not provided with sufficient food and fluid during his admission, and that '[o]ver [the holiday] weekend he went without food — period', which was 'a huge disgrace' and 'absolutely heartbreaking'.

Health NZ Counties Manukau

152. Health NZ Counties Manukau was given the opportunity to respond to the provisional opinion, and its response has been incorporated into this report where relevant and appropriate. In addition, Health NZ stated that staff 'endeavoured to take reasonable actions to mitigate Mr A's falls risk', and the interventions to reduce his falls risk were of an appropriate standard, and all four falls were assessed as minor 'according to the Health, Quality and Safety Commission severity code', with minimal injuries to Mr A occurring from the falls.

153. Health NZ acknowledged that 'there were shortcomings in the documentation of the care provided to [Mr A]'; however, it stated that the shortcomings were mitigated by the 'reasonable actions taken by staff to support [Mr A]'.

Opinion: Health NZ Counties Manukau

Introduction

154. HDC received a complaint from Mr B, Mr A's son, about the care provided to his father by Health NZ. Mr B raised concerns about several aspects of his father's care, including:

- Mr A suffered four falls during his admission, with two falls occurring in one night when he was supposed to be on 24-hour watch;
- Mr A was not meant to lie flat in his bed because of his chest infection, but often he was found that way;
- Staff did not follow the nutrition plan and dietary restrictions, resulting in severe weight loss; and
- Mr A was not shaved or washed regularly.

155. I have undertaken a thorough assessment of the information gathered in light of Mr B's concerns. It is clear that Mr B and his family advocated strongly for Mr A's health and wellbeing, and this is to be commended. In my assessment of this complaint, I have considered information from Mr B and Health NZ, and also independent clinical advice from RN Richard Scrase.

Falls management — breach

156. RN Scrase stated that if a fall has occurred in a hospital setting, it is extremely important that the relevant post-falls protocols are followed and that the necessary observations and interventions are completed.

157. RN Scrase said that the documentation, in particular the CAM assessments and care plans, show that Mr A was being monitored closely, and that staff were aware of his high falls risk and fluctuating presentation. In response to the provisional opinion, Health NZ Counties Manukau agreed with this advice.

158. RN Scrase advised that in many respects Mr A's falls were managed appropriately, Mr A was reviewed in a timely manner, documentation was largely in line with expectations, and appropriate interventions were put in place immediately afterwards. RN Scrase explained that the risk of falls can never be eliminated completely, particularly with the frail elderly, but the risk can be reduced with appropriate interventions and strategies in place.

159. RN Scrase stated that on several occasions staff endeavoured to take reasonable actions to mitigate Mr A's falls risk, while working in a busy ward environment. RN Scrase noted the interventions taken on 12 and 21 Month3, when a one-to-one care partner was allocated because of Mr A's unsettled behaviour. RN Scrase advised that Mr A's delirium would have been a key driver in his behaviour, and the nature of delirium is that it is ever changing and unpredictable, and this, alongside frailty, makes individuals very vulnerable.

160. However, RN Scrase advised that there were signs that a fall was likely to happen on the nights of 29 Month2 (second and third fall) and 21 Month3 (fourth fall). Although he acknowledged that both falls occurred in the evening or at night, when ward staffing levels would have been lower than during the day, further interventions should have been put in place to reduce the risk of a fall.

161. RN Scrase stated that the documentation around the second and third fall highlight the varying presentation with respect to Mr A's mobility and impulsiveness. He said that although patient observations forms indicate that Mr A was reasonably settled in the afternoon of 28 Month2 (the day before the second and third falls), he certainly required assistance with mobility at the time of the first fall, and clinical notes show that a registered nurse had asked a healthcare assistant to stay with Mr A because of his history of impulsiveness and his high falls risk.

162. RN Scrase outlined that the OT/PT review on 28 Month2 explicitly stated that Mr A was both impulsive and unsteady. RN Scrase stated that this important information does not appear to have been considered when planning staffing for the night ahead. RN Scrase advised that this, in itself, should have warranted a hospital watch (one-to-one care partner) and there is no evidence that one was requested that day. He explained that a hospital watch would not have eliminated the risk of falls, but it is likely to have reduced the risk. Furthermore, he advised that hourly rounding after the fall on 29 Month2 was not an appropriate response.

163. In response to the provisional opinion, Health NZ disputed RN Scrase's advice that it had not considered appropriate planning for Mr A on 29 Month2, prior to falls two and three. Health NZ stated that its 'staff are experienced in assessing whether a hospital watch (one-to-one care partner) is warranted'. It stated that 'in an elderly population, this risk is always considered and is assessed every shift with clinical reasoning'. In addition, Health NZ stated that a one-to-one care partner is 'only one intervention tool that can reduce falls' and noted RN Scrase's advice that the risk of falls can never be eliminated.

164. Furthermore, in response to the provisional opinion, Health NZ reiterated its comments outlined in paragraphs 43–45 that although the on-call night house officer requested hourly rounding following Mr A's second fall, nursing staff undertook more frequent half-hourly rounding as Mr A did not use the call bell. Despite this, Mr A walked to the toilet unaided and fall three occurred, following which a healthcare assistant was directed to watch Mr A, as a one-to-one care partner could not be provided until the morning. Health NZ told HDC that '[o]n that basis, staff had endeavoured to take reasonable actions to mitigate [Mr A's] falls risk'.

165. RN Scrase also advised that given Mr A's well-documented history, there were clear signs on 21 Month3 (the fourth fall) that Mr A was becoming more vulnerable again with respect to falls.

166. The fourth fall occurred after a discharge destination was agreed and a weaning of his one-to-one care partner was planned. RN Scrase stated that clinical notes over this period highlight the fluctuating nature of Mr A's presentation and the staff's responsiveness to it.

In particular, it is noted that between 20 and 21 Month3, initially Mr A was tolerating 15-minute checks, but later became unsettled and required a one-to-one care partner. RN Scrase acknowledged that the time scales, and therefore opportunities for interventions, were relatively small, but advised that timely intervention is of key importance in providing good nursing care.

167. RN Scrase also acknowledged the challenges that all areas of the health system were under during the COVID-19 pandemic. He reiterated that many falls among the older adult population are not preventable; however, there were clear opportunities to reduce the risk of Mr A's falls on 29 Month2 and 21 Month3 that were missed, which he considered a severe departure from the appropriate standard of care. RN Scrase emphasised the importance of care planning and ensuring that care plans are completed appropriately and utilised for their intended purpose.

168. I also acknowledge the challenges that Health NZ was facing during this time; however, this does not exclude Health NZ from fulfilling its duties under the Code of Health and Disability Services Consumers' Rights (the Code).

169. Due to the fluctuating nature of Mr A's presentation, often he became unsettled and attempted to mobilise by himself. Frequent clinical entries during Mr A's admission refer to staff reminding him to use the call bell if he needed assistance, and I acknowledge the proactive solution of having a healthcare assistant watch Mr A after his third fall, until a care partner arrived on the morning of 29 Month2.

170. However, I accept RN Scrase's advice and consider that on 29 Month2 a lack of critical thinking was applied to Mr A's falls risk assessment. It appears that a one-to-one care partner had been in place until 28 Month2, although it is unclear why this was ceased and 15–30 minute checks commenced, given that Mr A's falls assessment completed on 23 Month2 showed an increase in risk (as per paragraph 37), and the OT/PT review on 28 Month2 explicitly noted that Mr A was impulsive and unsteady. I accept RN Scrase's advice that a one-to-one care partner was warranted on 28 Month2 and, while I acknowledge Health NZ's comments that a one-to-one care partner is not the only intervention to reduce the risk of falls, I am of the view that Health NZ has a responsibility to implement all practicable interventions to reduce the risk of falls.

171. In addition, although I acknowledge that half-hourly rounding was undertaken by nursing staff following fall two, despite direction from the on-call night house officer for hourly rounding, I am concerned that this was still a decrease in the frequency of checks, given that Mr A had been on 15–30 minute checks prior to the fall, and that the mitigating action of a one-to-one care partner (a hospital watch) was not put in place until after the second fall that day (fall three).

172. Furthermore, I am concerned that warning signs that Mr A was becoming more vulnerable with respect to falls around 21 Month3 were not acted upon before his fourth fall. In addition, it appears that no falls incident form was completed after this fall, which is

inconsistent with Health NZ's 'Patient Falls — The Immediate Management' guideline (as outlined in paragraph 29 above), and therefore I am unable to comment on whether further appropriate interventions were put in place following the fourth fall.

Care planning — breach

173. RN Scrase stated that care planning, like all nursing documentation, is a fundamental part of communication, and therefore its accurate completion is paramount to ensuring good patient outcomes. He advised that although there were several examples of well documented care planning by Health NZ staff, it was not a consistent feature, and the overall impression was one of a lack of critical thinking, particularly around constipation, delirium, and pressure injury risk.

174. RN Scrase advised that there was a consistent lack of clarity in relation to the goals documented on Mr A's daily care plans. For example, there was frequent reference to Mr A's goal for the day being 'to be comfortable' and, although this may have been appropriate, it lacked clarity. Furthermore, it was rarely documented on the care plan whether or not this goal had been achieved. RN Scrase stated that while at times no goals at all were recorded, there were also times when the goals appeared more considered and person centred — for example, when the goals related to personal cares such as 'shower and shave', which was important to both the patient and family.

175. RN Scrase advised that sometimes the documentation was both incomplete and inconsistent with respect to mobility, which is concerning considering that Mr A was identified as a high falls risk. For example, on 6 Month2 Mr A was identified as needing assistance with mobility, but no further information was given in terms of the mobility aids required or what level of assistance was required. The following day, however, he was described as independent but requiring supervision with a gutter frame.

176. RN Scrase advised that Mr A's constipation issues were recorded appropriately but little clear action was taken, particularly in the initial days after his admission to hospital. Mr A's bowel assessment chart shows that Mr A had only one small bowel motion in the first 13 days of his admission, and although on some occasions Mr A declined laxatives, it was not always clear that his ongoing constipation was being escalated appropriately.

177. RN Scrase stated that although Mr A's delirium was referred to in the clinical notes frequently, correctly identifying someone as being at risk of delirium is not in itself an intervention, and there needs to be some evidence that action had been taken to address this issue. RN Scrase advised that delirium cannot always be avoided, particularly in acutely unwell older patients with an underlying cognitive impairment.

178. RN Scrase stated that he was surprised that Mr A, a frail 88-year-old, was not considered at risk of pressure injury for large parts of his initial inpatient stay. RN Scrase advised that given Mr A's age and comorbidities, he should have been documented as being at risk from admission, and appropriate safeguards and interventions should have been put in place.

179. RN Scrase advised that while Mr A's pressure injury care plans and skin integrity assessments were documented appropriately, some of the significant changes in Waterlow score appear to relate to incomplete information or differing interpretations, such as weight loss and tissue malnutrition. RN Scrase commented that although Mr A did not acquire a pressure injury during his admission, there should have been a consistent thought process among assessments and care plans. Furthermore, RN Scrase highlighted the fluctuating assessment of Mr A's risk of pressure injuries and stated that it is not clear what interventions were put in place to reduce the risk of pressure injury once the risk had been identified.

180. RN Scrase stated that he had the sense of a very busy working environment, where the care plan was a document isolated from other documents that needed to be filled in each day as one of the many other tasks. However, he said that a busy working environment is exactly why accurate and regularly reviewed care plans are so important, so that they have real purpose as part of a continuum of care.

181. RN Scrase advised that, overall, the issues with the consistency and quality of care planning and the degree to which they were reviewed proactively, particularly in the initial stages of Mr A's hospital admission, represented a moderate departure from accepted practice.

182. I accept RN Scrase's advice and am concerned that often Mr A's daily care plans were incomplete and inconsistent. In particular, Mr A's daily care plans did not always document a goal or whether the documented goals had been achieved.

183. As stated by RN Scrase, accurate care planning is key to directing nursing interventions, and I am concerned that only two of Mr A's daily care plans provided sufficient detail as to what mobility assistance was required. Nursing staff needed clear direction as to the kind of mobility assistance Mr A required, for example to the toilet and to his chair for meals. Regardless of whether staff were already aware of the type of assistance required, this should have been documented on his care plans appropriately to ensure continuity of care for staff unfamiliar with Mr A, particularly given his high falls risk.

184. I am also concerned that Mr A's constipation issues were not escalated appropriately. Although I acknowledge that on occasion Mr A refused laxatives, Mr A's bowel chart shows that he was not given laxatives until 15 Month2, despite having had only one bowel motion in the first 15 days of his admission and having been charted laxatives.

185. There is evidence that Health NZ attempted to reduce the risk and the effect of Mr A's delirium. I acknowledge that Health NZ instigated both 15-minute checks and a one-to-one care partner to manage Mr A's falls risk and his fluctuating cognition, and in addition Mr A was prescribed quetiapine to help with his sleep and ongoing confusion (see paragraph 22 above).

186. However, I am concerned that CAM assessments and care plans were not completed between 1 and 28 Month2, when the clinical notes show that Mr A had a fluctuating delirium score of 0–3, particularly in the context of his chronic cognitive impairment. Furthermore, I

am concerned that the process of repeating the CAM assessment each shift if a patient scores 1 or more on the assessment was not followed, especially on 27 Month3 when Mr A scored 2 on his CAM assessment, but a further assessment was not completed until 29 Month3, when he scored 4 (see paragraph 21 above).

187. I am also concerned that Mr A was not considered at risk of pressure injury for large parts of his initial inpatient stay, given his age and comorbidities. I understand that a patient's pressure injury risk can vary as mobility changes, but I note that there were discrepancies between his daily care plans and pressure injury/Waterlow assessments as to his risk.

188. I acknowledge Health NZ's statement that each Waterlow assessment would be different as a patient's condition changed; however, I find the inconsistencies in the assessments as to whether Mr A had lost weight and whether he had single or multiple organ failure disconcerting, given that this is not something that is applicable to change in such a short time.

189. I accept RN Scrase's advice that differing views as to weight loss and organ failure would have affected the total Waterlow score, and I am concerned that there was not a more consistent thought process as to the issues affecting Mr A's pressure injury risk, particularly given his mobility issues, which would have a flow-on effect on the interventions put in place to reduce this risk.

Conclusion

190. Health NZ is responsible for the operation of the clinical services it provides and has an organisational duty to provide an appropriate standard of care to consumers of its services.

191. In summary, I find that Health NZ Counties Manukau failed to provide services to Mr A with reasonable care and skill as follows:

- Timely interventions were not always provided to reduce his risk of falls; and
- There was a lack of consistency and quality in his care planning.

192. Therefore, I find Health NZ in breach of Right 4(1)[52] of the Code.

Bed positioning — adverse comment

193. The care plan considerations dated 15 Month2 state that Mr A was to be encouraged to sit up during meals and that his bed was to be raised to at least 30 degrees while sleeping.

194. Although nothing in the clinical notes from the telephone meeting with Mr B on 14 Month2 refers to Mr A's bed positioning, Health NZ stated that the care plan considerations were drafted following Mr B voicing his concerns about Mr A's breathlessness, despite Mr A's clinical observations showing no decrease in oxygen saturation levels or increased respiratory effort.

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

195. RN Scrase advised that in general, as acknowledged by Health NZ, it would be reasonable to raise a bed head (though not necessarily precisely to 30 degrees) if an individual was short of breath, and normally specific bed elevations would not be recorded (see paragraphs 82 and 85). It is also noted that there were references to bed positioning in the clinical notes prior to the care plan considerations being drafted.

196. RN Scrase advised that raising of the bed would be expected if that had been agreed between all parties in a family meeting, where personal and family views are considered alongside clinical best practice. RN Scrase explained that part of the reason for having a care plan is continuity of care and an agreed understanding for everyone, including those staff unfamiliar with the ward, and it is particularly important given that healthcare assistants work under the direct supervision of a registered nurse.

197. RN Scrase advised that whatever the clinical reasoning behind the decision, once bed positioning had been mentioned explicitly in the care plan considerations, it would be expected that Mr A be placed at 30 degrees or upright whenever possible, from this date until comfort cares became the priority (on 27 Month3). RN Scrase added that bed elevations should have been documented formally, as there needed to be some evidence that matters that were important to the family, even if considered normal practice by staff, were understood and taken on board.

198. RN Scrase advised that in terms of bed positioning after 15 Month2, if the nursing staff positioned Mr A as per the care plan considerations but did not write this on the daily care plan or in clinical notes, then he would consider this to be a moderate departure from accepted practice. However, if the nursing staff did not position Mr A according to the care plan considerations, then he would consider this to be a severe departure from accepted practice.

199. I accept RN Scrase's advice. Once it had been agreed that Mr A should be encouraged to sit out of bed during meals and should not lie flat, but rather be positioned at 30 degrees while he was sleeping, this should have been documented on the daily care plan or in the clinical notes.

200. Although I acknowledge Health NZ's statement that the care plan considerations were designed as a reference only for staff, I accept RN Scrase's advice that there needed to be some evidence that matters that were important to the family were acknowledged, so it could be seen that they had been heard.

201. I take this opportunity to commend Health NZ for taking Mr B's concerns about Mr A's breathlessness on board, and deciding on appropriate action to address these concerns, despite Mr A showing no respiratory distress or shortness of breath. However, I am concerned that the clinical notes from the telephone meeting on 14 Month2 did not document the discussion about bed elevation, given Health NZ's 'Documentation in the Clinical Record' policy dated 8 July 2019, which states: 'The clinical record is a legal record

of the patient's care and **evidence of the basis on which decisions on patient care were made**' (my emphasis).

202. There are regular clinical entries relating to Mr A being comfortable in bed. In addition, there are regular references to Mr A's EWS and oxygen saturation levels, and I note that on one occasion (23 Month2), Mr A was repositioned to increase his oxygen saturation levels and make breathing more comfortable. This indicates that the nursing staff were monitoring Mr A appropriately.

203. However, the issue before me is whether nursing staff positioned Mr A as per the care plan considerations. None of Mr A's daily care plans document that he should not lie flat or that his bed should be elevated to 30 degrees, nor that he should be encouraged to sit in a chair during meals, although I acknowledge that Mr A's daily care plans contain regular references to his need for assistance during mealtimes.

204. Regular entries in the clinical notes reflect staff awareness that Mr A should be encouraged to sit out of bed during meals and that this was actioned by staff. However, there is limited documentation as to the positioning of Mr A's bed. Although most of the clinical entries referring to the angle of the bed are written by an OT/PT, some were made by nursing staff in the rehabilitation ward, and this indicates that staff were aware of the care plan considerations and the need to keep Mr A elevated.

205. Furthermore, I acknowledge Health NZ's statement that staff on a respiratory ward are aware of the need to elevate a bed when a patient is short of breath, and regular clinical entries show that Mr A's respiratory distress and/or shortness of breath was being monitored sufficiently.

206. I consider it more likely than not that nursing staff were positioning Mr A as per the care considerations plan but did not document this on his daily care plans, or regularly in the clinical notes. However, I remain concerned about the lack of documentation, given the importance of showing that the agreed plan of care was being implemented.

Nutritional plan and dietary management — adverse comment

207. RN Scrase advised that Mr A's nutritional plan, which was developed in response to his changing presentation throughout his hospital admission, was sound and reasonable, and included dietician input, requests to monitor food and fluid intake, requests to encourage oral intake, and recording of weight. Furthermore, nutritional supplements were prescribed and dispensed for Mr A, and although nasogastric feeding was discussed, this option was considered not to be clinically appropriate. RN Scrase advised that all aspects of the nutritional plan were well documented by the health professionals concerned.

208. RN Scrase stated that supporting patients with complex health needs is challenging, particularly when they have delirium, and at times it can be about prioritising needs to achieve the best possible health outcome for the individual.

209. RN Scrase said that clinical notes highlight how extremely unwell and frail Mr A was when he was first admitted — Mr A was both dehydrated and he had delirium. Furthermore, the documentation highlights that Mr A's nutritional input and eating patterns were variable.

210. RN Scrase stated that nursing staff must acknowledge that patients have the right to decline any input, such as some meals, or to eat only small quantities, but at the same time, staff have a duty of care to ensure that appropriate measures are taken to address this if declining food or a reduced food intake should become an ongoing issue, and this is particularly important in the case of a frail, vulnerable older person who needs assistance with eating and drinking. RN Scrase said that it is important that when food has been declined, this is recorded accurately, and if it becomes an ongoing issue, then some action or input needs to follow.

211. RN Scrase advised that it would be his professional expectation that every effort was made to meet Mr A's nutritional and hydration needs as clinically appropriate at the time, and to address any concerns or issues as they arose. He said that an important part of ensuring that appropriate decisions are made around food and fluid intake is accurate nursing documentation, which is key to good communication in any health setting.

212. RN Scrase examined Mr A's food charts and noted that there were significant gaps during his initial admission on Ward 2, and several food charts were incomplete. However, he stated that food charts on the rehabilitation ward were largely completed, as were the food charts when he returned to Ward 2.

213. Mr B expressed concern that staff forgot to feed Mr A over a five-day period. I note that the clinical records show that staff were aware of Mr A's decreased oral intake and took steps to address this issue. RN Scrase examined the nutritional documentation over the holiday weekend in close detail, as this was a period when there was likely to have been fewer senior staff and less clinical support. RN Scrase advised that although there were some gaps, largely the food and fluid charts were completed and highlighted Mr A's ongoing poor oral intake. RN Scrase stated that Mr A was reviewed several times over that weekend, and concerns around oral intake were highlighted by nursing staff, with IV fluids charted by the medical team to support hydration.

214. Furthermore, RN Scrase advised that strategies were put in place to try to encourage Mr A to eat and drink more (such as simplifying the presentation, giving him more time to eat, and allocating staff to support him), and although largely these strategies were ineffective overall, this does not detract from the important fact that they were discussed, considered, and implemented.

215. RN Scrase stated that there were several documented requests for Mr A's fluid to be monitored or for oral intake to be between 1–1.5 litres a day. There were also occasions on which either subcutaneous or IV fluids were charted and administered, or where the target was reached after close monitoring, for example on 17 Month2. RN Scrase acknowledged that there were two occasions (8 and 9 Month2) on which the fluid balance charts showed

that the target of 1.5 litres a day was not met; however, the medical team were monitoring this, alongside other important indicators, such as blood results, pulse, and blood pressure.

216. RN Scrase advised that although there were gaps in the documentation, particularly in the food charts, nursing staff were taking reasonable actions to support and encourage Mr A with his oral intake.

217. However, RN Scrase advised that nursing staff did not always review Mr A's notes fully. For example, Mr A was given toast for breakfast despite the dietician having recommended a 'soft mechanical diet' on 15 Month2. RN Scrase advised that when viewed against the background of everything that was going on for Mr A, this might be considered a small detail, but in his opinion it highlights that the dietician notes had not been considered fully and that the approach was not particularly 'person centered'. Furthermore, RN Scrase advised that comments in the nursing notes stating 'E & D as tolerated' are not helpful when clearly dietary intake has been identified as an issue.

218. RN Scrase acknowledged that accurate completion of both food and fluid charts can be challenging in a busy clinical environment, but when required are important when it comes to clinical decision-making. RN Scrase advised that although the gaps in documentation were not over long periods and would not have changed the decision-making by the medical team in terms of supporting Mr A's nutritional needs, in his view the gaps would have made it more challenging for them, and therefore he considers that there was a mild departure from expected practice.

219. I accept this advice and am concerned that nursing staff did not always review Mr A's notes fully, and that as a result he was provided with food he could not eat. I also note that many of the clinical entries refer to 'E & D well' or 'E & D ok'. I am concerned that these entries do not reflect the reality of the situation, which was that Mr A had a multitude of interventions in place to address the ongoing issue of adequate oral intake.

220. In making these comments, however, I feel it is important to highlight that clinical notes show that Mr A's eating decreased considerably when his delirium was present, and I acknowledge Health NZ's statement that it is very difficult to optimise oral intake in patients with cognitive impairment/delirium. Furthermore, I acknowledge the difficulty faced by staff with regard to balancing their duty of care with the rights of the patient, especially in the context of a frail, confused and acutely unwell patient who was consistently refusing food.

221. While I acknowledge Mr B's concerns regarding the provision of adequate food and fluid for his father, I am satisfied that overall appropriate interventions were in place to try to manage Mr A's fluctuating oral intake. Mr A was reviewed by dieticians, geriatricians, and a speech language therapist regularly. He was trialled on soft and puréed diets and prescribed supplements, together with other strategies (such as simplification of meals) in order to meet his nutritional and hydration needs. Furthermore, I note the multitude of evidence that nursing staff were encouraging him to eat and drink consistently.

222. However, I am concerned about the lack of accurately completed food charts, and I take this opportunity to emphasise the importance of clear and objective documentation to inform decision-making and to ensure that family members are provided with an accurate record of the patient's nutritional and dietary management.

Personal cares — other comment

223. RN Scrase advised that the issue of personal cares needs to be viewed in the context of the clinical situation at the time — Mr A was a frail and acutely unwell 88-year-old man with multiple comorbidities, and he had been admitted with a significant infection and subsequent delirium. RN Scrase said that Mr A's documented delirium and confusion would have been a significant consideration with respect to any intervention and whether more distress would have been caused by pursuing a particular action, for example shaving.

224. The fact that Mr A was not showered every day did not lead RN Scrase to conclude that there had been poor practice. He noted the possibility that Mr A's medical situation (ie, his chest pain) and his reluctance to have a shower (and/or shave) was taken into consideration by staff when evaluating individual care. Furthermore, RN Scrase did not find any evidence (dermatitis, pressure injuries, excoriation) of Mr A having been left for long periods in soiled continence products, which would of course have been extremely concerning.

225. RN Scrase advised that no documented evidence of oral thrush was identified, which may have been the case had oral cares been poor. He noted the reference to Mr A's mouth being 'really crusty and dirty' on 24 Month2 but stated that the context is important as there was documented evidence around this date of challenging and resistive behaviour from Mr A (because of his ongoing delirium), which would have made the provision of any cares difficult, particularly those close to the face such as mouth cares.

226. RN Scrase noted the use of a Bair Hugger warming blanket as Mr A reached the end of his life and advised that documentation frequently referred to Mr A being restless and agitated, which would have led to him kicking off or pushing blankets at times, and this may have meant that keeping him covered appropriately was sometimes difficult.

227. RN Scrase acknowledged that clearly there were times when the family were concerned about the standard of Mr A's personal care but advised that when reviewing the documented evidence in the context of the other issues at the time, he did not consider there to have been a departure from the standard of care or accepted practice.

228. I accept this advice and consider that the standard of Mr A's personal cares was adequate in the context of the issues at hand. In addition to Mr A's comorbidities, frailty, significant infection, and delirium, I acknowledge the staffing restrictions faced by Health NZ during this time because of COVID-19 (as discussed in paragraph 149), which meant that Mr A's preference for male staff members to assist with his personal cares could not always be achieved.

229. I also acknowledge the numerous references to Mr A refusing personal cares, and the challenging and resistive behaviour from Mr A because of his ongoing delirium and confusion. I appreciate that this must have made shaving difficult for nursing staff, and I acknowledge Health NZ's apology that a daily shave was not always completed. Overall, however, it is clear that staff were offering assistance with showering, shaving, and oral care regularly and were attending to Mr A's toileting needs. Although there is limited documentation regarding Mr A's skin being moisturised, there is enough evidence to show that his skin was being monitored continually.

230. I share Health NZ's disappointment that the loss of Mr A's dentures was not reported earlier (as discussed in paragraph 107), and the reference to Mr A's mouth on 24 Month2 being 'really crusty and dirty' is concerning. I also note that there are gaps in the clinical records where reference to oral care was not documented. I accept RN Scrase's advice that Mr A's ongoing delirium would have made the provision of oral care particularly difficult, but I consider that this issue (alongside the loss of Mr A's dentures) should have been communicated to the family at an earlier stage in order to formulate a more appropriate plan around sustainable oral care.

231. Mr A was offered extra blankets regularly, and the provision of a Bair Hugger was appropriate as Mr A reached the end of his life. Although I appreciate that Mr A became cold when seated in his chair, I acknowledge that staff were encouraged to sit him out of bed during mealtimes because of his chest infection (see paragraph 78) and the risk of silent aspiration identified by the speech language therapist (as discussed in paragraph 120).

232. Documentation shows that Health NZ was aware of the family's concerns regarding Mr A's personal cares and instructed staff to act appropriately when an issue was raised. Although I consider that issues around Mr A's oral care should have been communicated to the family earlier, overall I am of the opinion that staff managed Mr A's personal cares appropriately.

24-hour watch — no breach

233. The issue before me is whether it was appropriate to stop Mr A's one-to-one care partner (24-hour watch) slowly once a discharge destination had been agreed.

234. RN Scrase stated that any patient being transferred to a residential care facility should not be taken off a 24-hour watch simply because they will not have one at their discharge destination, but rather, the decision should be clinically driven, with a focus on safety alongside a sound understanding of the discharge destination.

235. RN Scrase advised that clinical notes highlight a responsiveness to Mr A's varying and complex presentation, and the fact that Mr A had a fall later in his stay was an indication of issues at a specific point in time, not a failure of the plan as a whole.

236. In any event, RN Scrase advised that given that the decision to wean Mr A off his one-to-one care partner was being reassessed and revisited over the course of time, both the decisions around, and approach to, withdrawing the 24-hour care were clinically based and reasonable.

237. I accept this advice and consider that given Mr A's cognitive impairment, fluctuating delirium, high falls risk, increased frailty, and chronic empyema, it was appropriate for palliative care to be discussed. I note that Mr B agreed to a private hospital placement, and it was discussed on several occasions that to gain acceptance to a facility, Mr A needed to be off one-to-one care. I also note that Mr B questioned whether transfer to the rehabilitation ward could be an option; however, it was made clear that due to Mr A's fluctuating condition, he would continue to need clinical support, and therefore rehabilitation was not appropriate.

238. Both the palliative care team and NASC were involved in the planning of Mr A's discharge into private hospital care. Mr A was also reviewed by a consultant psychiatrist and a 'Behaviours of Concern' specialist nurse to ensure that Mr A was slowly and safely weaned off one-to-one care.

239. I acknowledge the fluctuating nature of Mr A's presentation and the staff's responsiveness to it. Staff appeared to be balancing Mr A's high falls risks against the agreed reduction of the one-to-one care partner, which, particularly between 20 and 21 Month3, required frequent revaluation of the level of assistance required. Notwithstanding my concerns about falls management, as set out in more detail above, I am of the view that, overall, both the decision to take Mr A off his one-to-one care partner once a discharge destination had been agreed, as well as the approach taken, was appropriate.

Changes made since events

240. Since these events, Health NZ has made, or is in the process of making, the following changes:

a) Health NZ obtained grant funding for a project to revise the current plan of care and develop an electronic version that supports and guides person-centred nursing practice, underpinned by Fundamentals of Care (FOC) and Māori-centred models of care. The project aims are:

- To further improve the quality of nursing documentation and care at Health NZ Counties Manukau;
- To adopt the nursing process at Health NZ Counties Manukau to ensure continuity of care, individualised care, standards of care, increased patient and family participation, and collaboration of care; and
- For the plan of care to reflect health and wellbeing needs of patients and their families.

b) In response to the provisional opinion, Health NZ told HDC that currently a care plan is being developed into the eNotes (electronic notes) platform, which will enable nurses

to view and easily add to an ongoing plan of care for their patient, as well as identify potential and actual risks, such as falls assessment risks and nutritional screening. In addition, Health NZ stated that the care plan will utilise the steps of the nursing process, including assessment, goal setting, interventions, and evaluation. Health NZ told HDC that once the care-planning document has been added to eNotes, ongoing audits will be added to the care compass[53] audit schedule to show its effectiveness in care planning over time.

c) As part of a quality improvement project to mitigate falls, a SAFETY II methodology review was used to explore ways to minimise falls. Continual improvement work is underway in developing recommendations that consider human factors in current working environments.

d) In response to the provisional opinion, Health NZ told HDC that the transition from paper documentation to eNotes was implemented in Adult Rehabilitation and Health of Older People (ARHOP) wards from November 2020 and Medicine wards from August 2021, and Health NZ provided evidence of this to HDC.

e) In response to the provisional opinion, Health NZ told HDC that in 2020, 'TrendCare' software was introduced as part of the Care Capacity Demand Management (CCDM) programme,[54] which matches staff resources to patient demand (acuity-based staffing), and was developed in order to improve patient care, utilise resources efficiently, and provide a better work environment for staff. Health NZ confirmed that over the past two years, it has had a 'significant uplift' of nursing staff in response to the CCDM full time equivalent (FTE) calculation, in particular an increase of 91 FTE in the ARHOP service and 155 FTE in the Medicine service. Health NZ stated that it is now better resourced to manage the high acuity workload, which will improve patient safety and overall care.

f) In response to the provisional opinion, Health NZ stated that it is committed to using the learnings from this investigation to improve its service.

[53] Care Compass is Health NZ Counties Manukau's point-of-care survey instrument, which collects data and measures local and system progress in providing care. See: https://www.countiesmanukau.health.nz/about-counties-manukau/performance-and-planning/quality-accounts/care-compass-point-of-care-measure-for-safety/. Accessed 18 Month3 2024.

[54] In response to the provisional opinion, Health NZ Counties Manukau stated that the CCDM programme is a partnership between Health NZ, the New Zealand Nurses Organisation (NZNO), the New Zealand Public Service Association (PSA), and the Midwifery Employee Representation and Advisory Service (MERAS).

Recommendations

241. I acknowledge the significant changes Health NZ has made since the time of the events. In addition, I recommend that Health NZ Counties Manukau:

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

b) Provide HDC with an update on its quality improvement project to mitigate falls. Health NZ is to provide HDC with this update within four months of the date of this report.

c) Update the falls policy to include a post-falls pathway that identifies the cause of the fall and possible interventions to prevent further falls. Health NZ is to provide HDC with evidence that this has been done, within seven months of the date of this report.

d) In response to my recommendation made in the provisional opinion, Health NZ provided HDC with an update on its project to revise the current plan of care. Having completed this, I now recommend that Health NZ report back to HDC on the effectiveness of the changes/improvements made, including the effectiveness of the care plan as both a communication tool and a source of reference for providing appropriate and consistent care. Effectiveness should be measured via an audit of a sample of records. This report is to be provided to HDC within 12 months following the implementation of the care plan into eNotes and the corresponding audit added to the care compass audit schedule.

e) Provide education/training to staff on pressure injury assessments and the importance of consistent and accurate completion of Waterlow assessments. Evidence confirming the content of the training and delivery, in the form of training material and attendance records, is to be provided to HDC within seven months of the date of this report.

f) Use this case as a basis for developing education/training for the implementation of care planning documents in eNotes, emphasising the importance of expected documentation standards to better inform decision-making. Evidence confirming the training and delivery, in the form of attendance records, is to be provided to HDC within six months following the implementation of the care plan into eNotes.

Follow-up actions

242. A copy of this report with details identifying the parties removed, except Health NZ Counties Manukau, Middlemore Hospital, and the clinical advisor on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Richard Scrase dated 29 March 2021:

> 'Thank you for the request to provide clinical advice regarding the care provided by Counties Manukau Health to [Mr A] during a hospital admission in [Month1–Month2]. In preparing the advice on this case, I am not aware of any personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> In preparing this report, I have reviewed:
>
> The copy of the complaint …
>
> The letter of response by Counties Manukau Health …
>
> The Counties Manukau Health Hospital notes for the period in question
>
> Other documents or papers referred to have been referenced and listed at the end of this report.
>
> As required by the Commissioner, I have endeavoured to provide an objective opinion on the questions posed from the documented information made available to me. Furthermore, as laid down in the Guidelines for Independent Advisors, where there are conflicting versions of events, I have undertaken to objectively consider and comment on these differing perspectives. When quoting relevant passages from documentation, I may not have quoted every passage relating to a specific issue, but in my professional opinion what I have quoted captures the essence of a specific issue as it appears in the documentation. Finally, in reviewing this case I have undertaken to view the events as they unfolded because the outcome was not known at the time that decisions were made.
>
> **Background**
>
> [Mr A] was admitted to Middlemore Hospital on [26 Month1] (initially under General Medical Services), with a ten-day history of lethargy, decline in mental function and shortness of breath. As well as his other comorbidities including significant kidney disease, on admission, [Mr A] was diagnosed with empyema with aspirated cultures growing ESBL e-coli. According to the documentation supplied, this was treated first with a chest drain and oral antibiotics and then subsequently with a course of IV antibiotics via a PICC line. [Mr A] remained on [Ward 2] (a respiratory ward) from [26 Month1] to [8 Month2], when he was transferred to a rehabilitation ward. Due to increased clinical care needs, [Mr A] was transferred back to [Ward 2] on [19 Month2]. Sadly, [Mr A] became increasingly frail and passed away on [9 Month4].

Concerns about whether the nutritional plan and dietary management was consistent with accepted practice and [Mr A's] needs.

Review of documents

Review of the hospital notes for the period in question highlighted how extremely unwell and frail [Mr A] was when he was first admitted. The documentation supplied stated that he was both dehydrated and he had a delirium on admission. Review of the documentation particularly highlighted:

— That [Mr A's] nutritional input was variable. For example, there was reference made in the nursing notes to [Mr A] "*eating and drinking well"* ([31 Month1]), but then the next day "*E & D minimal".*

— [3 Month2] Mr A was reviewed by a dietician. Recommendation was for monitoring weight, food charts and bowel charts.

— That food charts were commenced but at times there were significant gaps on his initial admission … for example between [5 and 8 Month2]. Furthermore, several food charts were incomplete. Food charts on the [rehabilitation] ward were largely completed, as were the food charts when he returned to [Ward 2]. Both highlighted variable eating patterns. Bowel assessment charts were identified and reviewed from [26 Month1–9 Month4]. [On 8 Month2], it was documented that [Mr A] was to be commenced on food and fluid charts and that they were to aim for 1.5ml of fluid per day. [9 Month2]. Doctors' notes. "*Please monitor and encourage oral intake and have food and fluid chart"*

— [9 Month2] a red tray system was commenced for [Mr A] and he was supervised and assisted with meals. Fluid balance charts were available and reviewed for the period [8–19 Month2], [23 Month2] and [7 Month3]. [12 Month2] IV/SC fluids were commenced and the Consultant made several recommendations relating to nutrition and hydration.

What is the standard of care/accepted practice?

When reviewing this particular concern I have considered dietary aspects to include all oral intake including fluids.

The Health and Disability Service Standards and in particular Health and Disability (Core) Standards NZS 8134.1:2008 apply throughout this case (1) particularly in terms of the overall duty of care. In terms of the concern raised by the complainant about food and fluid intake, the section entitled, *Nutrition, Safe Food and Fluid Management* is particularly relevant, with the specific Standard being: *Standard 3.13. A consumer's individual food, fluids and nutritional needs are met where this component is part of service delivery.*

However, nursing staff must comply with the Nursing Code of Conduct (2) and acknowledge that residents have the right to decline any input such as some meals or to only eat small quantities. At the same time though the staff have a duty of care to ensure that appropriate measures are taken to address this if declining food or reduced food intake should become an ongoing issue. This is particularly important in the case of a frail vulnerable older person who needed assistance with eating and drinking as outlined in the daily care plans in documentation supplied. It is therefore important that those times when food has been declined was accurately recorded and then some action or input needed to follow should it become an ongoing concern. Again, reference is made to the Nursing Code of Conduct and specifically, Standard 4.8, which refers to Registered Nurses keeping clear and accurate records of the assessments they make and how effective they have been.

Furthermore, the Counties Manukau Health publication Fundamentals of Care Standards (REF), Care Standard 6: Nutrition and Hydration, essentially summarizes this by stating that: *"The provision of appropriate nutrition and hydration is essential to promoting health and recovering from illness."* Therefore, there would be a professional expectation that every effort was made to meet [Mr A's] nutritional and hydration needs as clinically appropriate at the time, and to address any concerns or issues as they arose. An important part of ensuring that appropriate decisions are made around food and fluid intake is accurate nursing documentation which is key to good communication in any health setting.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (mild, moderate, or severe)?

The point I have specifically been asked to comment on is whether the nutritional plan and dietary management was consistent with accepted practice and [Mr A's] needs. When considering the appropriateness of the nutritional plan I did not consider this plan to be a single document but rather an evolving plan that developed in response to [Mr A's] changing presentation throughout his hospital admission. This was based on the Nursing Care Plan and input from the multi-disciplinary team including the Dietician as and when they had input into [Mr A's] nutritional and dietary needs. My professional view is that the developing nutritional plan was sound and reasonable; dietician input, requests to monitor food and fluid intake, requests to encourage oral intake, recording weight and also the important aspect of the nutritional supplements. All aspects of the nutritional plan were in my view consistently well documented by the health professionals concerned. Furthermore, nutritional supplements were prescribed and dispensed for [Mr A] although there were many occasions when he declined these throughout his admission. I note from the documentation supplied that NG feeding was also discussed later in the admission but this option was not considered clinically appropriate. Supporting patients with complex health needs is challenging particularly when they have a delirium and at times it can be about prioritizing needs to achieve the best possible health outcome for each individual. There were certainly gaps in the documentation particularly in the food charts but in my professional opinion, the nursing staff were taking reasonable actions to support and encourage [Mr A] with his

oral intake. The [holiday weekend] was a period when there are likely to have been fewer senior staff and clinical support and I examined this period in close detail with respect to the nutritional documentation. Again, although there were some gaps, the food chart and fluid charts were largely complete and highlighted [Mr A's] ongoing poor oral intake. [Mr A] was reviewed several times over that weekend and concerns around oral intake were highlighted by nursing staff with IV fluids being charted by the medical team to support hydration. Furthermore, strategies were put in place to try and encourage [Mr A] to eat and drink more, such as simplifying the presentation, giving him more time and allocating staff to support him. Although these strategies were largely ineffective overall, this doesn't detract from the important fact that they were discussed, considered and implemented. There were several documented requests for fluids to be monitored or for oral intake to be between 1–1.5 litres a day. As previously stated, there were certainly occasions where either sub cut or IV fluids were charted and administered or where the target was reached after close monitoring, for example [17 Month2]. On two specific occasions [(8 and 9 Month2)] the fluid balance charts showed that 600mls and 450 mls respectively were taken orally and as such the target of 1.5litres a day was not met. However, the medical team were aware of this and were monitoring this alongside other important indicators such as blood results and clinical observations such as blood pressure and pulse. A weekend plan was put in place and [Mr A] was reviewed by the medical team over the course of the weekend and blood results, observations and a clinical examination were documented. Weight was recorded as having increased from 91kg on admission to 93kg. As mentioned earlier though, there were gaps in the documentation and in particular the food charts. Furthermore, there was some evidence that notes were not always fully reviewed by nursing staff. For example, the dietician review on [15 Month2], documented a number of recommendations including a "*soft mechanical diet"* and the fact that his dentures were lost, and he was struggling with hard food. In the days after this dietician input, [Mr A's] breakfast included toast none of which he was able to eat. When viewed against the background of everything that was going on for [Mr A], this might be considered a small detail but in my professional opinion it highlights that the dietician notes hadn't been fully considered and that the approach wasn't particularly person centered. Finally, comments in the nursing notes stating "*E & D as tolerated*" are not helpful in terms of determining next steps when dietary intake has clearly been identified as an issue. Having examined all the available evidence, in my professional opinion there has been a moderate departure from accepted standards with respect to [Mr A's] dietary and fluid management particularly in the initial stages of his admission to hospital. My concerns specifically relate to poor documentation or gaps in documentation by the nursing team which would not have changed decision making by the medical team in terms of supporting [Mr A's] nutritional needs, but the gaps would in my view have made it more challenging for them.

How would it be viewed by your peers? It is my professional opinion that my peers would agree with my views**.**

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

My recommendations would be that: The DHB review their Food Chart and whether they can be changed to include all food and fluid. I found that the statement on the current document about including all food and fluid except tea, coffee and water was confusing and also it wasn't always adhered to in this particular case. That nursing staff are reminded of the importance of clear and objective documentation as this better informs decision making.

Concerns about whether in the circumstances of [Mr A's] condition it was appropriate to lie [Mr A] at a 30-degree angle when he was tired.

Review of documents

The Care Plan Considerations document dated [15 Month2] stated that [Mr A] should not lay flat and should be raised to at least 30 degrees while sleeping. This Care Plan appears to have been written following the family meeting on [14 Month2]. Examination of the daily nursing documentation and care planning provided highlighted limited reference to bed positioning both prior to and after the aforementioned Care Plan Considerations were written. There were two areas of note on [18 and 19 Month2], where bed positioning was clearly documented. Any specific plan with respect to positioning prior to [15 Month2] was not identified from my review of the documentation although there was referencing to bed positioning in areas of the clinical notes such as the physiotherapy report on [1 Month2]. However, as I highlight below it is important to consider bed positioning as part of a patient's overall nursing care rather than as an intervention sitting in isolation. I therefore also examined documentation in terms of [Mr A's] overall clinical presentation. There was regular reference to the Early Warning Score (EWS) which was largely recorded as being 0 or 1 (low). In addition, there was frequent reference to his observations which included oxygen saturation levels. This would indicate to me that the nursing staff were monitoring [Mr A's] condition appropriately. I could find no documented evidence of [Mr A] being in distress and short of breath whilst remaining in the supine position. There would be an expectation that he was sat up to make breathing more comfortable if this was the case.

What is the standard of care/accepted practice?

The question I have been asked to comment on is whether it was appropriate to lie [Mr A] at a 30-degree angle when he was tired. In my view, this issue is more complex than considering bed positioning from the perspective of a chest infection in isolation particularly when he was being actively treated for this infection. This is because an individual's care needs should be viewed from a holistic perspective and this relates to the important matter of care planning in general which I will address in the next section. As examples of this issue though, rest and sleep are both important parts of recovery during and after illness and sitting up at 30 degrees or more for long periods may have limited this as well as increasing the risk of pressure injuries on the sacrum and heels. Increased risk of skin sheer and subsequent pressure injuries can occur when someone

with fragile skin and limited ability to reposition themselves sits up in bed and then gravity means they slowly slide down causing a sheering effect on bony prominences. Regular change in position or movement is an important aspect in preventing pressure injuries and sitting up in bed would make an individual at greater risk of skin sheer. Alongside this we also have the factor of patient compliance which is likely to be challenging if there is the additional issue of a delirium which was the case here. Therefore, there are multiple issues to consider and their priority will vary over the course of a particular shift or day. That said, bed positioning was specifically identified in the Care Plan Considerations dated [15 Month2], which stated: "*Don't lay [Mr A] flat in bed. His bed head should be at least 30 degrees while he is sleeping."* And with respect to meals: *"Please encourage [Mr A] to sit out of bed during meals as this is good for his chest."* As of this date and until comfort cares became the priority it would be an expectation that [Mr A] was sat at 30 degrees or upright whenever possible. Whatever the clinical reasoning behind the decision, once bed positioning had been explicitly mentioned in the Care Plan Considerations dated [15 Month2], it would be my professional expectation that there would be referencing to care being provided accordingly on the Care Plan to indicate that this plan had been considered and seen prior to cares being provided or for there to be an acknowledgement that this couldn't be achieved with the reason given.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (mild, moderate, or severe)?

In my professional opinion, in terms of positioning after [15 Month2], it is my professional opinion that if the nursing staff had positioned [Mr A] as per the documented plan but had not written this on the Care Plan or notes then I would consider this a moderate departure from accepted practice. If however they had not positioned [Mr A] according to the Care Plan Considerations, then I would consider this a severe departure from accepted practice.

How would it be viewed by your peers?

It is my professional opinion that my peers would agree with this view.

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

Care planning and documentation should be reviewed so that appropriate and consistent levels of care are provided.

3. Whether [Mr A's] care plan considerations adequately met his needs and were proactively reviewed and adapted when/if they were inadequate

Review of documents

Care planning that is accurate, updated, and followed is key to directing nursing interventions and optimising outcomes. Throughout this review I have focussed on

looking at events as they unfolded rather than with the benefit of hindsight. In terms of paperwork both wards used the same daily Nursing Care Plan format. I have considered both how these Care Plans were completed given the presenting concerns at the time and also how they were updated following a medical review or changing presentation. I have also reviewed the specific care plans or care plan considerations, for example, that dated [15 Month2], and how and to what degree this has informed daily care planning. In addition, I have looked at the documentation with respect to broad ongoing themes over each ward setting as well as from the perspective of specific areas of concern.

On reviewing the Care Plans there were a number of areas where there was a consistent lack of clarity particularly with respect to goals. For example, early on in the admission, there was frequent reference to [Mr A's] goal for the day being "to be comfortable". This might be entirely appropriate, but it wasn't clear to me what this meant and, in any event, rarely was it ever documented whether this goal had been achieved or not on the Care Plan. On [Ward 2], while at times there were no goals stated at all, there were times when the goals appeared more considered and although often simple they gave an impression of someone having had a conversation with the patient and therefore of person-centred care. For example, on [4 Month2], the goal was "shower and shave" which other documentation highlights was important to both the patient and family. This is person centred care. I was surprised that a frail 88-year-old was not considered at risk of pressure injury for large parts of his initial inpatient stay and when he was, there didn't appear to be any documented action. In my professional opinion, assuming the Waterlow score was used as stated in the Care Plan, given his age and comorbidities, [Mr A] should have been documented as being at risk from the moment of admission and appropriate safeguards and interventions put in place. The fact that he did not acquire a pressure injury does not alter my concerns here. I do note that a Skin Integrity Assessment was completed on [31 Month1] when [Mr A] arrived on [Ward 2] and he was noted as being "At Risk". The subsequent documentation immediately appears appropriate and considered as [Mr A's] ongoing assessment continued. However, on [6 Month2] onwards, [Mr A] was largely documented as not being at risk until [14 Month2] when he was documented as being at risk until [17 Month2] when again he wasn't at risk. It wasn't clear to me what interventions had been put in place to reduce the risk of pressure injury once the risk had been identified.

[Mr A's] delirium was also frequently referred to in the nursing and medical notes. A delirium cannot always be avoided particularly in acutely unwell older patients with an underlying dementia or cognitive loss as well as an acute illness. However, there are ways of reducing the risk and of reducing the effect on the patient once a delirium is identified. Like any issue, correctly identifying someone as being at risk of delirium is not in itself an intervention and there needs to be some evidence of action to address the issue concerned. In addition, there are occasions when the documentation was both incomplete and inconsistent with respect to mobility which considering [Mr A] was identified as a high falls risk was concerning. For example, on [6 Month2] [Mr A] was identified as needing assistance with mobility but no further information was given. The

next day on [7 Month2], he was described as independent but requiring supervision with a gutter frame. Finally, there were examples of appropriate recording of information but with little clear action taken. This was particularly the case around issues of constipation in the initial days after his admission to hospital. The bowel charts highlight that [Mr A] had one small bowel motion in his first 13 days following admission. Although there were occasions when [Mr A's] declining of laxatives was documented, on other occasions it wasn't always clear that this ongoing constipation was being escalated appropriately.

What is the standard of care/accepted practice?

The Health and Disability Service Standards and in particular Health and Disability (Core) Standards NZS 8134.1:2008 apply throughout this case (1). This states that consumers receive timely services which are planned coordinated and delivered in an appropriate manner. The daily care plan is a fundamental part of ensuring that this occurs. Furthermore, the Nursing Code of Conduct, Principle 4.1 states that nurses must: Use appropriate care and skill when assessing the health needs of health consumers, planning, implementing and evaluating their care.

Care planning like all nursing documentation is a fundamental part of communication and therefore its accurate completion is paramount to ensure good patient outcomes. There were several examples of well documented care planning. However, this was not a consistent feature and the overlaying impression I got was one of lacking critical thinking particularly around constipation, delirium and pressure injury risk. Throughout I had the sense of very busy working environments where the care plan was a document sitting in isolation that needed to be filled in each day as one of many tasks. But a busy working environment is exactly why accurate and regularly reviewed care plans are so important so that they have real purpose as part of a continuum of care.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (mild, moderate, or severe)?

In terms of the consistency and quality of care planning and the degree to which they were proactively reviewed particularly in the initial stages of his hospital admission, I consider there to have been a severe departure from accepted practice.

How would it be viewed by your peers?

It is my professional opinion that my peers would agree with this view.

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

The primary areas to consider for review are in my opinion around critical thinking and nursing documentation. In addition, revisiting the importance of the Care Plan as both a communication tool and a source of reference for providing consistent care over time would be helpful.

4. Whether it was appropriate to "wean" [Mr A] off of his 24-hour watch after his family had decided on a placement for him.

Review of documentation

There is a significant amount of documentation that relates to weaning [Mr A] from his 24-hour watch. I have highlighted some of what I consider to be key areas that summarise events around this matter. [8 Month3] 09.00. Consultant ward round. *Trial small dose of Quetiapine to help his nocturnal agitation and to help his sleep.* [11 Month3] 09.00 Reg Ward Round. "*Continue with 1:1 carer please until his sleep cycle is better".* [11 Month3] 13.00. Reg ward round. "*NASC has identified a bed which is available from Thursday would need to be off 1:1 watch to go. Agreed to wean to 15 minute checks from tomorrow onwards."* [11 Month3] 14.15. Consultant psychiatrist review. "*Refused Quetiapine last night. Took it Friday and Saturday nights and slept better then." "Work towards weaning off 1:1 watch and onto 15 minute checks over the next 36 hours".* [12 Month3] 09.00. Registrar Ward Round. "*Very agitated, disorientated", "Stop Quetiapine. Commence 5mg Temazepam"*. [13 Month3] 10.00 Nursing notes. *Trying to get out of bed. Care partner in situ. Seems confused and agitated".* [16 Month3] Consultant ward round. *'has been settled overnight" "Aim to wean care partner as able"* [18 Month3] Nursing Notes. "*Care partner in situ. Not confused tonight". "Trying to wean off Care Partner"* [18 Month3]. Reviewed by Behaviours of Concern Nurse. "*Pt has been commenced on 15/60 checks this morning."* [19 Month3]. Ward Round *"On 15 min checks, settled overnight"* [21 Month3]. Nursing notes "*Completed 15/60 checks during the shift but Care Partner required in last hour of shift to settle pt."* Although by no means complete, the summary above is in my professional opinion a reasonable summary of events relating to the weaning off of the 24-hour watch. Importantly, in my professional opinion, it highlights the complex and changing nature of the issues involved as the medical staff planned towards weaning [Mr A] off his 24-hour watch.

What is the standard of care/accepted practice?

Safe and planned transfer of care is a fundamentally important part of the discharge process when a patient is in hospital. This applies whether the person is transferring to another hospital, if they are going home or as in this case if they are moving into an aged residential care facility. Any patient being transferred to an aged care facility should not be taken off a 24 hour watch purely because they won't have one at their discharge destination. Rather, the decision should be clinically driven with a focus on safety alongside a sound understanding of the discharge destination.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (mild, moderate, or severe)?

The issue I have been asked to specifically comment on is whether it was appropriate to wean [Mr A] off his 24-hour watch once a discharge destination had been agreed. On the face of it, the changing snap shots in time summarised above could be interpreted as lack of clarity and certainty in planning. However, in my professional view when read

in the context of the whole notes and with an understanding of the clinical situation at the time, what they highlight is a responsiveness to [Mr A's] varying and complex presentation. The documentation indicates to me that the clinical and nursing approach with respect to withdrawing the 24-hour watch was considered and reasonable. In my professional opinion, given the documentation shows that the decision to wean [Mr A] off his watch was being reassessed and revisited over the course of time, it was appropriate for this decision to happen and therefore I do not believe that there has been a departure from accepted practice. The fact that [Mr A] had a fall later in proceedings was in my view an indication of issues at a specific point in time but not of a failure of the plan as a whole. In my professional opinion, the decisions around withdrawing the watch were at the time events occurred, clinically based and reasonable. As an additional point though, whilst I acknowledge that the Aged Care Facility appear to have accepted [Mr A] as long as he wasn't on a 24-hour watch, I would question whether him leaving while on 15-minute observations was still appropriate for any ARC facility given staffing levels in these environments, particularly at night.

How would it be viewed by your peers?

It is my professional opinion that my peers would agree with this view.

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

This recommendation relates to my comment above about 15/60 observations and staffing levels in ARC. I appreciate that different DHBs have different processes and policies around additional staffing but something I have utilised on a number of occasions is to request from Planning and Funding additional resource so that the ARC facility can have a staff member allocated to a resident for a time limited period. This might be particularly useful in the case of someone that has a delirium and who will be in an unfamiliar environment with relatively low staff numbers. This may facilitate both a timelier discharge and a safe transfer of care.

5. Whether [Mr A's] falls were managed appropriately.

Review of documentation

In total, [Mr A] had four falls while in hospital and I have considered these separately below.

Events around first fall on [15 Month2] while on the rehabilitation ward.

Daily care plans identified [Mr A] as being a high falls risk throughout admission. Invisabeam insitu from arrival on the ward [8 Month2] onwards 15/60 patient check forms completed. [15 Month2] Physio review highlighted reluctance to mobilise. [15 Month2] Care Plan Considerations document high falls risk and interventions. [15 Month2] Fall just before midnight, while being assisted to go to the bathroom.

[Mr A] was reviewed by a doctor at 00.15 after his fall and invisabeam in place 24-hour care partner put in place. Patient observation forms noted. [16 Month2] Physio review. *"Pt remains a high falls risk due to fluctuating alertness."* [16 Month2] 24-hour Care partner introduced. [17 Month2], further physio input. Although there was no documented evidence that [Mr A] was wearing non slip socks at the time of the fall as written in Care Plan Considerations dated [15 Month2], the written nursing documentation indicates that [Mr A] over balanced rather than slipped and so it is my professional opinion that wearing these would not have changed the outcome. There is nothing to indicate that the staff member could have done anything different to avert the fall. [Mr A] was receiving 15 minute (15/50) checks prior to his fall according to documentation. All input and actions following the fall were in my professional opinion appropriate and completed in a timely manner.

Events around 2nd fall on [29 Month2] at approx. 00.35 while on [Ward 2].

[23 Month2] Nursing notes "*Unable to mobilise. Not safe to mobilise with patient due to impulsive and delirious state. At risk of falls*." [24 Month2] PT/OT Plan. *"If engaged and following instructions please A x2, t/f bed to chair or commode as able".* [27 Month2] "*While transferring pt back to bed with frame, pt landed on one knee."* [27 Month2] Patient observation form documents [Mr A] as settled and no agitation and impulsiveness from 15.00 to 24.00hrs. [28 Month2] OT/PT review. "*Pt very impulsive, OT/PT needed to give verbal instructions to remind pt to take his time, Pt mobile 15m with wf and 1A. Unsteady gait, pt independently sat back in chair*. [28 Month2] 07.00–15.00. Pt observation form documents [Mr A] as settled but walking in his room on occasion. 15.00–23.00 incomplete but no concerns highlighted. [29 Month2] 00.30. Unwitnessed fall in bathroom. RN had taken [Mr A] to bathroom and asked HCA to watch him but by the time she had got there he had already fallen. The summary above again highlights the varying presentation with respect to [Mr A's] mobility and impulsiveness. Although the interaction with the physiotherapist documented unsteady gait the Observation Forms for the period in question indicate that he was reasonably settled. He certainly required assistance with mobility at the time of the fall and the notes state that the RN had asked the HCA to stay with him because of his history of impulsiveness and his falls risk. In my professional opinion, at the time these events occurred, these were reasonable actions given that [Mr A] was on 15/60 observations and he had been reasonably settled. Post falls documentation and observations were appropriately managed.

Events around 3rd fall, on [29 Month2] at approx. 04.00 while on [Ward 2]

[29 Month2] 01.39. Medical review. Plan stated "*assist with mobility, hourly rounding. Lying and standing BP x3".* [29 Month2] 04.00. Unwitnessed fall in bathroom. Found by staff sitting on floor. Small skin tear on right hand. [29 Month2] 06.00. Nursing notes. "*Intentional rounding was done every 30 minutes. Pt doesn't ring the call bell at bedside. Care partner ordered. Falls intervention in place, signs, non-slip socks, night light, bed in low position, care partner*". There was little time between these two falls and they occurred overnight when the opportunities for additional staffing would have been

limited. However, if the Care Partner that was ordered at 06.00 was available after the first of these two falls then the risk of the second fall is likely to have been significantly reduced. Under the circumstances, hourly rounding as documented would not in my view be an appropriate response. We cannot say that the risks would have been eliminated by having a watch because [Mr A] fell on [16 Month2] whilst being accompanied to the toilet, but the risk would certainly have been reduced with closer observation.

Events around 4th fall on [21 Month3] while on [Ward 2].

[18 Month3] Reviewed by Behaviours of Concern CSN. "*Delirium resolved*, *High risk of falls. Continue 15/60 checks and trial 1hourly intentional rounding."* [20 Month3] Ward Round note. "*Sat out, doing well, obs all stable, tolerating 15 min checks. No falls".* [21 Month3] Nursing notes. 07.10 "*Completed 15/60 checks during the shift but CP (Care Partner) required in last hour of shift to settle pt"*. [21 Month3] Patient 15/60 Checks Form highlights [Mr A] awake much of night and unsettled particularly around 05.00am when 1:1 observation put in place again. [21 Month3] Ward Round note. 10.20 "*understand from nurse very unsettled last night*". [21 Month3] Patient 15/60 Checks Form highlights being unsettled and unsteady on feet at 16.00 and then again from 20.00 hours onwards. [21 Month3] 20.20hrs Patient 15/60 Checks Form "*Found patient's leg hanging down tried to get out of bed by himself."* [21 Month3] 22.25hrs. [Mr A] has unwitnessed fall. [21 Month3] 23.20 Post falls check list completed [22 Month3] 00.26 Medical review. Care Partner reinstated.

This fall occurred after a discharge destination was agreed and a weaning of his 1:1 watch was planned. Review of all the notes over this period highlights the fluctuating nature of [Mr A's] presentation and the ward's responsiveness to it. Given his well-documented history though there were clear periods on [21 Month3] when there were signs that [Mr A] was becoming more vulnerable again with respect to falls. I acknowledge that the time scales and therefore the opportunities for interventions were relatively small but timely intervention is of key importance in providing good nursing care.

What is the standard of care/accepted practice?

Falls prevention in all care settings has been an area of significant focus over the last few years (3,4,5). The aim is always to minimise risk and reduce harm whilst at the same time balancing this with the wish to support an individual's independence as much as is realistically possible. This requires skilled care planning and input because older adults in particular lose muscle mass and decondition extremely quickly without appropriate mobility input. Unfortunately, sometimes mobility can be the first thing that stops after a fall because both care staff and the individual affected are concerned about further falls. It is therefore a balance and about mitigating risk of further falls rather than eliminating risk, with appropriate interventions and strategies being put in place. At the same time, if a fall has occurred in a hospital setting it is extremely important that the

relevant post falls protocols are followed and that the necessary observations and interventions are completed. In the HQSC falls prevention strategies they refer to the risk mitigation process of "ask, assess and act" (5). Immediately after the third and fourth falls there was documented evidence that the "act" aspect of this process didn't happen when the written evidence at the time indicated that [Mr A] was at an increased risk of falls.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (mild, moderate, or severe)?

The question I have been asked to consider is whether the falls were managed appropriately. In many respects they were in that [Mr A] was reviewed in a timely manner, documentation was largely in line with expectations, and appropriate interventions were put in place immediately afterwards. The issue for me though goes beyond this question and while you can never eliminate risk particularly with the frail elderly, you can reduce risk. In my professional opinion, there were two specific periods of time where the signs were there that a fall was likely to happen. They did happen, and on both occasions they occurred in the evening or at night when the ward staffing levels would have been lower than during the day. It is important to acknowledge that on reading the notes it was clear that on many occasions staff were acutely aware of [Mr A's] falls risk and endeavoured to take reasonable mitigating actions when possible whilst working on a busy ward environment with other equally challenging priorities. For example, on [21 Month3], at 05.45 1:1 watch was commenced because of unsettled behaviour and then they returned to 15/60 checks a few hours later when [Mr A] had settled. There are several other examples of similar interventions being taken ([12 Month3], 13.30 for example) as [Mr A's] condition changed. His fluctuating delirium would have been a key driver in terms of his behaviour and the nature of a delirium is that it is often ever changing and unpredictable. However, ultimately there were clear opportunities that were missed to reduce the risk of two of these falls. This also comes back to the Care Planning and ensuring that they are completed appropriately and utilised for their intended purpose. I therefore consider there to have been a severe departure from accepted practice.

How would it be viewed by your peers?

In my professional opinion my peers would agree with my view.

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

Review staffing availability overnight in particular so that there are opportunities to better support staff in situations such as this. Ensuring that there is appropriate post falls review. In particular consider reviewing the post falls documentation. At present it appears to be a Post falls Checklist but of greater help to reduce further falls might be a Post Falls Pathway that fully reviews the fall in an effort to get to the root cause and in so doing prevent further falls.

6. Whether staff addressed [Mr A's] personal cares to an accepted standard (i.e. washing, shaving, toileting etc).

Review of documentation

The copy of the complaint expressed concerns about the standard of care in general. I have reviewed all the notes and there was frequent reference to [Mr A] being showered or of him declining the offer of a shower during the entire course of his hospital stay.

On many occasions the notes referred to the daily goal being to have a shower or to him having a shave although this wasn't always achieved, for example: [3 Month2] Care Plan Goal, "*to have a shave" "Not achieved*". Furthermore, I found evidence that the notes were updated when a shower occurred after initially declining [12 Month2]. "*Refused wash and shower."* Additional note "*had shower*". The addition of a Care Partner because of [Mr A's] falls risk may have given more opportunity to encourage [Mr A] to shower and shave as there were a number of references to these staff members assisting in this regard. For example: [7 Month3]. "*Care Partner assisted him for a shower, shave and oral cares."*

With respect to toileting, the notes consistently referred to [Mr A] being toileted and being continent. On the occasions when he was incontinent the documentation states that the continence product was changed. No documented evidence of continence associated dermatitis was identified and no documented evidence of oral thrush was identified which might have been the case had oral cares been poor. I also noted the use of a warming blanket as [Mr A] reached the end of his life and his peripheral areas became colder. However, there was one particular note from the nursing staff that indicated a possible lack of attention to some areas of care. [24 Month2] "*mouth cares done, and mouth appeared really crusty and dirty".*

Clearly it would not be acceptable to allow any patient to get into this condition unless there were extenuating circumstances. It is also acknowledged that the fact that I only identified this one example of [Mr A's] mouth being in poor condition is not in itself a mitigating factor because it shouldn't happen at all. However, the context is important, and on [24 Month2], there was documented evidence of challenging and resistive behaviour because of the ongoing delirium that would have undoubtably made the provision of any cares, but particularly those close to the face such as mouth cares difficult. Indeed, on [24 Month2] the nursing notes specifically documented that [Mr A] was *"uncooperative and aggressive while washing the pt and shaving. Couple of times pt attempt to hit the staff".* In terms of ensuring [Mr A] was warm enough and had enough blankets, documentation frequently referred to him being restless and agitated which would undoubtedly have led to him kicking or pushing blankets off at times and this may have meant that keeping him appropriately covered was sometimes difficult.

What is the standard of care/accepted practice?

Patients are always required to be treated with respect and dignity (1) and this includes interventions and support around washing, and toileting. Furthermore, Registered Nurses are required to provide planned nursing care (2). However, the issue also needs to be viewed in the context of the clinical situation at the time. In this case it was a frail and acutely unwell 88-year-old man with multiple comorbidities that had been admitted with a significant infection and a subsequent delirium. Even when the initial acute event had initially passed, and [Mr A] had moved onto the [rehabilitation] ward the documented delirium and confusion would have been a significant consideration with respect to any intervention and whether more distress would have been caused by pursuing a particular action such as for example shaving. This delirium continued once he returned to [Ward 2]. It is my professional opinion therefore that for planned nursing care to occur as stated above their needs also to be a process of evaluation and prioritisation for each individual. In other words, because something that should normally have happened didn't happen such as a shower doesn't necessarily lead me to draw the conclusion that there has been poor practice. For example, when [Mr A's] goal of having a shower on [4 Month2] was not achieved it is possible that the documented chest pain on the same morning was a factor both in terms of [Mr A's] reluctance to have a shower and how he was interacting with staff. Furthermore, although there were numerous documented references to [Mr A] declining a shower or shave I was not able to identify any documented evidence (dermatitis, pressure injuries, excoriation) of him having been left for long periods in soiled continence products which would of course have been extremely concerning.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be (**mild**, **moderate**, **or severe)?**

While I acknowledge that there were clearly times when the family were concerned about the standard of personal care, in my professional opinion when reviewing the documented evidence and when viewed in the context of the other issues at the time I do not consider there to have been a departure from the standard of care or accepted practice.

How would it be viewed by your peers?

In my professional opinion my peers would agree with my view.

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

I do not consider there to be any other matters that warrant comment in this review.

References

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5. HQSC (2021), Reducing Harm from Falls. https://www.hqsc.govt.nz/our-programmes/reducing-harm-from-falls/projects/dhb-assessment-tools-and-care-plans/ Accessed 18/03/21

Richard Scrase Registered Nurse'

The following further advice was obtained from RN Scrase dated 13 December 2022:

'Thank you for the opportunity to review this case and also for the significant further information and detail provided by Counties Manukau Health. In the light of the response from Counties Manukau Health and the supporting documentation, I have reviewed the specific areas to which they have responded. I have also taken the opportunity to reconsider those areas where I did not consider there to have been a departure from accepted practice. In each of these cases the new information provided has not changed my opinion and I do not consider there to have been a departure from accepted practice.

As was the case with my original report, I have considered matters at the time they occurred, as opposed to viewing events with the benefit of hindsight. In addition, I have considered the actions rather than the outcomes, as in general terms, it is possible that there is a good outcome despite poor interventions and likewise a poor outcome despite high quality clinical input and care. Furthermore, the nature of my role is that I have no contact or communication with the clinical area under investigation, and therefore I am relying on the documentation provided from which to formulate my opinion.

Concerns about whether the nutritional plan and dietary management was consistent with accepted practice and [Mr A's] needs.

I acknowledge the comments made by the independent dietician which is included in the response letter from Counties Manukau Health. Both this and Counties Manukau Health acknowledge that documentation was not clear or was incomplete at times. This was the primary issue that I raised in my initial report. As stated in my initial report,

many of the interventions were reasonable although I reflect on the suitability of toast for breakfast for someone that has no teeth and is documented as requiring a soft diet.

Although I agree that the accurate completion of both food and fluid charts can be challenging in a busy clinical environment, when required, they are important detail when it comes to clinical decision making. That said the gaps in these documents were not over long periods of time, but they were there. I note however as pointed out by Counties Manukau Health that [Mr A's] weight was stable and that he was prescribed and administered nutritional supplements. Given the response and information provided by Counties Manukau Health I have revised my initial opinion and consider that there has been a mild departure from expected practice with respect to the nutritional plan and dietary management.

Whether in the circumstances of [Mr A's] condition it was appropriate to lie [Mr A] at a 30-degree angle when he was tired.

In examining this point, I have considered what has been agreed between patient, family and the medical team alongside what is accepted good clinical practice under the circumstances described. In general, as acknowledged by Counties Manukau Health, it would be reasonable to raise up the head of an individual's bed (though not necessarily precisely to 30 degrees) if an individual was short of breath. In addition, it would also be expected if this had been agreed between all parties present in a family meeting where personal and family views are considered alongside clinical best practice. When considering my response to this question, it is these factors which have been the basis for my thinking.

In the response from Counties Manukau Health, it is stated that the *"Care Plan consideration word document was only designed as a reference to staff, especially the HCA in the room with [Mr A] to enhance care".* And that "*as the breathlessness was concerning to [Mr B] (the son) it was decided that [Mr A] would be placed at 30 degrees to assist with his shortness of breath."*

Furthermore, the Counties Manukau Health response stated that*, "while this document provided prompts for staff its design was not intended to be used as a formal care plan".*

I agree with Counties Manukau's comment that staff on a respiratory ward would be aware of the need to elevate a bed when a patent is short of breath and that bed elevations would not normally be recorded. That said, given the pressures on staffing it would have been quite likely that there would be the need for the use of pool or agency staff who may be less familiar with that ward environment and the management and support of patients on the ward. This is an important additional consideration when we view documentation as a whole; does it clearly inform someone that is unfamiliar with both the patient and the clinical environment in question.

However, the fundamental issue concerns the agreed plan of care as discussed at the family meeting from which the Care Plan Considerations document was based. If it was

agreed at the family meeting, even if the details were considered straightforward to people expert in their field, it needed to be appropriately documented which in this case meant as part of the care plan. As mentioned above, part of the reason for having a care plan is about continuity of care and an agreed understanding for everyone, including those staff unfamiliar with the ward. It is also about acknowledging what is important to the family and the patient so it can be seen that they are heard. Therefore, if bed elevations were an agreed plan of care they should in my view be formally documented in the Care Plan. This is particularly important given that the HCA works under the direct supervision of a Registered Nurse. Having notes at the end of the bed is reasonable (as long as matters of privacy have been considered) but they also need to be formally documented. Given that this did not occur I therefore stand by the conclusions made in my original report which was that if the nursing staff had positioned [Mr A] as per the documented plan but had not written this on the Care Plan or notes then I would consider this a moderate departure from accepted practice. If however they had not positioned [Mr A] according to the Care Plan Considerations, then I would consider this a severe departure from accepted practice. To be clear though, this finding is not specifically about the appropriateness of sitting [Mr A] at 30 degrees, as the decisions made at the family meeting appear to have concluded that this was appropriate. The finding actually concerns the lack of appropriate documentation and direction for nursing staff following this meeting. There needed to be some evidence that matters that were important to the family, even if they might be considered normal practice by medical staff were understood and taken on board, and it was this that I could identify, hence my finding.

Whether [Mr A's] care plan considerations adequately met his needs and were proactively reviewed and adapted when/if they were inadequate.

I acknowledge the significant additional information and documentation supplied by Counties Manukau Health, and in particular, the following:

The bowel assessment charts (enclosure 1)

The CAM delirium assessment tool (enclosure 2). I note that the CAM assessment was repeated on [8 Month4] the next shift as per policy because he was considered a high risk (score 3). The next day [(9 Month4)] [Mr A] settled to being low risk and so daily assessments were continued.

The CAM Care Plan (enclosure 3). Although these appeared to be identical for each day I was unable to identify a Care Plan for [8 Month4] when a high risk score was identified on the CAM (enclosure 2).

The Waterlow assessment charts (enclosure 10). These were completed on a regular basis and there were changes to these. However, some of the significant changes in Waterlow score appeared to relate to incomplete information or differing interpretations. For example, some staff highlighted "multiple organ failure" as an issue

which would have added significantly to the total score and some single organ failure and some no organ failure at all. These differences did not appear to relate to changes in the patient's clinical presentation. There were also similar differing views on weight loss which would have also impacted on the total Waterlow score.

The Pressure Injury Care Plans (enclosure 11). Related appropriately to the correct bundle which is what you would expect with an automated system. Where I would expect there to be cross population of data.

As stated in my introduction, the fact that there was no pressure injury or other poor outcomes does not detract from the fact care plans and the assessments that inform the care plans need to be complete, objective, and although they shouldn't necessarily be consistent in the sense that they are the same each day, there should be a consistent thought process. The example above of changes in the waterlow depending on whether it was considered they had weight loss in the last 6 months or had organ failure is an example of where this did not occur.

Given the further information supplied by the DHB and the fact that I have now viewed a number of care plans and assessments that were not previously available I do not now consider there to have been a severe departure from accepted practice. However, I do consider there to have been a moderate departure from accepted practice because of the inconsistencies as outlined above and also in my original report.

Whether [Mr A's] falls were managed appropriately.

My initial report identified the fall on [29 Month2] at 04.00 (following an earlier fall that same night) and the final fall on [21 Month3]. Further documentation has been supplied for which I am grateful. The CAM delirium screen indicated on the morning of [29 Month2] Mr A was at low risk of a delirium.

However, the screening tool indicated that he developed a mild to moderate delirium in the 24 hours after the fall. In addition, the OT/PT review on [28 Month2] (the day before the falls) stated that:

"*pt very impulsive, OT/PT needed to give verbal instructions to remind pt to take his time, Pt mobile 15m with walking frame and 1 assist. Unsteady gait, pt independently sat back in chair".*

The day prior to this on [27 Month2] the clinical notes stated that:

"While transferring pt back to bed with frame, pt landed on one knee."

Electronic Care Plan Charts which I had not viewed when compiling my original report have subsequently been supplied by Counties Manukau Health. These care plans start on [28 Month2] at 03.26. The corresponding CAM assessment identified [Mr A] as being at risk of delirium. Other occasions when a possible delirium was identified was followed by a corresponding Care Plan Chart. I note that the Care Plan Charts appeared

to be identical apart from a different date on each occasion. However, there did not appear to be a CAM assessment between [1 and 28 Month2] although nursing notes stated on [23 Month2] that:

"Unable to mobilise. Not safe to mobilise with patient due to impulsive and delirious state. At risk of falls."

These documents supplied after my initial report was written indicate that [Mr A] was being closely monitored and that the clinical and nursing staff were aware of [Mr A's] fluctuating presentation.

In the response letter from Manukau DHB I note the reference to a low SAC (Severity assessment code) score. A low SAC score, as a result of an event where there has been minimal or no harm or injury, is an indicator that further interventions may need to be put in place in order to prevent a further event that could cause either more serious injury particularly when the fall is a significant predictor of further falls in the older adult population.

Prior to the fall at 0030 hrs the RN had asked the HCA to remain with him in the toilet because of his risk of falls.

I acknowledge the challenges that all areas of the health system were under during the pandemic and indeed similar challenges with respect to staffing remain. I also acknowledge that many falls among the older adult population are not preventable. Although the question I have been asked is whether the falls were managed appropriately I would consider the more important question to be whether all reasonable efforts had been taken to reduce the risk of falls. This then leads me to ask the question as to whether the falls on the night of [29 Month2] were a surprise when they occurred? Whilst considering matters at the time events occurred, the answer to this question would be that they were not a surprise. Given this, accepting that the risk of falls cannot be eliminated and that some falls will always occur despite appropriate interventions put in place, were appropriate interventions put in place?

On reviewing this case, one of the key events was the OT/PT review mentioned above which explicitly stated that [Mr A] was both impulsive and unsteady. This was on the day prior to his falls. Both an OT and a Physiotherapist are invaluable parts of the multi-disciplinary team but this important information does not appear to have been considered when planning staffing for the night ahead. In my view this in itself should have warranted a hospital watch and there is no evidence that I am aware of that one was requested. This action would not have eliminated the risk of falls, but it is likely to have reduced the risk of a fall.

Whilst I acknowledge that patient observation forms were being completed and they did not highlight any concerns, the nature of delirium is that it can be variable and this alongside frailty makes individuals very vulnerable. It remains my view that warning

signs were not acted upon and I therefore stand by my original view that this was a severe departure from accepted practice.

Richard Scrase
12/12/22'