# Remuera Rise Limited

## A Report by the
## Aged Care Commissioner

## (Case 20HDC00708)

Health and Disability Commissioner
*Te Toihau Hauora, Hauātanga*

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## Complaint and investigation

1. The Health and Disability Commissioner (HDC) received a complaint from Mr A about the services provided to his wife, Mrs A (deceased), by Remuera Rise Limited. The following issue was identified for investigation:

   - *Whether Mrs A received an appropriate standard of care from Remuera Rise Limited from Month1 to Month12 (inclusive).*

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

3. The parties directly involved in the investigation were:

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| Mr A | Complainant/consumer's husband |
| Remuera Rise | Provider/care home |

4. Further information was received from:

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|---|---|
| Dr B | General practitioner (GP) |
| Te Whatu Ora<br>(previously a district health board) | |

5. Also mentioned in this report:

| | |
|---|---|
| Dr C | Registered nurse |

6. Independent advice was obtained from Registered Nurse (RN) Richard Scrase (Appendix A), and in-house clinical advice was obtained from GP Dr David Maplesden (Appendix B).

## Information gathered during investigation

### Background

7. On 31 Month1,[1] Mrs A was admitted to Remuera Rise care home.[2] Mrs A had been diagnosed with Parkinson's disease a number of years earlier, and in Month5 her condition deteriorated. Sadly, Mrs A passed away on 4 Month12, aged in her sixties.

8. Mrs A's husband, Mr A, raised concerns with HDC about the care provided by Remuera Rise. He feels that Mrs A passed away prematurely owing to a lack of care at the facility. He stated

[1] Relevant months are referred to as Months 1–12 to protect privacy.
[2] Remuera Rise was owned by Remuera Rise Limited at the time of the events. It has since been sold to another company and continues to trade as Remuera Rise.

that because of their concerns, her family visited her at least three times a day to make sure that she had eaten and had been given her medication.

9. Mr A complained about several issues, including the monitoring of his wife's food and fluid intake, the management (including monitoring and administration) of her medications, the management of clinical issues such as a hand infection, oral thrush, a cough, and pneumonia,[3] and the delayed discovery of broken ribs, which indicated an unnoticed fall. He also stated that Mrs A was denied timely toilet access, left in clothing soaked in urine or vomit, and was fed without sufficient care to avoid choking or aspiration.[4] Mr A said that his wife's condition deteriorated rapidly when her family were not allowed to visit and supplement her care during the COVID-19 lockdown in Month11, as Mrs A had been reliant on her family to supplement the care given at Remuera Rise.

**Remuera Rise**

10. Remuera Rise provides rest home and hospital levels of care. Remuera Rise's retirement village has 58 apartments and a 12-bed care facility with 24-hour nursing services. Remuera Rise stated that from 9 Month11 to 5 Month12, 10–11 of the beds in its facility were full at all times.

11. Remuera Rise employs six registered nurses, including a clinical manager, and seven healthcare assistants, as well as a contracted GP (Dr B) and a physiotherapist, who visits weekly (or more frequently if required). Remuera Rise told HDC that a typical day shift is staffed with one registered nurse and two healthcare assistants, and a night shift has one registered nurse and one healthcare assistant. Dr B provides 24-hour on-call care for Remuera Rise, and otherwise visits once a week.

**Admission to Remuera Rise**

12. Mrs A moved into Remuera Rise from Hospital 1 on 31 Month1. She was admitted for hospital-level care, based on a needs assessment and service coordination (NASC) assessment by Hospital 1. Mrs A was identified as a palliative patient in this assessment.

13. On admission, Mrs A's interRAI assessment (a comprehensive clinical assessment of a patient's needs) stated that an enduring power of attorney (EPOA) had not been activated, and that an advance care plan/advance directive had not been completed. In response to the provisional report, Mr A told HDC that this is incorrect, as Mrs A's EPOA had been activated well before she was admitted to Remuera Rise.

14. Remuera Rise told HDC that a care plan was developed on admission and was reviewed every six months or as changes were required to meet Mrs A's needs. Remuera Rise said that the care plans were completed in consultation with Mrs A and her family. The care plans also addressed any needs or risks identified in the interRAI. Remuera Rise said that Mrs A suffered from fluctuating function and cognition, including suffering from marked hallucinations that made her feel unsafe, and 'off periods' owing to her Parkinson's

[3] Inflammation of the lungs.

[4] Breathing in a foreign object (such as food or liquid). Aspiration can lead to aspiration pneumonia if food or liquid is breathed into the airways or lungs instead of being swallowed.

medication, which could include rigidity, difficulty swallowing, increased agitation, confusion, and impaired insight. She also suffered from heat intolerance. Mr A told HDC that quetiapine (an antipsychotic drug) had contributed to the above symptoms, and that he had not been made aware that Mrs A was being given this medication.

15. Mrs A was admitted to a single room with an en suite near the nurses station, because of her unstable condition and high falls risk. The room had a ceiling hoist and thermoregulation to assist with her heat intolerance.

16. Remuera Rise told HDC that Mrs A's condition was challenging to manage, and that staff collaborated with several specialist health services, including the neurology clinic, a pharmaceutical company [5] support team, mental health services for older people, occupational therapy services, and speech language therapy services. Remuera Rise stated that when Mrs A had acute conditions that staff felt would be better managed in a hospital setting, they facilitated transfer to the public hospital for treatment. Remuera Rise said that it provided training for its nursing team to assist them in caring for Mrs A, including an in-service education session on Parkinson's disease, and training on apomorphine [6] administration from a movement disorder nurse. A copy of the education and training record was provided to HDC.

**Clinical issues**

*Food and fluid intake*

17. In her transfer of care letter from Hospital 1, Mrs A's weight was recorded as 42.3kg, and the letter noted that Mrs A had poor oral intake of food. Throughout her time at Remuera Rise, Mrs A's weight was relatively stable. However, her weight dropped from 43kg on 13 Month11 to 40kg on 19 Month11.

18. Remuera Rise told HDC that Mrs A had a poor appetite and could tolerate only small amounts of food. Mrs A was taking a food supplement, Fortisip, and Remuera Rise told HDC that this was recorded in the medication administration record. Up until 28 Month11, Mrs A was taking two to three bottles of Fortisip per day. Her other hydration and food intake (such as any snacks and meals) were recorded in the progress notes intermittently; however, at times it is not clear whether food and fluid was not offered for a period or was not recorded.

19. Subcutaneous fluid was commenced on 28 Month11 and discontinued on 1 Month12, at which time a fluid monitoring chart was started. Mrs A reportedly ate only intermittently after 28 Month11.

[5] A pharmaceutical company. Nurse advisors provide support to nurses to ensure their competency in managing apomorpine administration.

[6] Apomorphine is used to treat Parkinson's disease. It works by acting in place of dopamine, a natural substance produced in the brain that is needed to control movement.

20. Remuera Rise told HDC that PEG or an NG tube[7] for feeding was offered to assist with Mrs A's difficulty swallowing. Mrs A's speech language therapist documented on 30 Month11 that Mrs A accepted her aspiration risk and declined a PEG or NG tube. Remuera Rise told HDC that the use of such a tube would have helped to improve Mrs A's nutrition, hydration, and medication administration.

21. In response to the provisional report, Mr A told HDC that a consultant at Hospital 2 had informed him that a PEG was not suitable for Mrs A, and that an NG tube was not an option because previously Mrs A had had a broken nose.

22. Remuera Rise stated that Mrs A suffered from night and day reversal (she was active during the night and slept during the day), so when she was asleep staff tried to avoid disturbing her. Further, Remuera Rise said that an ingredient in her medication[8] meant that it needed to be taken one hour before or after meals, so this restricted when staff could offer snacks. Remuera Rise also stated that staff would save snacks for Mrs A for when she was ready, and they would offer a bigger breakfast (alongside normal snacks) if it was later in the day. Remuera Rise said that while food was not withheld from Mrs A, her ability to swallow was considered when providing hydration and nutrition. Where possible, staff would attempt to improve her swallowing with medication, and would offer soft food options such as ice cream, yoghurt, and Fortisip.

23. As noted above, Mrs A's weight dropped from 43kg on 13 Month11 to 40kg on 19 Month11. Remuera Rise told HDC that staff did not increase monitoring of her weight at this time as she was receiving end-of-life comfort cares, and it would have caused her discomfort and risked injury to have moved her to record her weight.

*Medication management and administration*

24. Mrs A took Sinemet[9] for her Parkinson's, alongside apomorphine. Remuera Rise told HDC that on a typical day, nurses administered regular oral medications to Mrs A 18 times in 24 hours. In addition, her apomorphine pump was changed daily, a Fortisip supplement was given three times daily, and, when required, extra doses of Sinemet and apomorphine were provided.

25. In his complaint to HDC, Mr A expressed concern that there were periods where Mrs A was under-medicated, and her symptoms worsened as a result. In particular, he noted that her ability to swallow was reduced, and therefore she aspirated, which led to pneumonia. He also raised with staff at Remuera Rise the issue of the use of certain medications at times, including midazolam spray, lorazepam, and apomorphine.

[7] 'PEG' stands for 'percutaneous endoscopic gastronomy' — a flexible feeding tube is placed through the abdominal wall into the stomach to allow feeding and/or medication administration. 'NG' stands for 'nasogastric' tube — a tube placed through the nose, down the throat, and into the stomach for feeding and/or medication administration.

[8] Levodopa in her Sinemet medication.

[9] A medication used to treat symptoms of Parkinson's disease. It contains two active ingredients, levodopa and carbidopa, and improves symptoms such as shaking/tremor, muscle stiffness, and slow/unsteady movement.

26. Remuera Rise told HDC that staff understood the importance of a strict medication regimen for Mrs A, and oral medications were administered as close to the prescribed time as possible, in consideration of swallowing ability, mood, mealtimes, and personal cares.

27. At times, Mr A assisted in administering Mrs A's medications. Remuera Rise told HDC that it is not its standard practice to involve family in administering medicines, but as Mr A had been involved in Mrs A's care since her diagnosis, staff felt that it was beneficial to Mrs A and its resident-centred model of care to involve the family in her cares and medicine management. Remuera Rise said that its team worked closely with Mr A, and at times with their daughter, in relation to Mrs A's medication needs. Remuera Rise stated that when Mrs A suffered symptoms such as hallucinations and anxiety when she felt that staff were giving her the wrong medication or poisoning her, it was reassuring for Mrs A to have her husband or daughter administer her medicines.

28. However, Remuera Rise stated that regardless of family involvement, the management of Mrs A's medication remained the responsibility of the medical and nursing staff responsible for her care. Remuera Rise said that care staff attempted to review care plans with Mr A and maintain open communication with him, but at times the clinical team felt uncomfortable with Mr A's decisions relating to Mrs A's medications, and they would challenge this accordingly.

29. On 20 Month8, Mrs A was admitted to Hospital 2 at Mr A's request, with symptoms of drowsiness, chesty phlegm, and occasional coughing. Mr A expressed concern that she was under-medicated. Remuera Rise stated that staff were uncertain why Mr A had concerns about Mrs A being under-medicated. However, Remuera Rise noted that Hospital 2 reviewed Mrs A's Sinemet dosage and increased it. The family may have been concerned that the previous Sinemet dosage had not been effective at controlling her symptoms. Lorazepam was also stopped after this review. Remuera Rise told HDC that the ward nurse from Hospital 2 informed the registered nurse on duty at Remuera Rise that Mrs A had a chest infection, which would be the underlying reason for her change in condition, and she was placed on antibiotics to treat this.

30. Mr A told HDC that on 3 Month10 Mrs A was under-medicated and distressed, and not attended to by Remuera Rise staff. Remuera Rise told HDC that Mrs A refused her 2am dose of Sinemet as she did not trust the staff and thought that they were giving her different medications. The nurse showed Mrs A the tablet coming out of the original packaging of Sinemet, and eventually she agreed to take it. At 2.11am, the progress notes state that Mrs A was given midazolam nasal spray (used to reduce anxiety) because she shouted and screamed that there was someone in her room and she did not feel safe. Staff recorded that the nasal spray had minimal effect.

31. On 26 Month11, Mrs A was compliant with her medication until lunchtime, when her condition changed and she began to hallucinate and became agitated and restless. Her condition was discussed with Mr A, and she was given an extra dose of Sinemet.

32. During the afternoon shift on 26 Month11, the duty nurse noticed that Mrs A's speech was slurred, and she was drowsy and unable to swallow her tablets whole. Mrs A was given crushed medications, and Mr A was kept updated. He prompted Mrs A to take her medications via a video call.

33. The night duty nurse on 26 Month11 noted that Mrs A was providing minimal verbal responses. Mr A video called at 11.45pm and was informed that Mrs A was becoming stiff. Mr A suggested an extra dose of apomorphine, which the nurses agreed with and administered. Mrs A's condition improved slightly, and Mr A was informed of this when he called again at 12.15am. In this call, Mr A further suggested an extra half tablet of Sinemet, which was administered at 1.30am on 27 Month11 alongside Mrs A's usual dose (totalling one full tablet). Remuera Rise stated that Mrs A was awake all night and was offered and assisted with fluids and biscuits throughout the night.

*Crushing of medication*

34. Remuera Rise told HDC that staff did their 'very best' to stick to Mrs A's medication regimen to control her symptoms, but they were not always successful. Remuera Rise said that when Mrs A had a 'wearing off' episode, where the benefits of her Sinemet would wear off between doses, she would experience rigidity and not be able to swallow tablets. This would be treated with a bolus dose of apomorphine, and if successful she would take her Sinemet tablets. If necessary, the tablets would be crushed and/or dissolved and administered by syringe.

35. Remuera Rise told HDC that crushing or dissolving medications was not specifically discussed with the pharmacist, and staff did not initiate this practice but were advised that this practice was used by Mrs A's neurologist at Hospital 2, by a movement disorder nurse specialist at Hospital 2, and by the pharmaceutical company support team. Guidance that Mrs A's Sinemet tablets could be crushed when she could not swallow them whole was included on Mrs A's electronic medication chart. Remuera Rise stated that the medication chart was viewed frequently by Dr B and the pharmacy provider when dispensing and reviewing medications.

36. Remuera Rise's medication administration guidelines state:

> '[T]he prescribing medical practitioner or pharmacist must verify the appropriateness of crushing medication. When it is necessary to crush medication for ease of administering, place these in a carrier such as puréed fruit or yoghurt to administer. Avoid using jam as a carrier due to the high acidity in jam possibly altering the effectiveness of some medications.'

37. Mrs A requested lemonade as a carrier for Sinemet instead of water, as it disguised the taste better. The guideline does not comment on dissolving medications.

*Hand infection management*

38. On admission to Remuera Rise, Mrs A's medical history included recurrent infection on both hands related to fixed flexion of her fingers. This was caused by her nails digging into her palms and breaking the skin.

39. On 3 Month10, staff identified that Mrs A's hands had become infected. Dr B was contacted, and he prescribed flucloxacillin (an antibiotic). The progress notes state that Mrs A was given 1gm of flucloxacillin in crushed form, and a protective dressing was applied to her hands at around 1pm following her shower. A further 500mg of flucloxacillin was given at 2pm as per Dr B's instructions.

40. On 29 Month11, Mr A reported that Mrs A's hands were not being dressed and had become badly infected. On 31 Month11, it was noted by staff that the recurrent infection on Mrs A's hands appeared to have returned, and a wound swab was taken and sent to the laboratory for testing. However, Remuera Rise told HDC that the swab was not processed owing to COVID-19 prioritisation. Dr B was informed. He charted oral antibiotics, and the duty nurse cleaned the wound and applied a protective dressing.

41. Remuera Rise did not provide HDC with documentation such as wound assessment charts or short-term care plans for this infection.

*Oral thrush management*

42. On 28 Month11, Mr A reported a thick yellow substance in Mrs A's mouth. Mrs A was also complaining of soreness in her mouth. The clinical manager inspected Mrs A's mouth and noted thick yellow patches as well as redness of her tongue and corners of her mouth.

43. This was discussed with Dr B by telephone. He confirmed oral thrush and charted a mouth gel as treatment, which was started immediately.

44. The clinical manager told Mr A that Mrs A had oral thrush, possibly because she had recently completed a course of prednisone for shingles. Oral thrush can also be a side effect of antibiotics. In contrast, Mr A stated that on 30 Month11 he was informed by the duty nurse that Mrs A had oral thrush from her antibiotics from her hand infection, and that antibiotics had been stopped but the thrush not yet treated. Mr A said that he asked for the antibiotics to be started again and for the thrush to be treated immediately. Remuera Rise told HDC that antibiotics for her hand infection were extended while the oral thrush treatment was occurring.

45. No short-term care plan was provided to HDC in relation to management or monitoring of the oral thrush.

**Care provided from 27 Month11 to 2 Month12**

46. Mrs A's condition changed on 27 Month11. The morning nurse on duty noted that Mrs A was dyskinetic,[10] and crushed her Sinemet tablets at both 7.30am and 8.00am. Remuera Rise told HDC that despite this, Mrs A spat out her medications.

47. Mr A video called regularly to observe the medication being administered and to prompt Mrs A to accept her medication, as she continued to spit it out. At 12.30pm she spat out her Sinemet despite Mr A being on the phone. The nurse suggested trying midazolam spray and

[10] Dyskinesia is involuntary, uncontrollable and erratic movements of the body. It can involve one body part or the entire body, and can look like writhing, fidgeting, wriggling, head bobbing, or body swaying.

extra morphine, but after discussion with Mr A it was agreed not to give extra medication at that time.

48. At 1.00pm the nurse recorded in her progress notes that Mrs A was lethargic, which could be related to her poor compliance with the oral Sinemet.

49. The progress notes record that Mr A had indicated to staff that Mrs A was under-medicated but had declined staff suggestions to give her apomorphine or midazolam spray. The notes also state that Mrs A had been given crushed Sinemet since 7.30am nearly half hourly, but it is not recorded how many times the medication was spat out.

50. Staff discussed with Mr A whether Mrs A should be sent to hospital with Mr A for assessment and review. Mr A indicated that he did not want Mrs A to be sent to hospital at that time, and staff instead discussed her care with Dr B.

51. Dr B contacted Hospital 2's neurology service for assistance. The movement nurse at the service, who was familiar with Mrs A's condition, advised him that Mrs A's medication regimen should remain unchanged but that extra doses of apomorphine should be given as charted, as Mrs A was not tolerating oral medications. Dr B discussed these recommendations with Mr A, who agreed, and the care staff at Remuera Rise were advised of this.

52. Over the course of the day, Mrs A took her medications crushed with sips of juice. She declined to eat but accepted approximately 20ml of Fortisip supplement. Episodes of rigidity were managed with extra doses of apomorphine and her apomorphine pump infusion.

*28 Month11*

53. Mrs A was able to swallow (in crushed form) the medications given to her before 8.00am on 28 Month11, although she spat out many of them.

54. After 8.30am, the duty nurse spoke to Mr A, and extra doses of Sinemet were given to Mrs A at his request when this was considered appropriate. At 11.30am, a subcutaneous saline infusion was commenced in Mrs A's right upper arm, on the advice of Dr B. Later in the day the saline drip was stopped because fluid had accumulated in Mrs A's arm. The nurse on duty elevated Mrs A's arm with a pillow to promote absorption and movement of the accumulated fluid. The infusion site was monitored and showed no signs of inflammation.

55. During the COVID-19 lockdown, Mr A was given access to visit Mrs A on compassionate grounds. Mr A stayed overnight and assisted with Mrs A's medications. Remuera Rise told HDC that this was very helpful, as Mrs A appeared to accept medications from Mr A better than from staff.

56. The duty nurse and Mr A agreed to withhold Mrs A's oral medications (except Sinemet) due to her difficulty swallowing tablets even when crushed and dissolved in lemonade. Mrs A complained of a headache and was treated with charted analgesia. She also appeared very lethargic.

57. On 28 Month11, Mr A spoke with Mrs A via video call and was concerned that she was deteriorating rapidly. He called Remuera Rise to ask that she receive intravenous (IV) hydration, as she had not eaten since 23 Month11, and he requested a special pass for their daughter to come to the facility to be with her mother. This was granted, and both Mr A and their daughter stayed overnight at the facility with Mrs A.

*29 Month11*

58. On the morning of 29 Month11, Mrs A asked to have a shower, and a healthcare assistant helped her with this. Immediately after the shower, the healthcare assistant and Mr A noticed that Mrs A had lost consciousness for a short period while being transferred from the bathroom to her bed. Oxygen was administered at Mr A's request. Mrs A remained restless and was not swallowing or conversing well. Mr A asked for her Sinemet to be replaced with Kinson,[11] as he believed it dissolved better. This was agreed to by staff.

59. At 2.30pm, Mrs A's daughter called for help as Mrs A had lost consciousness again. Mrs A was unconscious for approximately two minutes. Remuera Rise stated that a staff member observed Mr A tapping Mrs A's chest. Mrs A regained consciousness and her oxygen was increased. The second episode of unconsciousness was discussed with Dr B, who advised that no treatment was necessary as Mrs A had recovered, but he advised staff to monitor her condition.

60. Mr A continued to administer Mrs A's medications throughout the afternoon, in coordination with the nurses. Mrs A remained on oxygen and was given crushed and dissolved medication. Mr A asked that subcutaneous fluid be restarted, and this was commenced after inspection of the infusion site.

61. Mrs A was given a dose of Kinson at 7.00pm on 29 Month11, but the rest of her medications were withheld.

*30 Month11*

62. Mr A continued to administer Kinson in crushed and dissolved form, and he applied gel for her oral thrush. Mrs A's swallowing improved somewhat, and she was able to take Fortisip supplement and ice cream. Mr A asked that the apomorphine infusion site and line not be changed, and the nurse agreed to this after inspecting the site and determining that there was no sign of infection.

63. Mr A asked that IV fluids be commenced, but staff explained that if IV fluids were required, it would be better for Mrs A to be transferred to the hospital for further review. Remuera Rise told HDC that IV therapy is not commonly provided in aged residential care, and it was not provided at Remuera Rise. Staff discussed with Mrs A's family the options of active treatment in a hospital, or palliative care at Remuera Rise. Mr A told staff that he would observe Mrs A overnight and make a decision the following day.

[11] Kinson is a tablet medication that contains levodopa and carbidopa (the same active ingredients as Sinemet). Sinemet and Kinson are described by Medsafe as 'bioequivalent'.

*31 Month11*

64. At 5.00am on 31 Month11, Mrs A was given her medications, and Mr A requested that her cares not be undertaken as she was comfortable. At 6.00am, Mr A reported that his wife might be having chest pains. The nurse on duty took Mrs A's vital signs but was unable to confirm the location of the pain, as Mrs A was unable to explain it. Pain relief was administered with good effect. Mr A informed the nurse that he did not want to take Mrs A to the hospital at that time.

65. Mrs A consumed three bottles of Fortisip and appeared more responsive than the previous day. Her apomorphine pump had been removed accidentally, and this was replaced. At this time the subcutaneous saline infusion was stopped at Mr A's request.

66. Mrs A's family informed nurses that her right palm was smelly with a yellowish discharge. Staff noted that Mrs A's hand infection had recurred, and the wound was cleaned and dressed, and a wound swab was sent for laboratory testing.

*1 Month12*

67. At 4.00am, Mr A reported to the duty nurse that Mrs A was coughing occasionally with phlegm and that she might have pneumonia. The duty nurse recorded Mrs A's vital signs and reiterated the option of admitting Mrs A to hospital. Mr A declined, and continued to give Mrs A her medications by syringe when she allowed him to.

68. At 7.20am, Mrs A was assisted with her cares and given a bolus dose of apomorphine at Mr A's request. The nurse noticed that this had minimal effect, so suggested stronger pain relief such as morphine, which was declined by the family.

69. Mr A told staff that he had spoken to a Parkinson's nurse specialist who had suggested that he ask Dr B to start IV antibiotics and IV fluids. The clinical manager discussed the risk of acquiring pneumonia or aspiration pneumonia and advised that the option remained to admit Mrs A to hospital for further assessment and diagnosis. The clinical manager again noted that IV therapy could be provided only in hospital, not at Remuera Rise. The family declined, noting concerns that Mrs A had nearly died at the hospital on her last admission, and that they might not be allowed at the hospital with Mrs A.

70. At the request of the clinical manager, Dr B visited Mrs A at 6.30pm. The clinical notes state that her health was declining, with poor oral intake and tolerance of medications. The oral thrush was noted to be improving, but the results of the swab from Mrs A's hand infection had not yet returned owing to COVID-19 delays. Under the title 'GP advice', the notes state that Mrs A could be in the last days of her life, and that hospital admission had been declined by the family, and that going forward her regular medications should continue as tolerated, with morphine added to her chart to be administered when requested by the family. Dr B also advised to keep Mrs A comfortable and to coordinate her cares with the family.

71. Remuera Rise told HDC that Dr B spoke with Mr A and his daughter. Dr B told them that Mrs A might be in the last days of her life, and likely had pneumonia; however, this is not recorded in the progress notes. Dr B advised the family that either they could have Mrs A admitted to hospital, or comfort cares could be provided at Remuera Rise. Mr A

acknowledged that he understood that Mrs A's organs were shutting down, but he declined hospital admission on the basis that Mrs A might not survive a transfer to hospital. Remuera Rise believed that Mr A understood that Mrs A was likely to be in the last days of her life if she remained at Remuera Rise, and that care going forward would focus on managing symptoms rather than curative treatment. Dr B charted relevant medications to manage end-of-life symptoms. Mr A expressed concern that Dr B did not assess Mrs A, but only observed her from the doorway of her room. Mr A stated that Dr B did not examine Mrs A or diagnose her pneumonia. Dr B's clinical notes do not mention pneumonia, and state that he believed she was for palliative care, and that this had been discussed with Mrs A's husband and daughter.

72. Mr A also stated that he felt that Dr B showed very little interest, compassion or empathy, and that because he did not examine Mrs A, he did not diagnose her pneumonia, which Mr A described as a 'fatal incorrect diagnosis'.

73. Around 9.30pm, Mrs A was provided with personal and skin cares by staff and family, and she was able to tolerate gentle movement. Mrs A's daughter was given a fluid monitoring chart and asked by staff to fill out the fluids taken for the day, which she agreed to do. The apomorphine line was maintained. The family declined additional pain relief at that time, and asked staff to continue to avoid moving or turning Mrs A as she was sensitive to touch. The family also asked for Mrs A's 1.30am and 4.30am medications to be withheld to prevent waking her, but they assisted in giving her 2.00am and 5.00am doses.

*2 Month12*

74. Mrs A continued to accept small sips of fluids and medications administered through a syringe by Mr A or her daughter. Mrs A had an occasional cough but was unable to expectorate phlegm. Her daughter requested suctioning to clear the phlegm, but staff offered saline nebulisation as a more gentle and less distressing option for Mrs A, which appeared to work.

75. Mr A asked for Mrs A's current antibiotics for skin and soft tissue infection to be replaced with another antibiotic that could manage her chest infection as well. This was discussed with Dr B, who agreed and gave a verbal order to replace the flucloxacillin with amoxicillin, and he confirmed the order by email.

76. Around 9.00pm, Mrs A had an episode of a dry cough. Mrs A's daughter reported to the nurse on duty that Mrs A was swallowing very well and able to eat some yoghurt, and asked for another dose of saline nebulisation, which had good effect. Mrs A was reassessed for pressure injuries, and none were found, and her personal cares, skin cares, and oral cares were able to be provided.

*2 Month12*

77. Around 11pm on 2 Month12, Mrs A vomited. Mr A was concerned that she might have developed pneumonia, and he passed this onto the nurse. The nurse noted that Mrs A looked uncomfortable and was struggling to breathe, and discussed with the family sending Mrs A to hospital. The family agreed, and the nurse called an ambulance to transfer Mrs A

to hospital and organised the relevant medications to be taken. Mrs A was transported to Hospital 2 at 1.00am on 3 Month12.

78. The ambulance service report states:

> 'Handover from nurse patient vomited once and now is short of breath, has been sick for a week doesn't know why, just has, doctors seen patient but don't know what he diagnosed patient with … When asked what the patient was diagnosed with by the doctor, told to ask family who were with patient.'

79. On 3 Month12, the admitting clinician at Hospital 2 recorded: '[F]amily confirm [Mrs A] is [not for resuscitation] but is otherwise full treatment.'

**Palliative care**

80. Remuera Rise stated that Mrs A's family were conflicted about beginning palliative or end-of-life cares, despite their conversation with Dr B on 1 Month12 about beginning comfort cares.

81. Remuera Rise stated that the family requested multiple treatments such as IV fluids, IV antibiotics, and the insertion of a nasogastric tube, but were told that these procedures required hospital admission as they could not be completed at the care home. This was explained several times to the family, who did not want Mrs A to be hospitalised. Remuera Rise also noted that at her previous hospital admission in Month8, Mrs A had refused the insertion of any sort of feeding tube.

82. Remuera Rise told HDC that involvement of hospice services was considered, but under the lockdown, hospice nurses would not have been able to visit Remuera Rise. Remuera Rise acknowledged the importance of the hospice team as a resource but noted that providing palliative care and end-of-life care are core components of aged residential care, and often are facilitated without hospice involvement. Remuera Rise told HDC that in the final days of Mrs A's life, staff were caring for her as well as providing emotional support to her family.

**Other issues**

*Broken ribs*

83. On Mrs A's admission to Hospital 2 on 3 Month12, a chest X-ray showed an incidental finding of fractured ribs. The X-ray showed multiple segmental fractures[12] involving ribs 3 to 8 on her right-hand side (6 ribs in total), some of which were moderately displaced.[13] Te Whatu Ora noted that these fractures were not present in Mrs A's chest X-ray taken at Hospital 2 in Month8. Te Whatu Ora also noted that it was likely that Mrs A had osteoporosis.[14]

84. Remuera Rise told HDC that while there were two incidents in which Mrs A lost consciousness (both on 29 Month11), in neither instance did she fall or hit herself on a hard object. Remuera Rise stated that Mrs A was very frail, and this was the only event staff can

[12] Each rib was fractured in at least two places.
[13] The bone had moved so that it was no longer in line with the rest of the bone.
[14] A condition in which the density and quality of bones is reduced.

recall that could possibly have been sufficient to cause a small rib fracture, and at the time there was no reason to suspect an injury. Remuera Rise noted that during Mrs A's 'off' medication periods she could become rigid and hold her arms tightly against her rib cage, which potentially could have caused a stress-related fracture to her ribs.

85. Remuera Rise told HDC that Mrs A did not have any falls or other incidents to explain a fractured rib. Remuera Rise said that had a rib fracture been suspected, the only treatment is pain relief while it heals. Remuera Rise said that injuries could have occurred during the transfer to hospital or at the hospital. Te Whatu Ora noted that if the rib fractures were relatively recent, the associated severe pain could have resulted in poor respiratory effort, which would have predisposed Mrs A to pneumonia.

**Subsequent events**

86. When Mrs A was admitted to Hospital 2, Mr A informed hospital staff that over the previous week Mrs A had become less communicative and had a dry cough and a reduced oral intake.

87. Te Whatu Ora told HDC that the history, clinical findings, and early investigations were consistent with a diagnosis of sepsis, secondary to multi-lobar pneumonia,[15] which was likely due to aspiration in the context of advanced Parkinson's disease. Mrs A also had severe hypernatraemia[16] related to severe dehydration, as well as the incidental finding of right-sided rib fractures of unknown origin (as discussed above).

88. Te Whatu Ora told HDC that over the course of the day on 3 Month12, Mrs A's condition deteriorated, and further discussions were held with her family regarding her care. It was discussed that Mrs A was unlikely to survive her illness, and a decision was made that the focus should be on keeping her comfortable. Mrs A passed away at 11.54pm on 3 Month12 with her husband and daughter present.

**Further information**

89. Remuera Rise provided comments from Dr C, a registered nurse with qualifications in residential aged care.

90. Dr C stated that the progress notes written every shift are extensive, often with more than one entry per shift. She highlighted that the Progress Note Writing Guide at Remuera Rise states that when writing progress notes, the writer should report on aspects of interventions, signs and symptoms, changes in function or level of assistance, etc that relate to the individual resident, to record the resident's progress against their care plan goals.

91. Dr C acknowledged the degree of family input, including difficulties staff faced when Mr A was suspicious, accusing, or angry towards staff. Dr C said that Remuera Rise met the relevant standards in its communication with, and inclusion of, Mr A.

92. Regarding medication management, Dr C stated that while my clinical advisor, RN Richard Scrase, was concerned about Mr A leading Mrs A's medication management rather than

[15] Pneumonia that affects multiple lobes within the lungs.
[16] A high concentration of sodium in the blood.

staff, it is important also to consider that the involvement of family should be acknowledged, valued, and encouraged in the provision of care. Dr C said that the expertise of a resident and their family should be recognised, and they should be involved in the provision of care if it is safe to do so. She noted that Mr A had managed Mrs A's medication when she was in Hospital 1, and he had been trained in the use of apomorphine when Mrs A had been in Hospital 2.

93. Dr C stated that there is evidence that staff challenged Mr A's advice when needed, including his requests that Mrs A not be given bolus doses of apomorphine during her last week at Remuera Rise. Dr C also noted that there is clear documentation in Medi-Map[17] indicating when medication was administered by Mr A, as well as whether medication was crushed or given whole. She noted that Remuera Rise also confirmed that medicines are stored in a locked trolley and supplied as due. Remuera Rise also stated that registered nurses would either stay while Mr A administered medication, or, if it took an extended amount of time, they would come back to confirm that it had been given and its outcome before completing Medi-Map charting.

94. Regarding crushing of medication, Dr C stated that according to a publication guide for crushing medication for residents with swallowing difficulties, Sinemet can be crushed, but Sinemet CR[18] tablets cannot. She stated that it is best practice to consult with a pharmacist or GP before crushing medications but said that Medi-Map was accessed by the pharmacist to dispense the medication, and by Dr B to chart and review the medication, and each would be aware of this practice and able to advise if it was contra-indicated. In addition, she noted that Dr B signed off on the long-term care plan, which notes that Sinemet was to be crushed when necessary.

95. With regard to medication administration, Dr C noted that Mrs A's family did not have access to her medications but were given medication by the registered nurses on duty, for the family to administer. Dr C stated that the documentation of medication management is of a high standard, and it notes when the medication was administered by Mr A. She said that Mr A demonstrated knowledge of what Mrs A needed at times when Mrs A had 'off' periods, and the nurses sought his input on the use of PRN[19] medication, and it was reasonable to allow Mr A to assist with medication administration.

96. Dr C stated that there is no evidence that Remuera Rise missed prescribed doses of Sinemet, except possibly on the morning of 28 Month11, when nurses reported in Medi-Map that Mrs A was non-compliant with taking her medication.

97. Regarding nutrition and hydration, Dr C commented that she would have advised that a food and fluid intake chart be commenced at the time Mrs A's weight loss was first recorded, or at least at the start of the lockdown period when Mrs A began to refuse to eat or drink. Dr C stated that the care plan should also have been altered at the same time, as the Age-

[17] Medication management software.
[18] Sinemet CR is a sustained-release combination of carbidopa and levodopa used for the treatment of Parkinson's disease.
[19] 'As required.'

Related Residential Care Services Agreement requires assessment and care plans to be updated if there is a significant change in the resident's condition. She said that while Mrs A's care plan was updated on 19 Month11, it lacked additional guidance for care staff as Mrs A's intake declined. Dr C stated that not implementing recording of food and fluid intake, and not updating the care plan was a departure from the accepted standard. She clarified that taking into account the context and the COVID-19 lockdown, this would be a moderate departure.

98. Dr C noted that although Remuera Rise responded promptly to Mr A reporting oral thrush, there is no evidence that there was a plan in place for prevention and early identification, despite Mrs A being high risk, and following the diagnosis there was no short-term care plan to detail how the infection would be managed. Dr C stated that this was a significant departure, but again noted that COVID-19 may have affected staff abilities to complete this work.

99. Regarding Mrs A's hand infection, Dr C stated that standard practice would be to put in place a short-term care plan, including goals, interventions, and progress of the infection until resolution. However, she acknowledged the impact of COVID-19 on staff and the laboratory processing of the swab and stated that given that Mrs A's previous wound care plan contained instructions, and that care staff understood that Mrs A was for end-of-life care, this was a minor departure.

100. Dr C noted Mr A's comments that had the family been aware that Mrs A had pneumonia, they would have sought active treatment. Dr C stated that, in her view, Dr B made it very clear that Mrs A was likely to have pneumonia, and the family understood when refusing her transfer to hospital for active treatment that Mrs A was going to die without treatment. Dr C noted that a referral to hospice, and input from hospice staff to support Mrs A, her family, and care home staff, may have reduced stress during this time and assisted in decision-making.

101. Dr C stated that she was unable to establish when Mrs A's rib fracture occurred, or to determine any evidence of neglect. She noted that it is possible that an injury occurred on 29 Month11 when Mrs A was unresponsive, during the transfer to her chair following a shower. Dr C acknowledged that Mrs A's end-stage Parkinson's disease could mean that even a small knock or abnormal movement could have caused a fracture, and there is no evidence that there was an injury due to neglect. She stated that the correct approach was taken for a resident in the last days of life, and there was no departure from accepted standards, as the goal appeared to be keeping Mrs A comfortable. However, Dr C stated that when Mrs A reported chest pain, this could have been assessed more fully and cardiac and respiratory functions examined, although this was unlikely to change the outcome, as Mrs A was for comfort care rather than active treatment at this time.

102. Dr C said that after the review of Mrs A's care plan on 8 Month11, Mrs A's needs changed, and the care plan did not reflect these changes. Dr C recommended that the facility provide nursing staff with training on the acute and gradual deterioration sections in the frailty guides released in Month8 to enhance critical thinking.

103. Dr C stated that early discussion with both Mrs A and her family about the level of involvement of family members in the provision of care, clarity regarding Mrs A's wishes, and what the care home could offer, would have been appropriate. Dr C said that this should have included a discussion regarding the involvement of hospice.

**Responses to provisional opinion**

*Mr A*

104. Mr A was given the opportunity to respond to the 'facts gathered' section of the provisional opinion. Mr A's comments have been incorporated into this report where relevant.

*Dr B*

105. Dr B was given the opportunity to respond to the provisional findings. Dr B's comments have been incorporated into this report where relevant.

*Remuera Rise*

106. Remuera Rise Care Home was given the opportunity to respond to the provisional findings. Remuera Rise accepted the proposed breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) and the recommendations contained within the provisional report.

## Relevant standards:

**The Health and Disability (Core) Standards NZS 8134:2008**

107. Standard 3.12 states: 'Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.'

108. Standard 3.13 states: 'A consumer's individual food, fluids and nutritional needs are met where this component is part of service delivery.'

**Nursing Code of Conduct**

109. Standard 3.2 states:

> 'Respect health consumers' rights to participate in decisions about their care and involve them and their family/whānau where appropriate in planning care. The concerns, priorities, and needs of the health consumers and family/whānau must be elicited and respected in care planning.'

## Opinion: Remuera Rise — breach

### Introduction

110. This report considers the care provided to Mrs A at Remuera Rise. First, I express my sincere condolences to Mrs A's family for their loss.

111. I note that the care provided to Mrs A from Month11 to Month12 occurred in the context of a COVID-19 lockdown. I have taken this into account, and I acknowledge that staff in care facilities at this time were dealing with an unknown and fast-changing situation while also providing care to an extremely vulnerable group.

112. To determine whether the care provided to Mrs A was appropriate, I sought independent clinical advice from RN Richard Scrase. RN Scrase similarly acknowledged the impact of COVID-19 on staffing in aged residential care — a sector that was already dealing with significant staff shortages — and noted the stability in staffing levels that the facility was able to maintain.

### Clinical issues

*Food and fluid intake — management*

113. Mrs A's ability to eat and drink was affected by her Parkinson's symptoms, including difficulty swallowing and the time constraints of eating around her regular medications, which could be administered up to 18 times every 24 hours. Mrs A had declined receiving any kind of feeding tube, and while often she ate only small portions, she expressed that she wanted to eat as 'normally' as possible.

114. On 13 Month11, Mrs A's weight was recorded as 43kg, but by 19 Month11 it was recorded as 40kg. On admission to hospital on 3 Month12, Mrs A was diagnosed with severe hypernatraemia related to severe dehydration.

115. RN Scrase acknowledged that residents are within their rights to decline meals, and Mrs A had made personal choices about her nutritional intake (such as declining a feeding tube), which made feeding and hydration more difficult. However, RN Scrase expressed concern that there was no clearly documented plan of how this would be managed going forward. I share this concern.

116. Regarding Mrs A's weight loss identified on 19 Month11, there is no evidence of any plans put in place to rectify or investigate this, or acknowledgement of the weight loss in Mrs A's progress notes. RN Scrase advised that options for intervention at this time could have included re-recording the new weight in case of error, involvement of Mrs A's GP, and discussion of whether a dietitian's input would be beneficial, or a short-term care plan.

117. RN Scrase identified that staff have a duty of care to ensure that appropriate measures are taken to address situations where declining or reduced food intake is an ongoing issue. He stated that in this case, Mrs A was a very frail and vulnerable older person who needed assistance when eating and drinking, meaning that accurate documentation and intervention was needed.

118. Mrs A's weight record ends on 19 Month11. Remuera Rise told HDC that staff did not continue to weigh Mrs A, as she was receiving end-of-life cares, and moving would have caused her discomfort. However, on 25 Month11 Mrs A was still receiving full cares and moving around. The family had requested from 30 Month11 that Mrs A not be moved because of discomfort, and end-of-life comfort care was discussed between the family and Dr B only late in the day on 1 Month12, with no clear conclusion.

119. Regardless, it is my view that weighing Mrs A was not the only intervention option available to Remuera Rise. By 19 Month11, it was already clear that she was losing weight, and this could have been investigated or responded to in several ways other than continuing to weigh her. RN Scrase also stated that if Mrs A was nearing the end of her life, and comfort cares prioritised over consistent nutritional intake, then this should have been discussed with the family and documented clearly. I accept this advice.

120. RN Scrase raised concerns regarding the lack of documented planning, and I share these concerns. RN Scrase noted that there was a lack of clearly documented planning and consistent understanding of how Mrs A's nutritional input would be managed appropriately. He stated that even though this can vary depending on whether a patient is receiving end-of-life care or active treatment, this needs to be agreed upon and documented. I agree that this is necessary regardless of the stage of life. RN Scrase considered that this was a serious departure from the accepted standard of practice.

121. In response to RN Scrase's advice, Remuera Rise accepted that documentation could have been improved, and that a clearly documented short-term care plan would have assisted. However, Remuera Rise disagreed that this amounted to a serious departure, noting that on Medi-Map and within the progress notes there is significant notation, and a food and fluid monitoring chart was commenced in Month12. I note that on 1 Month12 a food and fluid monitoring chart was given to the family to fill out. In the absence of a clear plan about improving food and fluid intake, or whether nutrition would not be prioritised due to end-of-life cares, I do not consider that a food and fluid chart functioned as a sufficient documented strategy to support Mrs A's dietary needs.

*Medication management: administration*

122. Mrs A was reliant on timely administration of her regular medications to control her symptoms of Parkinson's disease. In the periods when her medication wore off, her symptoms of rigidity and difficulty swallowing could prevent the administration of future doses of medication. This meant that her medication regimen was very time sensitive.

123. Mr A expressed concern that there were periods of time when Mrs A was under-medicated, and that without family assistance over the COVID-19 lockdown period, Mrs A's medication needs were not met, and her condition declined significantly.

124. Remuera Rise told HDC that Mr A's involvement in Mrs A's medication was of great comfort and benefit to Mrs A. Remuera Rise stated that despite heavy involvement of family in management and administration of medication, the management of Mrs A's medicines still remained the responsibility of the medical and nursing staff responsible for her care. Remuera Rise said that if the family were administering medication, a nurse would either

remain in the room or would return later to check that it had been given, and the outcome. Following this, the nurse would record the administration in the Medi-Map database, including who administered the dose. Remuera Rise also stated that the storage of Mrs A's medication was managed by nursing staff.

125. While Remuera Rise staff were clear that they held responsibility for medication management, Mr A's complaint raised concerns that staff were not able to meet Mrs A's medication needs without additional support from the family.

126. RN Scrase highlighted standards from the Health and Disability Core Standards and the Nursing Council of New Zealand Code of Conduct that need to be interpreted together. The first is that service providers ensure that people receive their medication in a safe and timely manner that complies with the current legislative requirements and safe practice guidelines.[20] The second is that consumers have the right to participate in decisions about their care, and where appropriate they and their family and whānau should be involved in planning care.[21]

127. RN Scrase stated that Mrs A's family would have been familiar with many aspects of her care while she lived at home, and it was reasonable to involve them in appropriate aspects of her care. However, he noted that registered nurses are accountable for their practice, including medication management, which is particularly important with respect to monitoring effectiveness of medications given, any contraindications, and their safe administration. RN Scrase advised that it is not clear from the documentation what degree of support or supervision was given while the family administered medications. RN Scrase also stated that ultimately Remuera Rise is responsible and accountable for the care provided, and it needs to make sure that all care provided, including medication management, is carried out in a safe and effective manner.

128. RN Scrase acknowledged that at times the wishes of family members differed significantly from those of staff, and this created challenges. Remuera Rise told HDC that Mr A's views were challenged by staff when they did not agree with his suggestions. I understand that Mr A's expertise and familiarity with Mrs A's medication regimen was of benefit to her care, and Remuera Rise was grateful for this.

129. Mrs A was admitted to an aged residential facility because of her deteriorating clinical and physical condition, which meant that her care needs could no longer be safely met at home. RN Scrase stated that in his view, professional supervision of Mrs A's medication administration was paramount. Accordingly, administration of Mrs A's medication by Mrs A's family without the professional supervision of nursing staff responsible for the medications administered was not safe or clinically appropriate.

[20] Standard 3.12. RN Scrase stated that accepted relevant guidelines include NZNO guidelines for nurses on administration of medicine, and the Ministry of Health publication 'Medicines Care Guides for Residential Aged Care'.
[21] Standard 3.2 of the Nurses Code of Conduct.

130. I accept this advice. While it is appropriate and imperative to involve family in the planning of care, it is not appropriate for nursing staff, who are accountable for medication administration, to allow family to administer medication to a vulnerable patient without supervision. I do, however, acknowledge staffing limitations, and I also accept Remuera Rise's statement that there were periods in which Mrs A suffered from symptoms such as anxiety, and it was reassuring for her to have her medicine administered by her family.

*Medication management: crushing/dissolving medication*

131. RN Scrase also raised concerns about the practice of crushing and/or dissolving Mrs A's medication without clear pharmaceutical advice. He stated that it would be expected practice to discuss crushing medications with a pharmacist, and he could not find any evidence in the clinical records about whether this had occurred. Remuera Rise told HDC that an extra note was present on Mrs A's Medi-Map chart that instructed that Sinemet be crushed and dissolved in lemonade if she was having difficulty swallowing. Remuera Rise said that this information was updated after a discussion with Dr B and advice from a neurology clinical nurse specialist, and although direct advice had not been sought from a pharmacist, the note would have been sighted by the facility pharmacist, who used Medi-Map frequently.

132. Remuera Rise's policy regarding medication administration states:

> 'The prescribing Medical Practitioner or Pharmacist must verify the appropriateness of crushing medication. When it is necessary to crush medication for ease of administering, place these in a carrier such as puréed fruit or yoghurt to administer. Avoid using jam as a carrier due to the high acidity in jam possibly altering the effectiveness of some medications.'

133. Remuera Rise confirmed that Dr B (the prescribing medical practitioner) was present in Month9 during the drafting of Mrs A's long-term care plan, which stated that medication could be crushed when Mrs A could not swallow it whole.

134. Remuera Rise also stated that these practices were either approved or went unquestioned by other individuals involved in Mrs A's care. Remuera Rise said that Mrs A's private neurologist documented in a consultation in Month4 that Mr A had learned to dissolve Sinemet in a carbonated drink such as lemonade and to administer it through a syringe, and that the medication started to work after around 20 minutes. Remuera Rise said that a movement disorder nurse specialist at Hospital 2 documented that Mrs A needed strict Sinemet timing, and that it could be dissolved in water and given via syringe to assist swallowing. Finally, a movement disorder nurse from the pharmaceutical company support team told Remuera Rise that it was acceptable to crush Mrs A's medication when there was no other way to provide it.

135. Remuera Rise also referred to the Te Whatu Ora Waitematā publication 'Guidance for Crushing Oral Medications for Residents with Swallowing Difficulties in Residential Aged Care' (2021), which states that Sinemet can be dissolved in water and taken immediately. I note that there is no documentation to confirm that Mrs A's doses were administered immediately, and there is no specific advice confirming that substituting water for lemonade

is appropriate. Remuera Rise noted that the Health Navigator publication 'How to take Levodopa and Carbidopa' (2021) states that if a patient is struggling to swallow the tablets, they can be crushed and mixed with a liquid or soft food.

136. I acknowledge RN Scrase's concerns about the practice of crushing and/or dissolving Mrs A's medication without clear pharmaceutical advice. While it may have been useful for staff to discuss this with a pharmacist, Remuera Rise's policy regarding medication administration permits the prescribing medical practitioner to verify the appropriateness of crushing medication. Furthermore, the Sinemet tablets prescribed to Mrs A were not a controlled-release medication (which should not be crushed), and no adverse effects or harm were caused by the crushing. Given the extensive involvement by other clinicians who did not raise concerns about the practice, I consider that in these circumstances it was reasonable for Remuera Rise not to consult with a pharmacist.

*Hand infection*

137. Mrs A experienced contractures of her fingers as part of the rigidity symptom of her Parkinson's, and as a result her fingernails could dig into the palms of her hands and cause pressure injuries. Her long-term care plan[22] notes that her fingernails were to be kept trimmed and filed, and that her palms needed to be checked regularly for pressure wounds.

138. Mr A told HDC that he noticed the hand infection returning around 29 Month11. The first time the infection is documented is on 31 Month11, when Mrs A's progress notes record that her right palm had a 'foul smell' due to an infection from her fingers digging into her palms despite protective dressings. A swab was taken on this date.

139. There are no records of nail filing or trimming in her progress notes, or any previous notes regarding when protective dressings were commenced, and how often they were changed. RN Scrase stated that Mrs A's skin on her hands and fingers should have been checked regularly to ensure that it was either intact, or any wounds or pressure injuries were noticed, documented, and managed. He suggested that a short-term care plan or a wound chart would have been the best way to do this.

140. Remuera Rise did not provide HDC with a wound chart relating to Mrs A's palms, and no short-term care plan was in place to identify treatment plans. A short-term care plan would also have been a useful reminder for staff to follow up on the swab that was sent for laboratory testing, as this result was not returned.

141. Remuera Rise stated that as the hand infections were recurrent and chronic, there was no need to create a short-term care plan or infection report, as these are for acute conditions lasting under 30 days, or for new infections (respectively). RN Scrase stated that documentation needs to be thorough enough for someone unfamiliar with the patient to carry out any intervention needed from that information alone. He said that the documentation should include products used, products recommended, frequency of use, what to monitor, and outcomes of treatment, and that these were absent in the

[22] Dated 4 Month8.

documentation about the hand infection. I accept this advice. While Mrs A's hands appear to have been being monitored and dressed regularly, this was not documented adequately. As such, I am critical of the failure to document this important information consistently, and I agree with RN Scrase's advice that this was a moderate departure from expected standards.

*Oral thrush*

142. On 28 Month11, Mr A reported symptoms of oral thrush to Remuera Rise staff. Review by staff and commencement of treatment occurred that day. Remuera Rise told HDC that the thrush was monitored, with treatment reviewed and discussed with Dr B, and the family kept updated. Remuera Rise maintained that treatment for the oral thrush was initiated promptly after the thrush was diagnosed.

143. I consider that the response by staff to Mr A's concerns about Mrs A's symptoms was appropriate. Mrs A received oral cares twice a day, and I agree with RN Scrase's statement that this should have identified the thrush in a timely manner. I am satisfied that had Mr A not reported it, this would have been picked up by staff. RN Scrase also stated that there is no evidence that Mrs A's symptoms of poor swallowing and reduced appetite were caused by oral thrush, and, once commenced, treatment was effective. I accept this advice.

144. However, I am concerned that no short-term care plan was developed in response to this issue. RN Scrase stated that a short-term care plan should have been used to document the issue and ensure that it was resolved successfully. He also noted that there was limited documentation showing any plans to review or monitor Mrs A's mouth and oral cares. RN Scrase stated that given Mrs A's frailty and vulnerable nutritional status, a management plan should have been documented and followed to resolve the oral thrush. RN Scrase considered the absence of a plan and relevant documentation to be a significant departure from accepted practice.

145. In response to RN Scrase's advice, Remuera Rise acknowledged that a short-term care plan should have been commenced, and expressed regret that this did not occur. Remuera Rise noted that while a short-term care plan and infection report did not occur, the clinical notes and Medi-Map did note the identification of oral thrush and the treatment plan.

146. While I acknowledge that the clinical records identified Mrs A's oral thrush and set out a treatment plan, I agree that in this instance, a short-term care plan should have been commenced. Given Mrs A's frailty and difficulties with eating and obtaining adequate nutrition, it would have been appropriate to have put in place a clearly documented management plan to assist with resolving Mrs A's oral thrush. I am critical that this did not occur.

*Broken ribs*

147. On Mrs A's admission to Hospital 2, a chest X-ray found that she had multiple fractured ribs. The cause of this is unknown, and Remuera Rise told HDC that no known adverse incident at the care home could have caused trauma. RN Scrase noted that the cause of the fractures and the point in time when they may have occurred cannot be ascertained from the documentation.

148. Remuera Rise stated that Mrs A did not present with any symptoms of rib injury, such as strong chest pain when breathing in, swelling or tenderness of the affected area, bruising, or feeling or hearing a crack. They acknowledged that in Mrs A's 'off' medication periods she could become rigid and hold her arms tightly against her rib cage, which potentially could have caused a stress-related fracture to her ribs. Mrs A's long-term care plan refers to interventions to prevent rigidity, including instruction to monitor for any indication of pain and to manage accordingly.

149. Remuera Rise also noted that injuries could have occurred during the transfer to hospital or at the hospital, or potentially when Mrs A lost consciousness on 28 Month11. Remuera Rise stated that it is confident that the injury did not result from staff neglect. Based on the available evidence, I am unable to make a finding as to the exact cause of Mrs A's rib fractures.

*Chest pain*

150. On 31 Month11, it is recorded that Mrs A was experiencing chest pain. No further recordings were made about whether any monitoring was carried out by staff following this. RN Scrase advised that the source of pain had not been identified at this point, and it could have been attributable to a range of issues, including a cardiac event, but there was no evidence of pain assessment, management, or monitoring of pain levels. RN Scrase stated that this was a serious departure from accepted practice, and I accept this criticism. Regardless of the cause of the pain, documentation of pain management was inadequate, and a short-term care plan and pain management chart would have been appropriate.

151. Remuera Rise accepted that no pain assessment chart was commenced but stated that the nurses monitored and documented Mrs A's comfort levels continuously and offered pain relief as needed. Remuera Rise stated that there was no indication that Mrs A was suffering from new pain, and her care was in accordance with the frailty guides and comfort care approach.

152. RN Scrase stated that care planning and documentation should reflect the monitoring and investigation of any new issues such as pain, and appropriate pain assessment tools and management should have been utilised. RN Scrase stated that regardless of a patient's clinical trajectory, or other factors such as resuscitation status (as Mrs A was not for resuscitation), reasonable actions should have been taken to ensure that Mrs A was as comfortable as possible, and that any appropriate interventions were taken. RN Scrase said that given that the cause of the pain was unknown, it would be reasonable to expect staff to use critical thinking to try to identify the cause.

**Pneumonia diagnosis and subsequent end-of-life care**

153. On 1 Month12, the duty nurse noticed that Mrs A was coughing intermittently, and her family expressed concern that she might have pneumonia. The family requested that IV antibiotics be started for this, but the nurse on duty explained that for this kind of treatment, and for a full diagnosis of the cause of her cough, Mrs A would need to be transferred to hospital. Remuera Rise told HDC that it is not unusual for someone with a fluctuating

swallow function to cough frequently, and on this date Mrs A did not have a persistent cough, but this was often noted after Mrs A had ingested something.

154. The clinical manager arranged for Mrs A's family to meet with Dr B to discuss her care pathway. Recollections about what the meeting entailed vary, but a discussion occurred about whether Mrs A should remain at Remuera Rise or be transferred to hospital.

155. Remuera Rise told HDC that at this meeting, Dr B explained that Mrs A was possibly in the last days of her life, and the options were to transfer her to hospital for active treatment of pneumonia or initiate a comfort care pathway at the care home. Remuera Rise stated that Mrs A's family did not want her to be transferred to hospital at that time, and it accepted that this was appropriate given the difficult circumstances surrounding the COVID-19 lockdown at the time. Remuera Rise said that while a palliative care plan was not documented, there was a clear plan of care for Mrs A following this discussion, and Dr B recorded this in the progress notes.

156. A registered nurse also made more detailed notes in Mrs A's progress notes, under the heading 'Medical Review/Dr B', which acknowledged that Mrs A's health was declining, and advised that she might be in her last days of life. The nurse noted that the family had declined hospital admission and had agreed to continue to give her regular medications as tolerated. Dr B also reviewed Mrs A's essential medications and charted morphine to be administered when the family requested it. Remuera Rise told HDC that morphine can be used as a cough suppressant, as well as to manage pain and discomfort. The notes also contain instructions to keep Mrs A comfortable and to coordinate her cares with the family.

157. In contrast to these notes, Mr A told HDC that Dr B did not assess Mrs A, but observed her from the doorway of her room and told the family that her organs were shutting down and that she was in the final days of her life.

158. RN Scrase told HDC that there appears to be a lack of shared understanding between the family and the medical team about Mrs A's prognosis and the most appropriate course of action. RN Scrase stated that it is not clear from the documentation whether addressing Mrs A's cough was from a curative or comfort perspective. He advised that if Mrs A continued to have active treatment, interventions such as antibiotics, regular observations, and consideration of hospital admission were appropriate. However, if it was felt that Mrs A was not able to receive active treatment, then the facility needed to be clearer about how it would support Mrs A and her family. RN Scrase stated that the Ministry of Health document 'Te Ara Whakapiri — Principles and guidance for the last days of life' provides guidance in this area, with the third principle of Te Ara Whakapiri stating:

> 'Communication is clear and respectful: care providers clearly communicate information about the status of people in their last days of life, their care plans and their treatment, to the person and their family/whānau. They create opportunities for the family/whānau to provide input. They support the family/whānau beyond the death of the person.'

159. RN Scrase told HDC that he accepts that some documentation exists, but it is inconsistent, and it does not contain a cohesive management plan in one clearly defined location. He expressed criticism regarding a lack of critical thinking, and he emphasised that documentation should not be completed just for the sake of it. RN Scrase stated that it was a serious departure from accepted practice to have such a lack of documented clarity about whether active treatment or palliative care was the most appropriate way forward. However, I note the limitations imposed on staff and clinical assessments at this time due to COVID-19. Dr Maplesden advised that while a physical examination and documentation of the findings would normally be required, in the clinical scenario presented to Dr B, it seemed apparent without formal clinical assessment that Mrs A was approaching the end of her life, and that pneumonia was the most likely cause. I agree with Dr Maplesden's advice.

160. End-of-life care is a particularly sensitive area that requires shared understanding between the patient, their family, and clinicians. Ensuring that family can provide input into these important conversations around a consumer's care plan and treatment, including the use of active treatment or the palliative care pathway, requires sensitivity and adequate time for discussion. Such discussions require clear information about the patient's health status and should ensure that family understand the approach being taken. As highlighted by RN Scrase, there is inadequate documentation to show that this occurred, and I am highly critical of this.

**Conclusion**

161. As acknowledged by my clinical advisor, RN Scrase, the clinical issues in this case are all connected, and would have impacted on each other to varying degrees. Mrs A's ongoing care needed to be viewed in the context of her very advanced Parkinson's disease and reviewed accordingly in a timely manner as her overall health declined.

162. I share RN Scrase's concerns about the lack of documentation and planning to indicate that staff were taking a holistic approach to Mrs A's care.

163. RN Scrase was also critical that there does not appear to be any documented, agreed, over-arching care plan in place, such as an advanced care plan, shared goals of care, or an acute plan, to ensure that there was a mutual and agreed understanding of what care could and should be provided by the facility, and when hospital admission was appropriate. RN Scrase was also critical of the failure to commence a short-term care plan for Mrs A's weight loss and oral thrush management. I agree with these criticisms and note that this disconnect between the understood goals of Mrs A and her family and care staff was particularly evident towards the end of her life.

164. Mrs A's family were heavily involved in her care but were not given sufficient information and time to assist their decision-making regarding Mrs A's care at the end of her life, and whether to begin a palliative care pathway. RN Scrase stated that greater consideration needed to be given to an early discussion with Mrs A and her family about the important contextual issue of Mrs A's condition due to her Parkinson's disease, which would cause her health to continue to decline. He said that Remuera Rise should have ensured that there

was an agreed understanding of the most clinically appropriate and respectful approach to the care provided. I agree with this statement. These discussions needed to be documented clearly, and in this case they were not. RN Scrase stated that the lack of critical thinking, and the failure to document and formulate a short-term care plan for Mrs A's care appropriately, amounted to a serious departure from accepted standards throughout Mrs A's care. I agree, and for the reasons set out above I find Remuera Rise in breach of Right 4(1) of the Code.[23]

## Opinion: Dr B — adverse comment

165. Mr A also raised concerns about Dr B's conduct during his provision of care to Mrs A. Mr A stated that Dr B showed very little interest, compassion, or empathy, and did not examine Mrs A during his visit on 1 Month12. Mr A was also concerned about the delayed diagnosis and treatment of Mrs A's oral thrush, hand infection, and aspiration pneumonia, and that Dr B did not administer intravenous fluids.

166. My in-house medical advisor, GP Dr David Maplesden, provided advice on Dr B's care. Dr Maplesden was not critical of the diagnosis and treatment of Mrs A's oral thrush, hand infection, or her pneumonia. Dr Maplesden advised that Dr B prescribed appropriate treatment for Mrs A's oral thrush and hand infection once notified of her symptoms, and that it was reasonable for Dr B to take a comfort cares/palliative approach when managing Mrs A's pneumonia. I accept Dr Maplesden's advice that Dr B's management of Mrs A was appropriate. I also accept Dr Maplesden's statement that the diagnosis of Mrs A's rib fractures at Hospital 2 does not reflect any deficiency on the part of Dr B in his management of Mrs A.

167. Regarding IV hydration, Dr Maplesden stated that the prescription of subcutaneous saline as needed was appropriate. Dr Maplesden said that in his experience, it is not usual practice for aged care facilities to offer IV rehydration, and usually if this is felt to be appropriate then hospital admission is required. He advised that at the time, due to COVID-19, GPs were discouraged from sending anyone other than acutely unwell patients to hospital, and he considers that subcutaneous fluids at the care home was an appropriate alternative. I accept this advice and note that at this time Mrs A's family did not want her to be transferred to hospital.

168. Dr Maplesden acknowledged that it appears that during the COVID-19 restriction period, when Mrs A's family were unable to provide the intensive support they had undertaken previously, particularly in regard to assistance with medication administration, Mrs A's general condition deteriorated at a rate faster than had been observed previously. He noted that it is difficult to state when Mrs A's pneumonia began, but that according to the clinical records, respiratory symptoms were apparent from 1 Month12. Dr Maplesden advised that with Mrs A's co-morbidities and prognosis, it was important to seek the views of family

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

members when it came to formulating a plan to manage her deterioration. I agree with this advice.

169. There appears to have been some confusion between the family, Dr B, and other staff surrounding Mrs A's care and prognosis. Clearer documentation would have assisted in care coordination with ambulance service staff on 3 Month12, and discussions with Mrs A's family about end-of-life care options could have been documented more comprehensively.

170. In response to the provisional findings, Dr B disputed the above. Dr B stated that he met with Mrs A's family together with one of the senior nurses at Remuera Rise, and he explained to the family that Mrs A was dangerously ill, likely with pneumonia, and would need either hospital investigation and treatment or palliative care. Dr B told HDC that this was recorded in file notes, with palliative measures administered as charted.

171. In his response to the provisional findings, Dr B maintained that communication with Mrs A's family was not inadequate, and he noted that after choosing palliative care they asked that Mrs A be transferred to hospital.

172. While I acknowledge Dr B's comments, I remain concerned that there was an absence of documented clarity between all parties involved, and I agree with Dr Maplesden's advice that it would have been beneficial to have had clear notes to show that Mrs A's family were adequately informed when making significant decisions about her care.

173. Regarding Dr B's assessment on 1 Month12, Dr Maplesden stated that under normal circumstances a physical examination would be required, as well as documentation of the findings, but he noted the limitations imposed on such assessments at the time due to COVID-19. Dr Maplesden said that in the clinical scenario presented to Dr B, it seemed apparent without formal clinical assessment that Mrs A was approaching the end of her life, and that pneumonia was the most likely cause.

174. In response to the provisional findings, Dr B stated that although he did not document pneumonia as the likely diagnosis at the time, his file note was adequate, and showed that Mrs A's family were offered active measures or palliative care, and they chose palliative care.

175. While I accept that COVID-19 may have limited Dr B's ability to carry out a physical assessment, and I agree that his omission to document the possible diagnosis of pneumonia did not amount to a breach of the Code, contemporaneous and accurate documentation of clinical findings is important. As such, Dr B should still have documented his findings, and I remain concerned that pneumonia is not mentioned in the notes. I also suggest that if Dr B had taken time to explain to Mrs A's family the limitations in his practice due to COVID-19, this would have provided some reassurance.

## Changes made since events

176. Remuera Rise told HDC that its experiences with Mrs A enriched its knowledge about the challenges of Parkinson's disease. Since Mrs A's death, it has reflected and made changes to its services, including the following:

a) Implementation of a communication form to be used by registered nurses with the GP when referring acute conditions;

b) Training to refamiliarise nurses with the medication administration policy;

c) Training to refamiliarise nurses and healthcare assistants on clinical documentation;

d) Training to refamiliarise nurses and healthcare assistants on the pain assessment and management guidelines;

e) Training to refamiliarise nurses and healthcare assistants on the nutrition and hydration guidelines;

f) Training to refamiliarise nurses and healthcare assistants on the communication policy and guidelines;

g) Training to refamiliarise nurses and healthcare assistants on the delirium guidelines;

h) Training to refamiliarise nurses and healthcare assistants on the challenging behaviours or behaviours of concern management policy; and

i) Training to refamiliarise nurses and healthcare assistants on the last days of life guidelines.

177. No internal review was completed as Remuera Rise was not aware of the complaint until being notified by HDC. However, Remuera Rise noted that a clinical review was completed by Te Whatu Ora; however, this was not provided to HDC.

178. Remuera Rise told HDC that it is testing new software that it believes will increase the efficiency of how care is documented, allowing improved documentation, and enabling staff to spend more quality time with residents. However, staff training in the software has been delayed by COVID-19.

179. Remuera Rise also told HDC that it plans to make the following changes:

a) Robust implementation of advanced care planning for able residents by adapting an Advance Health Care Plan recommended by Te Whatu Ora;

b) Generation of a policy and procedure for when family are involved in medication management, including assessment of the skills of family members;

c) Generation of a policy and procedure for nutrition and fluid intake based on the Frailty Guides 2019;

d) Reflection on the procedure regarding care plan review, and generation and implementation of procedures that focus on good discussions to capture resident and family wishes;

e) Review of its dietary care plan, and implementation of changes and procedures when a resident's condition changes;

f) Advancement of care staff training on its new documentation software, and for it to be fully operational within six months;

g) Implementation of changes so that short-term care plans are generated and handed over to ensure that nurses are aware that they exist, and that they follow the plan (the full operation of the new documentation software will mean that nurses will receive notifications when a short-term care plan has been activated);

h) Organisation of training for nurses on critical decision-making; and

i) Organisation of medication competency training that focuses on accountability, safety, and avoiding patient harm.

## Recommendations

180. I recommend that Remuera Rise provide a formal apology to Mrs A's family for the deficiencies identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding to Mr A.

181. I recommend that Remuera Rise undertake the following, and report back to HDC within three months of the date of this report:

a) Provide an update on the implementation of its new documentation software and whether it has improved documentation at Remuera Rise;

b) Provide documentation training for all staff to ensure that they are aware of the standard required, and the need to think critically about the information they record, and whether it necessitates any action or escalation;

c) Provide training to all staff around short-term care plans and when they should be used and what details should be included;

d) Use an anonymised version of this report as a case study for staff to encourage reflection and discussion on caring for and supporting residents with Parkinson's disease;

e) Consider reviewing its end-of-life care policy, to ensure that it gives adequate guidance to providers on how to discuss end-of-life care with residents and their family;

f) Provide an update on the provision and availability of the Health Quality & Safety Commission frailty care guides to nursing staff; and

g) Review its medication administration policy to ensure that there is clarity on the appropriateness of family members administering patient medicine with or without the presence of a registered nurse, and rules around self-medicating.

182. I recommend that Dr B:

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

b) Provide to HDC, within six months of the date of this report, evidence that he has attended training sessions run by Remuera Rise in response to HDC's recommendations regarding documentation.

## Follow-up actions

183. A copy of this report with details identifying the parties removed, except Remuera Rise Ltd (trading as Remuera Rise) and the clinical advisors on this case, will be sent to the new owner, the Ministry of Health (HealthCert), and Te Whatu Ora.

184. A copy of this report with details identifying the parties removed, Remuera Rise Ltd (trading as Remuera Rise) and the clinical advisors on this case, will be sent to Te Tāhū Hauora|the Health Quality & Safety Commission and 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:

> 'Thank you for the request to provide clinical advice regarding the care provided to [Mrs A] at Remuera Rise Care Home. In preparing the advice on this case, to the best of my knowledge, 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.
>
> I started my nursing career in 2000 as a Nursing Auxiliary at Torbay Hospital in Devon, UK. After completing my Nursing Diploma, I started work in 2005 as a Registered Nurse on an acute surgical ward at Torbay Hospital in the UK. In 2006 I moved to New Zealand and worked at Christchurch Hospital on an acute colorectal and general surgical ward. I transferred to Older Persons Health in 2009 and worked as Registered Nurse on a rehabilitation ward before moving across to the Community Team at Older Persons Health in Christchurch which included working as an RN in a newly formed early supported discharge team. Following this I became a Gerontology Nurse Specialist in 2013 in a role that supported Aged Residential Care Facilities with areas such as clinically complex residents, education, and care planning support. In 2018 I was appointed as Nursing Director Older People — Population Health for Canterbury and West Coast DHBs. This role focuses on supporting nursing in both the Community and Aged Residential Care settings whilst continuing to be direct Line Manager for the Gerontology Nurse Specialist Team. It also involves investigating and reporting on any complaints and concerns raised to the Canterbury DHB and West Coast DHBs about care provided in local Aged Residential Care Facilities. In addition to this I have completed my post graduate diploma in Gerontology Nursing, and I have been an author on five published peer reviewed articles focussing on health-related issues in New Zealand's frail older population. I am currently part of the national group that has been formulating the ARC Covid Response Plan for New Zealand. I am also Chair of the HQSC National ARC Leadership Group.
>
> The Commissioner has requested that I review the documentation provided and advise whether I consider the care provided to [Mrs A] by Remuera Rise was reasonable in the circumstances and why.
>
> I have specifically been asked to provide comment on:
>
> 1. Whether the management of [Mrs A's] feeding and hydration was appropriate.
> 2. Whether the management and administration of [Mrs A's] medication was appropriate.
> 3. The appropriateness of the management of [Mrs A's] oral thrush and hand infection.
> 4. The appropriateness of the management of [Mrs A's] cough, including whether the assessment and treatment provided were appropriate in the circumstances.
> 5. The appropriateness of the management of [Mrs A's] injuries, including whether the assessment and treatment provided were appropriate in the circumstances.

6. Appropriateness/adequacy of the overall care provided to [Mrs A] at Remuera Rise.
7. Any other matters in this case that may warrant comment.

For each question, I am asked to advise on:

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

b) If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be?

c) How would it be viewed by my peers?

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

In preparing this report, I have reviewed:

1. Letter of complaint dated 19th [Month12].
2. Letter of response from Remuera Rise dated …
3. Clinical documentation provided by Remuera Rise covering the period 23rd [Month11] to 2nd [Month12].
4. Other material referred to is referenced at the end of this report.

As required by the Commissioner, I have looked to provide an objective opinion on the questions posed. Furthermore, as laid down in the Guidelines for Independent Advisors, where there are conflicting versions of events, I have endeavoured 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 endeavoured to view the events as they unfolded because the outcome was not known at the times that decisions were made.

**Background.**

[Mr A] raises concerns about the care his late wife, [Mrs A], received at Remuera Rise.

[Mrs A] ([in her sixties]) had advanced Parkinson's disease and was admitted into Remuera Rise on 31 [Month1]. [Mr A] reports visiting up to three times a day to ensure her care was provided appropriately.

Due to the COVID-19 pandemic, Remuera Rise entered a state of lockdown [in Month11] and visitation restrictions were introduced. [Mr A] reports that his wife's condition started to deteriorate. Concerns raised included issues around medication management, food and fluid intake, and identification and management of oral thrush and wound care. [Mrs A] also developed a persistent cough and on 2nd [Month12] she

was transferred to Hospital by ambulance where she was diagnosed with pneumonia and dehydration.

**1. Whether the management of [Mrs A's] feeding and hydration was appropriate.**

**Review of documents.**

The letter of complaint dated 19th [Month12] raised a number of specific concerns about [Mrs A's] food and fluid intake once the lockdown came in place. In summary the complainant's letter stated that, "From 23 [Month11] [Mrs A] was left to become dehydrated and was deprived of food rapidly becoming extremely weak and frail".

In terms of reviewing the Facility's response with respect to food and fluid intake, I have also examined the Facility clinical notes for the period in question as well as external clinical documentation provided relating to [Mrs A's] nutritional status so that we can have a clear understanding of the context.

According to the interRAI assessment completed on admission to the Facility EPOA for personal care and welfare had not been activated and there was no Advance Care Plan recorded.

The Transfer of Care letter from [Hospital 1] when [Mrs A] was first admitted to Remuera Rise can be summarized as the following with respect to nutrition:

- 31st [Month1]. *Admission weight 43.4kg BMI 17.4 Oral intake (on admission) poor 25–50% of meals. Discharge weight 42.3kg. Please continue to monitor weight and nutritional status and refer to your contracted dietician if any further nutritional issues arise.*
- *Marked dysphagia. PEG tube was discussed for nutrition and medication administration however patient declined.*

Subsequent Speech and Language Therapist visits to the Facility stated:

- 30th [Month9]. *Discussion on recent recommendation from discharge from [Hospital 2] for swallowing was soft diet and thin fluids. [Mrs A] chose to have a normal diet and accepts the risk of chocking (sic). She is not offered food when unable to initiate a swallow. Recommendations. Normal diet, normal fluids.*
- 10th [Month11]. *Normal diet, normal fluids, sit upright for all oral intake, supervision when eating. To be discharged from our service.*

Further review of the Facility documentation highlights the following:

- The Facility weight chart for [Mrs A] indicated that her weight was relatively stable from her admission. However, according to the notes provided her weight had dropped from 43kg on 13th [Month11] to 40kg on the 19th [Month11].
- Review of the medication chart indicates that Fortisip nutritional supplements were dispensed as prescribed 3 times a day.

- The Long-Term Care Plan dated 4th [Month8], refers to a goal weight of 56kg and water intake being improved.
- Examination of the Facility notes from the point of admission indicate that food intake became more variable as time progressed. Fortisip had been prescribed three times a day according to the medication chart provided.

In terms of the care provided by the Facility specifically relating to nutrition and hydration from the point of lockdown onwards (23rd [Month11]), the Facility notes included several comments around food intake, including:

- 23rd [Month11] 14.40. *Ate yoghurt and cornflakes, toast with Jam and coffee for breakfast*
- 23rd [Month11] 22.15 *Asked to have some crackers and jam, given as requested.*
- 24th [Month11] 14.15. *Refused to have anything to eat for breakfast and lunch despite prompting by staff*
- 27th [Month11] 03.15*. … been eating biscuits when she is alright*
- 28th [Month11] 12.30. *Had a good lunch.*

**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). 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 and had a BMI of 16 according to the documentation supplied. It is therefore important that those times when food was being declined was accurately recorded and then some action or input needed to follow should it become an ongoing concern.

Although the documentation indicates that [Mrs A] was being offered food, and also that fluid was being either offered when medications were being given or as a Fortisip drink during this period this documentation is not consistent or complete and how frequently food and fluid was being offered was not always clear even though nutritional status was highlighted as an area to monitor on the hospital discharge summary.

It is my professional view that [Mrs A] was being offered food and fluids but there were a significant number of times when she was either declining or eating very little. The fundamental issue here for me was that there was no evidence of a plan of how to have a proactive approach to supporting [Mrs A's] nutritional requirements. This lack of a plan was a recurring theme throughout my review of this case.

An example of this was the significant weight loss recorded on 19th [Month11] which was prior to the Facility going into lockdown. This is concerning, and while I accept that [Mrs A's] weight had been stable at approximately 40kg in the weeks and months prior to this (but equally not increasing as stated in the Care Plan), the fact remains that this was still a significant weight loss in less than a week. There didn't appear to be any comment or follow up with respect to this and this was the last recorded weight on any of the weight charts supplied. It would be my professional expectation that follow up would include interventions such as:

- The weight is recorded again in case the first was an error.
- That if the original weight was confirmed as accurate, the GP be informed and discussion about dietician input as per transfer summary from Hospital 2 above.
- If appropriate, a short-term care plan be drawn up and followed to manage weight loss and ensure appropriate nutritional and fluid intake.
- An alternative plan be discussed with the family regarding [Mrs A's] declining health if it was agreed she was reaching the end of her life and consistent nutritional intake was no longer the focus.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be? How would it be viewed by my peers?**

In terms of offering food and fluids, a failure to regularly offer fluid and nutrition in some form to a resident where there are no medical guidelines to the contrary would be a serious departure from accepted practice and would be viewed with severe disapproval by my peers. However, if these interventions were undertaken but not recorded, my view is that would be a moderate departure from accepted practice and would be considered with moderate disapproval by my peers.

As mentioned though, my fundamental concern was the lack of documented strategy around supporting [Mrs A's] dietary needs as highlighted in the Long Term Care Plan particularly when it became a clear issue of concern. In other words, "this is the plan, but how are we going to achieve it?". I would view this as a serious departure from accepted practice and I believe this would be viewed with severe disapproval by my peers.

**Recommendations for improvements that may help to prevent a similar occurrence in the future.**

- I would recommend that the Facility focus on improving documentation in all areas of care. Furthermore, when information is documented it needs to be completed in

a manner which would be clear to everyone including those unfamiliar with the facility such as agency staff. For example, the Long-Term Care Plan relating to Dietary Needs dated 4th [Month8] is hand written and has a significant degree of annotation on it and this and other Long-Term Care Plans supplied are not as clear as they need to be because of these undated and unsigned additional comments.

- I would recommend that there needs to be a focus on critical thinking so that staff don't simply record information but act on it appropriately.
- I would also recommend that the Facility use the HQSC Frailty Care Guides (3) as a regular resource and in particular the section on Nutrition and Hydration.

**2. Whether the management and administration of [Mrs A's] medication was appropriate.**

**Review of documents.**

Review of the documentation highlighted the challenges faced in terms of medication management as [Mrs A's] Parkinson's Disease progressed, despite the additional use of Apomorphine to help manage symptoms (4).

The letter of complaint makes several references to concerns about [Mrs A] being under medicated with respect to her Parkinson's medications. The Facility documentation also makes it clear that medical interventions and changes were undertaken in close consultation with family wherever possible.

Throughout the Facility notes there was reference to medications being crushed in order to facilitate administration or dissolved and in several instances being dissolved in water and given via oral syringe to [Mrs A].

Furthermore, there were also numerous references to medications being administered by family members including those medications crushed and also dissolved in water and administered via an oral syringe.

**What is the standard of care/accepted practice?**

The Health and Disability (Core) Standards apply (1) and in particular:

*Standard 3.12. Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.*

*The NZNO Guidelines for Nurses on the Administration of Medicines (5)* and the MoH published *Medicines Care Guides for Residential Aged Care (6)* are also accepted guidelines within nursing to inform our decision making with respect to safe medication management in Aged Residential Care. In particular, medicine administration needs to be considered alongside the important direction of the NZNO *Guidelines for Nurses on the Administration of Medicines; Appendix1: Standards for the administration of medicines. (5)*

It is however important to involve family in decision making and in providing care where appropriate and should they desire, as outlined in the Nursing Code of Conduct (2) and Standard 3.2 in particular:

*Respect health consumers' rights to participate in decisions about their care and involve them and their families/whānau where appropriate in planning care. The concerns, priorities and needs of the health consumer and family/whānau must be elicited and respected in care planning.*

However, the ARC Facility are ultimately responsible and accountable for the care provided at that Facility as outlined in the Service Standards, (1) and they need to ensure that all care provided including medication management is carried out in a safe and effective manner.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be? How would it be viewed by my peers?**

It was reasonable for the Facility to involve the family members in appropriate aspects of [Mrs A's] care if this was their wish as appears to be the case particularly as they would have been so familiar with many aspects of care when she was living at home. However, Registered Nurses are accountable for their practice including medication management (2,5). This is particularly important with respect to monitoring for effectiveness of medications given, any contra indications, and their safe administration.

[Mrs A] was a clinically complex and vulnerable resident particularly with respect to her swallow as referenced in the previous section. Although family members were very experienced in supporting [Mrs A], she was becoming frailer and potentially more vulnerable as the disease process relating to her Parkinson's progressed. It is not clear from the documentation supplied to what degree there was any supervision and support whilst medications were being administered by family members.

To be clear, I am not criticising family members or questioning their competence, knowledge or ability. My professional concern is about the degree of medication oversight and support for family and resident by the Facility particularly given the documented frequency with which it occurred for an increasingly clinically complex resident with several health issues including a poor swallow.

Furthermore, the documentation strongly indicated that medication management and intervention was at times being led by [Mr A] rather than the Facility staff. It is my professional opinion that this should not have been necessary if the staff had a good understanding of Parkinson's Disease and if there was an agreed understanding between all parties involved of the degree of support that medical intervention could provide for someone in the final stages of Parkinson's Disease.

Finally, I could not identify any evidence in the notes as to whether the crushing of medications had been discussed with a Pharmacist which would be expected practice in order to ascertain whether this was appropriate or not (5).

In terms of the management and administration of [Mrs A's] medication, it is my professional opinion that there has been a serious departure from accepted practice and this would be met with severe disapproval by my peers.

**Recommendations for improvements that may help to prevent a similar occurrence in the future.**

In my professional opinion, I would recommend that the Facility ensure:

- That all staff have a good understanding of supporting residents with Parkinson's Disease appropriate education sessions.
- That if a future resident is admitted with a disease process or illness that staff are known to be unfamiliar with, that education is given in order to provide the staff with the required level of knowledge to safely support the resident in question.
- That all staff revisit medication competencies and in particular issues around, accountability, safety and avoiding patient harm.
- That Facility Policies around medication management are followed by staff and that these Policies are reviewed and updated as necessary.
- That Facility Policies on Self Medication are also reviewed and updated as necessary.

**3. The appropriateness of the management of [Mrs A's] oral thrush and hand infection.**

For clarity, I have reviewed these as two separate issues.

**i) Oral thrush.**

**Review of Documents.**

The letter of complaint dated 19th [Month12] stated:

- *Infections such as that in her hand and oral thrush would be contributing to her difficulty taking her Parkinson's meds and limiting their effectiveness*
- 29th [Month11]. *It was then it was suggested perhaps her trouble swallowing was due to oral thrush.*

The letter of complaint timeline dated 19th [Month12] stated:

- 30th [Month11]. *The duty nurse mentioned to me that [Mrs A] had oral thrush due to the antibiotics she had been given for her hand infections since [Month6].*

The Facility notes provided stated:

- 28th [Month11]. "*had a good lunch*"

- 29th [Month11]. 13.40. *[Mr A] reported yellow thick substance in mouth, [Mrs A] confirmed feeling sore … On inspection of mouth, cheesy yellowish patches noted, redness of tongue and corners of mouth. Unable to inspect throat. Complained of discomfort. Discussed with GP. Decozol oral gel charted.*
- 1st [Month12]. *Oral thrush, receiving treatment, improved*
- The Long-term Care Plan for Dietary Needs for [Mrs A] dated 4 [Month8] states, "Requires assistance with oral/dental care twice daily"
- According to the interRAI assessments [Mrs A] did not have dentures and had her own teeth

**What is the standard of care/accepted practice?**

In terms of resident care in general, the expectation would be that services are provided of an appropriate standard as laid out in the MoH Service Standards (1) so that it is individualised, and person centred. This then leads to the use and implementation of Long-Term Care Plans such as for Dietary Needs, which we would expect to be followed. In the case of oral care for [Mrs A] this is documented as twice daily in which case the oral thrush should have been identified in a timely manner.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be? How would it be viewed by my peers?**

Although there was documented evidence of [Mrs A] having a poor swallow and having reduced appetite for several days prior to the oral thrush being identified I could identify no documented evidence that clearly indicated that these issues were caused by oral thrush in the days before it was identified.

In my professional opinion, although the oral thrush would have impacted on [Mrs A's] oral intake and her ability to take medications I could not identify any clear documented evidence to indicate that the oral thrush was not identified in a timely manner. Furthermore, once the thrush was identified the treatment was effective.

However, I was also unable to identify a Short-Term Care Plan which should in my professional opinion have been utilised to document the correct process to manage issues such as this and to ensure that it has been successfully resolved. There was also limited documented evidence of a plan to review and monitor [Mrs A's] mouth and oral care.

Although the oral thrush resolved relatively quickly, there was no clear evidence of a plan of how to manage and monitor the oral thrush and the effectiveness of the medication prescribed. In my professional opinion, particularly given [Mrs A's] frailty and vulnerable nutritional status a management plan for her oral thrush should have been documented and clearly followed. The documentation I have viewed suggests that this did not happen, and I would consider this a significant departure from accepted practice and in my professional opinion my peers would view it with significant disapproval.

**Recommendations for improvements that may help to prevent a similar occurrence in the future.**

In my professional opinion, I would recommend that the Facility ensure:

- As previously stated, I would recommend that the Facility focus on improving documentation in all areas of care.
- In particular I would recommend that they focus on utilising and updating Short Term Care Plans as appropriate.

**ii) Hand infection.**

**Review of Documents**

The letter of complaint timeline dated 19th [Month12] stated:

- 29th [Month11]. *I noticed that xxx's hands were not being dressed and had become badly infected.*

The Facility notes provided stated:

- 18th [Month6]. GP *Tending to broken skin (illegible) contracted fingers*
- 22nd [Month7]. Extensive physio report including hands
- 4th [Month8] Physiotherapist notes *Lpalm — started abx today. Ongoing difficulty moving 3rd, 4th, 5th fingers of both hands. Suggested referral to xxxx physio clinic*
- 6th [Month11]. interRAI assessment completed*. No skin conditions identified*
- 31st [Month11]. Recurrent infection due to permanent flexion of fingers. Fingers digging into palms despite protective dressing.

**What is the standard of care/accepted practice?**

The accepted practice for someone requiring support with all cares in a Hospital Level of Care environment would be that their skin is checked regularly to ensure it is intact and that any pressure injuries or wounds are documented and managed utilising a clearly outlined plan which would usually be in the form of a Short-Term Care Plan or a Wound Care Chart.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be? How would it be viewed by my peers?**

Throughout the facility documentation there was periodic reference to [Mrs A's] finger contraction. There was also mention of a dressing that was put between finger and hand to prevent injury although it wasn't clear what this might be. There was limited information of both the Long-Term Care Plan and the interRAI assessments with respect to skin and pressure injury risk. A Short-Term Care Plan had been utilised on two occasions to manage these wounds, the last having comments added on 4th [Month9]. I could not identify further Short-Term Care Plans relating to this issue. However, the last plan does state that they were monitoring for signs of infection and that it was to

be covered with a dressing which needed to be changed regularly. It is not clear what the dressing should have been though.

In my professional opinion, if the hand was not being monitored and was not being regularly dressed it would be a serious departure from accepted practice and would be viewed with severe disapproval by my peers because of the risk of significant infection. If, however it was being dressed appropriately but hadn't been documented accordingly then this would be a moderate departure from accepted practice and would be viewed similarly by my peers.

**Recommendations for improvements that may help to prevent a similar occurrence in the future.**

- Recommendations would be as for those relating to oral care above with respect to improving documentation and Short-Term Care Plans.

**4. The appropriateness of the management of [Mrs A's] cough, including whether the assessment and treatment provided were appropriate in the circumstances.**

**Review of documents.**

The letter of complaint dated 19th [Month12] stated:

*On 1 [Month12] we continued to have growing concerns for [Mrs A's] health. She had signs of coughing and we were worried about the possibility of pneumonia.*

*By 2nd [Month12] [Mrs A's] coughing had become worse, it sounds very chesty. We were assured by the clinical manager that [Mrs A's] lungs sounded clear and that it was not pneumonia.*

*Late Thursday evening [Mrs A's] cough became worse and her breathing laboured and the decision was made to call an ambulance.*

Under Key Concerns. *If it had been established earlier that [Mrs A] had pneumonia we would have sought active treatment.*

The Facility notes provided stated:

1st [Month12]. 05.00 *Noticed her coughing intermittently, [Mr A] verbalised that [Mrs A] may have pneumonia due to cough and phlegm. Advised [Mr A] that the other option is to send her to hospital but family not keen on sending her to hospital.*

1st [Month12]. 18.05 *Medical Review by GP. May be in her last days of life. Declined hospital admission. Continue giving regular medications as tolerated. Essential medications reviewed. Morphine added to chart.*

2nd [Month12]. *Occasional cough, chesty able to cough but not strong enough to expectorate phlegm. Salbutamol nebulisation rendered to help loosen phlegm.*

The notes indicate that there was a family meeting on 1st [Month12] but I have not viewed any minutes of this meeting or any detailed records of what was discussed and any agreed understanding between parties following this meeting.

**What is the standard of care/accepted practice?**

The Facility have a clear duty of care but any treatment needs to be appropriate and considered in the context of the clinical prognosis of the individual concerned. Accordingly, if this resident was entering the final stages of her life as indicated by the Facility note dated 1st [Month12], then following the principles outlined in the MoH document, Te Ara Whakapiri Principles and guidance for the last days of life would be appropriate (7).

In my professional opinion, it is not possible to focus solely on [Mrs A's] cough without looking at the wider picture in the context of her declining health at this stage of proceedings. From the documentation I reviewed, there appeared to be a lack of shared understanding between the family and the medical team about [Mrs A's] prognosis and the most appropriate course of action. There was not a clear, consistent and agreed plan for the days ahead between all parties. The cough still needed to be addressed but whether it was from a curative or a comfort perspective was not made clear from the documentation I reviewed. If [Mrs A] remained for active treatment, then appropriate interventions considered such as antibiotics and regular observations (BP, Pulse etc) and further consideration given to hospital admission. If as indicated by the Facility notes [Mrs A] was nearing the end of her life, then the Facility needed to be clearer about how they would support [Mrs A] in line with the 3rd principle of Te Are Whakapiri (7):

***Communication is clear and respectful.*** *Care providers clearly communicate information about the status of people in their last days of life, their care plans and their treatment, to the person and their family/whānau. They create opportunities for the family/whānau to provide input. They support the family/whānau beyond the death of the person.*

**If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be? How would it be viewed by my peers?**

Whatever the health care setting and size of the facility in question, documentation is a key communication tool. In my professional opinion, there was a lack of documented agreed decision making about the pathway ahead for [Mrs A], and in my view this is where the departure from accepted practice lies.

In view of the lack of documented clarity about the most appropriate pathway forward (active treatment or for palliative care) I would consider there to have been a serious departure from the accepted practice and it is my professional opinion that my peers would agree with this view.

**Recommendations for improvements that may help to prevent a similar occurrence in the future.**

- Attention needs to be given to documentation and in particular to a clear and accurate recording of discussions at any family meeting that highlight the issues discussed and agreed understanding of the clinical approach being taken.
- Education and understanding of, and the principles behind Te Ara Whakapiri. (7)
- Reference to and use of the HQSC Frailty Care Guides (3) and in particular here the sections on Acute and Gradual Deterioration, The Last Days of Life, and Advance Treatment Planning.

**5. The appropriateness of the management of [Mrs A's] injuries, including whether the assessment and treatment provided were appropriate in the circumstances.**

**Review of documents.**

The letter of complaint dated 19th [Month12] stated:

Saturday 28th [Month11]. Referred to [Mrs A] having 2 broken ribs.

Under Key Concerns the letter referred to:

*[Mrs A] was in pain and this was not assessed and most likely caused by her broken ribs. Which raises the question how did her ribs become broken?*

The Facility notes state:

31st [Month11]. *[Mrs A] is having chest pain* BP 90/60, T36.1, SPO2 97%, P 74. BS 9.8.

Subsequently followed up by nurse but notes not clear

1st [Month12]. 15.30 *[Mrs A] was moaning, ?pain upon moving her to her sides.*

1st [Month12] 18.05. *Morphine added to chart*.

No record in notes of a recent fall or event that may have caused the rib fractures. I note that [Mrs A's] discharge summary from [Hospital 2] refers to a previous DEXA scan but no indication of results has been seen by the author. This scan is typically used to measure the degree of any Osteoporosis and Osteopenia in an individual which can both increase the risk of fracture. The cause of the rib fractures or a point when they might have occurred cannot be ascertained from the documentation provided.

**What is the standard of care/accepted practice?**

Care Planning and documentation should reflect the monitoring and appropriate investigation of any new issues such as pain. The use of appropriate pain assessment tools and management would be appropriate in these circumstances. Regardless of an individual's clinical trajectory and other factors such as their resuscitation status, reasonable actions should be taken to ensure that an individual is as comfortable as

possible, and any appropriate interventions have been taken. Given that at the time the pain was identified the cause was not known it would be reasonable to expect staff to utilise critical thinking to endeavour to identify the cause of the pain.

**If there has been a departure from the standard of care or accepted practice, how significant a departure do I consider this to be? How would it be viewed by my peers?**

It appears that the first mention of chest pain in this particular episode was on 31st [Month11]. Although clinical observations were documented it is not clear what further monitoring was carried out by the staff. The source of the pain hadn't at this stage been identified and could have been because of several issues including an event which was cardiac related. There was no evidence of any pain assessment and management in place and no monitoring of pain levels evident. In my professional opinion there was an absence of critical thinking. This is a serious departure from accepted practice and in my professional opinion would be viewed similarly as a serious departure from accepted practice by my peers.

**Recommendations for improvements that may help to prevent a similar occurrence in the future.**

- Staff development and education around the important area of critical thinking would be important.
- A greater understanding of pain assessment and management particularly in those that are less able to verbalise their level of discomfort or the source of the pain.

**6. Appropriateness/adequacy of the overall care provided to [Mrs A] at Remuera Rise.**

In reviewing this case I have been asked to consider a number of separate issues and to comment on each of them individually. However, in my professional opinion the clinical issues are all in some way connected and all will have impacted on each other to varying degrees. Furthermore, [Mrs A's] ongoing care needed to have been viewed in the context of her very advanced Parkinson's and reviewed accordingly in a timely manner as her function declined.

Throughout the documentation there was understandably, a strong focus on [Mrs A's] medications, but other important areas of care were not in my view, given the same emphasis. For example, what consideration was given to supporting [Mrs A] with her Parkinson's related hallucinations and to determining whether in fact there were times when she had a delirium secondary to an issue not directly related to her Parkinson's? In my professional view, there was limited documented evidence of a holistic view supported by critical thinking. This needed to be responsive to [Mrs A's] changing and varying needs as her Parkinson's Disease inevitably progressed.

Furthermore, in my professional opinion there didn't appear to be a documented agreed overarching plan in place such as an Acute Plan, an Advance Care Plan or Shared Goals of Care so that everyone had a mutually agreed understanding of what could and what should be provided in terms of care by the Facility and when hospital admission was appropriate.

In my professional opinion, in view of the apparent lack of critical thinking, the failure to document appropriately, including an agreed proactive approach to care for all of [Mrs A's] needs, I consider that there was a serious departure from accepted standards throughout which would be met with severe disapproval by my peers.

**7. Any other matters in this case that may warrant comment.**

In my professional opinion, greater consideration needed to be given to an early discussion with both the resident and the family about the important contextual issue of [Mrs A's] condition due to her Parkinson's Disease so that everyone could have had an agreed understanding of the most clinically appropriate and respectful approach to the care provided and to any ceilings of care if appropriate.

Finally, in my professional opinion and experience, the impact on the staff of lockdown and the national restrictions that were put in place following the Covid-19 outbreak at the time cannot be overstated. I note from documentation provided with respect to the initial period of lockdown that staffing levels remained stable at this time and this is to their great credit. In addition, access to external support and input from other agencies apart from the GP was likely to have been severely limited because of the restrictions on visitors in place.

**References.**

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2. Nursing Council of New Zealand. 2012, Code of Conduct for Nurses. Wellington, Nursing Council of New Zealand.
3. Health Quality and Safety Commission, Frailty Care Guides. 2019. Downloaded on 13/01/2020 from https://www.hqsc.govt.nz/our-programmes/aged-residential-care/publications-and-resources/publication/3818/
4. Carbone. F, Djamshidian. A, Seppi. K, Poewe W, 2019. Apomorphine for Parkinson's Disease: Efficacy and Safety of Current and New Formulations, CNS Drugs.
5. New Zealand Nurses Organisation. 2018, Guidelines for Nurses on the Administration of Medicines, Wellington. NZNO.
6. Ministry of Health, 2011, Medicine Care Guides for Residential Aged Care, Wellington, MOH.
7. Ministry of Health. 2017. Te Ara Whakapiri: Principles and guidance for the last days of life. (2nd edn). Wellington: Ministry of Health.

Richard Scrase.
Registered Nurse.

19th January 2021'

The following further expert advice was obtained from RN Scrase:

> 'Thank you for the opportunity to review this case again, particularly considering the extensive report and documentation provided by [Dr C]. In examining this case again I have considered the guidance given by the HDC alongside the documentation provided. In particular I have focussed on the action or actions in question rather than the intent or the outcome.
>
> In my original report and in this subsequent review, I have considered matters at the time they occurred, rather than with the benefit of hindsight. Furthermore, when considering the severity of any failure in practice, I have looked at each concern as a separate issue rather than comparing one issue's level of severity with another.
>
> I fully acknowledge the impact that covid has had on staffing across our health system and in particular ARC. I also fully acknowledge the registered nurse shortages across this sector which have been compounded by the pandemic. However, challenging though these issues are, it is my view that they cannot be considered a mitigating factor when examining overall quality of care. Furthermore, when staffing may be an issue then this is even more of a reason for documentation and care plans to be clear and up to date which is one of the reasons I have considered this aspect such an important focus.
>
> I accept that some of my peers may have differing views about the degree in severity of any departure in care. However, my professional opinion is that a departure from accepted practice in a number of the concerns raised below as a result of either unclear planning or management could have resulted in a poor outcome which is therefore reflected in my findings.
>
> Finally, I acknowledge and support the actions taken by the facility in terms of addressing this matter in addition to those mentioned in my original report.
>
> **1. The management of [Mrs A's] feeding and hydration.**
>
> In my professional opinion one of the fundamental aspects of good care is good documentation and good care planning which is updated to meet current needs and health conditions. I appreciate that [Mrs A] had made choices about her style of nutritional intake which made this aspect more challenging. In addition, I agree that she was being offered food and was at times declining it and also that she was nearing the end of her life. However, from my perspective what was missing was a clearly documented and consistent understanding of how [Mrs A's] nutritional input would be appropriately managed at whatever stage of life she was at. This would vary depending on whether somebody was for active treatment or for end-of-life care, but this needed to be agreed and documented. I therefore stand by my original view that this was a serious departure from accepted practice.
>
> **2. The management and administration of medications.**
>
> In terms of the overall management of the medications though I stand by my original comments. I totally accept the challenges faced by the facility in terms of [Mrs A]

accepting her medications, the significant time pressures that this would have created and the fact that this resident's husband was experienced with administering medications in a variety of forms when they were at home. However, [Mrs A] was admitted to an aged residential care facility because her care needs could no longer be safely met at home due to her deteriorating clinical and physical condition. Furthermore, [Mrs A's] condition was going to continue to deteriorate including her ability to safely swallow medications and as such, professional supervision of this aspect of her care provision was in my view paramount. I appreciate that [Mrs A's] husband appeared to want to administer and was also apparently comfortable administering her medications. However, this does not make it either safe or appropriate clinical practice particularly given the Registered Nurse on duty would be accountable for all medications administered and [Mrs A] was becoming more clinically complex as she declined in health and becoming more clinically vulnerable. I acknowledge that the documentation supplied highlights that medication was correctly charted and that it was documented appropriately. However, it was the management of the medications which was part of the question I was asked to comment on, and this was where I had concerns.

Having reviewed the original documentation and the additional information supplied, my professional opinion is therefore that this was a serious departure from accepted practice.

**3. The management of the oral thrush.**

Having reviewed the documentation and the comments made by [Dr C], I have not changed my original view, and consider this to be a significant departure from accepted practice.

**4. The management of the hand infection.**

I have again reviewed the original documentation and made note of the points raised by [Dr C]. Ultimately though I consider there to have been an issue with documentation. The question for me around nursing documentation in any setting is whether someone that was unfamiliar with an environment, or a particular patient or resident could carry out any intervention from the information provided. In this case, my view is that this should involve information about products, frequency of change to any product, outcomes and what specifically to be monitoring. From my perspective, there appeared to be a lack of documented clarity around these factors, and I therefore stand by my original conclusions.

**5. The management of the cough.**

I acknowledge the points made in [Dr C's] response about the cough. However, the lack of a care plan is in my view significant and goes above and beyond documenting events or GP actions. This is not about documentation just for the sake of it but it indicates that critical thinking is being utilised and that there is a consistent and cohesive management plan in one clearly defined location in the documentation. In view of this, I stand by my original view with respect to the management of the cough.

**6. The management of the injuries.**

In this section I focussed on the pain that was evident on and about the 1st [Month12]. I again acknowledge the input and comments of [Dr C] and agree that there were a number of areas where information around the aspect of [Mrs A's] pain was recorded. I would also agree with [Dr C's] views on the possible cause of the fractures. My concerns and comments are therefore about pain management and the documentation around this rather than the cause of the injury. In my view the fundamental issue remains about the lack of documented evidence of managing and monitoring pain in a consistent and objective way which goes beyond writing in the nursing notes and medication being given. Furthermore, even though it was not entirely clear whether the pain continued for several days or not, at the time the events occurred this would not have been known. Therefore, in my view, at the time a short-term care plan and a pain management chart would be appropriate. In view of this I stand by my original findings for this aspect of care.

**Appropriateness of the overall care**

As highlighted in my original report, my primary concerns lay around the medication management for [Mrs A] and the lack of a documented plan for specific aspects of her care. Addressing these early in the relationship may have avoided some of the later challenges. Clear documentation, care planning, and in this specific case, short term care plans for the specific areas mentioned above are a fundamentally important part of providing good quality care which is why they are such a strong focus in the audit process for aged residential care. They become particularly important in the ongoing pandemic and staffing shortage situation that ARC finds itself in, when clear care planning and documented and well communicated identification of ceilings of care are crucial for guiding staff, particularly those unfamiliar with a facility or resident.

Having reviewed the original evidence and the additional information provided by Remuera Rise and [Dr C], there was never in my view any evidence of neglect or a lack of compassion on the part of the facility staff. In my view it was also evident that the wishes of family members differed significantly at times from those of the facility in terms of appropriate interventions or the way ahead which in itself created significant challenges for a therapeutic relationship.

In my professional opinion though, the management of medications and clear and cohesive care planning is so important when supporting our most vulnerable older population that I stand by my original view that there was a serious departure from accepted practice.

Richard Scrase
Registered Nurse.

8th May 2022.'

## Appendix B: In-house clinical advice to Commissioner

The following in-house advice was obtained from Dr David Maplesden:

'**CLINICAL ADVICE — MEDICAL**

1. Thank you for the request that I provide clinical advice in relation to the complaint from [Mr A] about the care provided to his late wife, [Mrs A], by [Dr B]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors. I have reviewed the following information:

Complaint from [Mr A]

Response and care documentation Remuera Rise Care Home (RR)

Response and clinical notes [Dr B]

Patient Report Form [ambulance service] Clinical notes [Hospital 2]

2. [Mr A] complains about aspects of his late wife's care while she was residing at RR having been admitted there in 31 [Month1] under the care of [Dr B]. Those aspects of the complaint related to [Dr B's] care of [Mrs A] include:

Delays in diagnosis and treatment of oral thrush

Delays in diagnosis and treatment or a hand infection

Delays in diagnosis and treatment of aspiration pneumonia

Refusal to administer IV fluids when requested

Inadequate treatment of Parkinson's disease

3. [Mrs A] (B: [year of birth]) had [a long] history of Parkinson's disease (PD) which had progressed to end-stage. She was on a complex regime of anti-Parkinson's medication: apomorphine hydrochloride by subcutaneous infusion — 4.5mg/hour from 2300 to 0500; 5mg/hour from 0500 to 2300 with additional bolus doses as required for Parkinson's "off" periods[1] of 3.5mg with 30 minute lockout following. levodopa 100 mg + carbidopa anhydrous 25 mg tablet, (Sinemet 100/25) Half tab at: 0730, 1030, 1330, 1630, 1930, 2230, 0130, 0430 — One tab at: 0800, 1100, 1400, 1700, 2000, 2300, 0200, 0500 midodrine hydrochloride — 2.5mg PO TDS (0800, 1200, 1700). She was also taking domperidone for nausea, lactulose syrup, midazolam nasal spray (for anxiety/agitation) and Fortisip nutritional supplement (low BMI). She had previously suffered episodes of aspiration pneumonia secondary to swallowing difficulty associated with her PD but had declined avoidance strategies such as PEG or NG tube feeding. Normal oral intake was maintained with [Mr A] and his daughter assisting with the regular administration of

[1] "Off" periods are times when levodopa levels fall and, as a result, Parkinson's symptoms return. These can include both motor symptoms, such as tremor and rigidity, and non-motor symptoms, such as anxiety.

[Mrs A's] oral medications in tablet form or ground up and administered via syringe when swallowing was more impaired.

4. The RR response details [Mrs A's] care in the nine days between implementation of [COVID-19] precautions (23 [Month11]) and [Mrs A's] admission to [Hospital 2] (3 [Month12]). The response appears consistent with the contemporaneous clinical documentation and I will not reiterate it in any detail in this report. I understand expert nursing advice has been sought regarding the nursing aspects of [Mrs A's] care.

5. [Mrs A] apparently developed shingles in mid-[Month11] (left upper back) and was commenced on acyclovir on 18 [Month11] ([Dr B]). At the time she was completing a course of flucloxacillin for hand infection. GP notes dated 20 [Month11] include: *hands not seen but apparently resolving. Developed shingles, on acyclovir.* There was increasing difficulty administering [Mrs A] her oral medications from around 24 [Month11] despite remote assistance from [Mr A]. [Dr B] was notified of the situation on 27 [Month11] and together with RR staff he sought advice from the DHB neurology service with written and verbal advice provided: to attempt administration of usual medications and utilize additional boluses of apomorphine as required. The recommendations were conveyed to RR staff. [Dr B] states he discussed the recommendations also with [Mr A] (documented).

Comment: Management was consistent with accepted practice. [Mrs A] was on a complex anti-Parkinson's regime and it was appropriate to seek specialist advice when adherence to the original regime was difficult. There was no apparent indication given to [Dr B] that [Mrs A] required specific assessment, and remote consultations were recommended during [the COVID-19 lockdown] unless there was a clear clinical indication for face-to-face review. [Dr B's] notes on this date include a record of [Mrs A's] vital signs which were unremarkable.

6. On 28 [Month11] [Dr B] was advised that [Mrs A's] poor swallowing was persisting and interfering with her fluid and food intake and that [Mr A] had requested charting of SC fluid. [Dr B] charted SC saline 1000ml/24hrs PRN and this was commenced later that morning. [Mr A] and his daughter were given special dispensation to enter the facility to try and assist with [Mrs A's] medication administration from this date.

Comment: I believe it is a reasonable assumption that registered nurses in an aged care facility are familiar with signs and symptoms of significant dehydration and steps to take when a patient's fluid intake decreases including monitoring for dehydration (in particular, monitoring of fluid intake and output). I believe charting of SC saline on a PRN basis was consistent with accepted practice for management of reduced fluid intake in the aged care environment, provided the patient (or their legal authority) consented to the treatment (and [Mr A] had requested the treatment). I would expect nursing staff to notify [Dr B] if there were ongoing concerns regarding inadequate fluid input or output which might suggest sub-optimal hydration. If [Mrs A] was becoming increasingly dehydrated, I believe accepted practice (noting her co-morbidities) would be to establish with the patient/family the degree of intervention they were happy with

regarding further investigation of the likely cause of reduced fluid intake and treatment of dehydration. In my experience, it is not usual practice for aged care facilities to offer IV rehydration, and hospital admission is usually required if this intervention is felt to be appropriate. I note also that at the time of these events, GPs were discouraged from sending other than acutely unwell patients to hospital because of the Covid situation.

7. On 29 [Month11] [Mr A] reported that [Mrs A] had *yellow thick substance in mouth* and indicated she had a sore mouth. The clinical manager assessed [Mrs A] and noted yellowish plaques in her mouth with diagnosis of possible oral thrush. [Dr B] was notified and prescribed miconazole gel. Earlier that morning and later in the afternoon [Mrs A] suffered two episodes of transient loss of consciousness. Oxygen was provided on each occasion. It is not clear if [Dr B] was notified of these events.

Comment: [Dr B] prescribed appropriate treatment for [Mrs A's] suspected oral thrush once he was notified of her symptoms. There has been no contemporaneous GP record provided of this prescribing or the saline previously prescribed, but the prescriptions themselves are documented in Medimap and there is reference in the nursing notes to the management provided. Best practice is to document clinical advice/interventions in the GP notes as soon as is practical following the advice/interventions and [Dr B] might provide comment on his usual practice in this regard.

8. On 30 [Month11] [Mrs A's] condition appeared stable although she was still being administered supplementary oxygen. Oral intake remained poor and [Mr A] requested consideration of IV fluids. The RR response indicates there was discussion that hospital admission would be required if IV fluids were to be considered, and [Mr A] preferred a "wait and see" approach at this time. Around 0500hrs the following morning [Mrs A] complained of chest pain which responded to simple analgesia. Vital signs at this point showed hypotension (90/60) but normal pulse (74) and temperature (36.1). Care notes refer to [Mr A] reporting he remained *not keen on hospital admission.*

Comment: It is not apparent [Dr B] was notified of any deterioration in [Mrs A's] condition on 30 [Month11] and there was no opportunity for him to influence her management on this date. I note [Mrs A] was later diagnosed with rib fractures (see below) which could manifest as chest pain. However, in the absence of any documented trauma to [Mrs A's] chest wall, or notification of recurring complaint of unexplained chest pain, I do not believe [Dr B] had the opportunity to diagnose [Mrs A's] rib fracture prior to her admission to hospital.

9. On 31 [Month11] [Mrs A] was notified to have a recurrence of infective symptoms affecting her right hand. Swab was taken but could not be processed because of laboratory commitments to Covid testing. [Mr A] requested the infection be treated and [Dr B] was contacted with empiric prescription for flucloxacillin provided. SC fluids had been recommenced at this stage but then stopped at [Mr A's] request. Care notes suggest an overall improvement in [Mrs A's] general condition (*Appears more active than yesterday. Managed to drink 3 bottles of Fortisip*). There is no reference to any concerns regarding respiratory symptoms. Comment: Treatment of a skin infection with

oral flucloxacillin is consistent with accepted practice, and empiric prescribing is reasonable (ie no swab required) for uncomplicated wound infections[2]. It does not appear [Dr B] was informed of any additional concerns regarding [Mrs A's] condition on 31 [Month11].

10. On the morning of 1 [Month12] [Mr A] noted his wife had developed an intermittent phlegmy cough and he *verbalized that* [she] *might have pneumonia.* Nursing assessment was performed (temp 36.0, O2 sats 90% on 2L oxygen, P 74. Nursing notes include: *Advised* [Mr A] *that the other options is to send her to hospital but family is not keen on sending her to the hospital.* Later notes refer to [Mr A] having spoken with his wife's neurology clinical nurse specialist who had apparently recommended IV fluids and IV antibiotics and it was discussed such treatment would require admission to [Hospital 2]. [Dr B] was notified and attended about 1730 hrs to discuss management options with [Mr A] and his daughter.

11. [Dr B] includes the following points in his response in relation to [Mrs A's] management on 1 [Month12]: (i) He met with [Mrs A's] family in the presence of the senior nurse. *I told them I thought [Mrs A] was likely to have pneumonia. I said she was in the last days of her life without treatment. I said that any prospect of treating the pneumonia would require a hospital transfer. I also explained they had the option of comfort care at Remuera Rise*. (ii) *Mr and [Mrs A] were clear they did not want hospitalisation or active treatment. They were also clear they understood that [Mrs A] was going to die without it. I recall [Mrs A's daughter] getting upset when she realised that the lockdown meant they wouldn't be able to have a funeral. I emphasised that she would still get all measures relevant to alleviating distress … However, I would have sent [Mrs A] to hospital if [Mr A] and [their daughter] had chosen it.*

12. Following the meeting [Dr B] prescribed SC morphine to use for comfort cares. On 2 [Month12] he changed the antibiotic [Mrs A] had been administered for her hand infection to amoxicillin (indicated for treatment of community acquired pneumonia) at [Mr A's] request. [Dr B] said he was not contacted subsequently and was not involved in the eventual decision to send [Mrs A] to hospital. Accompanying GP notes are brief: *Very frail and withdrawn. I believe is palliative. Very little intake. Discussion husband and daughter. LDL* [last days of life] *Rx on chart.* Care notes are consistent with the response.

13. The RR response refers to [Mrs A's] condition being relatively stable on 2 [Month12] although she required administration of nebulized saline on occasions for relief of cough symptom (unclear if Covid PPE precautions were taken during use of nebulizer as per Ministry of Health guidance in place at the time). In the late evening [Mrs A] vomited with deterioration in her breathing status following this. After discussion with family, an ambulance was called and transported [Mrs A] to [Hospital 2] around 0100hrs on 3 [Month12].

[2] https://bpac.org.nz/BT/2013/June/infected-wounds.aspx Accessed 10 May 2021

14. [The ambulance] patient report form dated 3 [Month12] includes: *Hand over from nurse patient vomited once and now is short of breath, has been sick for a week doesn't know why, just has, doctors seen patient. but don't know what he diagnosed patient with, patient on saline neb, 3L oxygen. When asked what patient was diagnosed with by the doctor, told to ask family who were with patient. On arrival to patient, neb removed and turned off due to not being indicated under current [ambulance service] covid protol. A clear, B rapid, lung sounds pleuritic rub with diminished right side, sp02 82 on air, high flow 02 via nrb with surgical mask covering it applied. C strong radial, cool to touch, locked up with parkinsons, arms bent, only able to get palpated bp.* Vital signs were GCS 11/15, P 90, resps 40, BP 100/82, temp 35.5. [Mrs A] was transported to [Hospital 2].

15. On review at [Hospital 2], documented history (provided by [Mr A]) includes*: Last 1/52 seemed more deconditioned, not eating, not having enough sinemet as per husband as this results in her having a pronounced Left sided facial droop. Nursed by husband on Saturday and overnight to Sunday, given syringes of electrolyte fluid and fortisip, given medications on time, seemed to improve, more perky, talkative. Not had any solid food for >1 week. Dry cough for last 2/52, and occasional sore throat, shortness of breath seemed progress and acutely worse today. Today, since the morning stopped talking, seemed to deteriorate, ?had a vomit and then became SOB tonight. Ambulance called, on arrival [Mrs A] on 3L oxygen with salbutamol neb*. Vital signs were recorded as GCS 11/15, BP 95/58, P 98, O2 sats 99% (4L). Lung auscultation findings were: *anterior transmitted upper airways sounds with bibasal creps, worse on the right … clinical examination very dry, sodium of 160* [and elevated serum urea consistent with dehydration]. Chest X-ray showed an area of consolidation in the right lower zone and diagnosis was: *Aspiration pneumonia secondary to Parkinson's disease.* Covid swab was taken and IV antibiotics commenced (Augmentin) with cautious fluid replacement.

16. [Hospital 2] discharge summary dated 3 [Month12] notes [Mrs A's] death just before midnight on 3 [Month12] (death certificate lists direct cause of death as *multilobar aspiration pneumonia — 1 week*) and includes the following information: *[Mrs A] is [in her sixties] with late stage Parkinson's disease which she has lived with for [many] years. She was BIBA from the Private Hospital with SOB and hypoxia. History of being unwell for 1 week with reduced oral intake, less communicative and dry cough. Had not been able to swallow usual meds including sinemet. (usually her husband would spend many hours by her bedside and administer this). In view of the current [COVID-19] Alert and lockdown he has been unable to visit her as much … On arrival she was hypoxic sats 82% on air. Tachyponeic and hypotensive. Clinical findings were consistent with severe sepsis secondary to multilobar pneumonia, likely aspiration and dehydration with Na 160. CXR revealed multiple Right sided rib fractures which were new compared to the prey imaging in [Month8] (unclear how these were sustained) … During the subsequent days there have been discussions with the duty coroner regarding the case and unclear cause for rib fractures/possible neglect contributing to her death. It has been decided by the coroner that he will take jurisdiction and a post-mortem may be considered after discussions with her family. Police have been notified.*

17. Comment: [Mrs A] had advanced end-stage PD which was becoming increasingly difficult to control. Pneumonia is more common in patients with PD than the general population and is a leading cause of death in patients with PD[3]. It appears [Mrs A's] general condition deteriorated at a rate faster than that previously observed from around the time her family were unable (because of Covid restrictions) to provide the intensive support they had undertaken previously, particularly in regard to assistance with medication administration. It is difficult to state when [Mrs A's] pneumonia arose, but respiratory symptoms were apparent from 1 [Month12]. Noting [Mrs A's] co-morbidities and prognosis, I believe it was important to seek the views of family members when it came to formulating a plan to manage her deterioration. It was certainly very reasonable to take a comfort cares/palliative approach and the responses and clinical notes suggest this was the approach agreed between [Dr B] and family members with some concession given to trying to maintain hydration (SC fluids) and request for oral antibiotics. I believe the decision to defer [Mrs A's] hospital admission following discussion with family, and to put in place comfort care prescribing, was consistent with reasonable and accepted practice in palliative and terminal care. Had the family insisted on more aggressive management, it would have been equally reasonable to arrange hospital admission and this was done when the family made such a request late in the course of [Mrs A's] illness. By this stage, [Mrs A] had been in the terminal phase of life for a few days although notes suggest there was adequate control of pain and other end-of-life symptoms when [Mr A] consented to treatment. I believe the fact severe dehydration was diagnosed on [Mrs A's] admission to hospital is not an unexpected finding in an actively dying patient, and her diagnosis of pneumonia had already been discussed by [Dr B] as likely to be a terminal event. It is unclear if [Dr B] physically examined [Mrs A] prior to the discussion he held with family members. Under normal circumstances I believe examination was required together with documentation of the findings. However, during [the lockdown] remote assessments were encouraged unless a face-to-face assessment was likely to influence clinical management and, in the clinical scenario presented to [Dr B], it seemed apparent without formal clinical assessment that [Mrs A] was approaching the end of life and pneumonia was the most likely cause. If there was persistent unexplained pain as a symptom, further assessment for an easily reversible cause might have been considered. Under the circumstances I am not particularly critical if a formal assessment was not undertaken, but if it was undertaken and not documented I would be mildly critical of the standard of clinical documentation. However, I believe the discussion with family members around end of life care options for [Mrs A], indicating the decision they made was adequately informed, could have been better documented in this case. The important issue of events leading to [Mrs A's] rib fractures remains unclear but I do not believe this diagnosis reflects any deficiency on the part of [Dr B's] management of [Mrs A]. It does not appear possible to state when the fractures might have occurred and such fractures can occur with relatively minimal trauma (eg transfers) in a very osteoporotic patient.'

[3] Won J et al. Risk and mortality of aspiration pneumonia in Parkinson's disease: a nationwide database study. Sci Rep. 2021; 11: 6597