Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Deputy Health and Disability Commissioner

(Case 21HDC02016)

Introduction

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

2. The report discusses the care provided to the late Mr A by Te Whatu Ora Waitematā (Te Whatu Ora) (formerly Waitematā District Health Board[1]). The report principally focuses on the events surrounding an episode of Mr A choking on food, which ultimately led to his death. However, the report also recognises that Te Whatu Ora was responsible for meeting both Mr A's medical and disability needs for the duration of his four-day admission.

3. I express my sincere condolences to Mr A's family for their loss.

4. Mr A (aged in his eighties at the time of events) was born with intellectual disabilities owing to brain damage caused at childbirth. Mr A had dementia with behavioural and psychological symptoms of dementia (BPSD). He also had severe language impairment and minimal communicative capacity. Mr A had resided in residential care for the majority of his life and was dependent on caregivers for all activities of daily living. At the time of events, Mr A resided at a care facility for people with intellectual disabilities.

5. Mr A was at risk of choking and aspiration[2] from eating and drinking. He had a comprehensive eating and drinking plan (dietary plan), which provided that he was to

[1] On 1 July 2022, the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand. All references in this report to Waitematā District Health Board now refer to Te Whatu Ora Waitematā.
[2] A condition in which food, liquids, saliva or vomit is breathed into the airways.

receive only puréed or liquid foods, and that he had to be supervised at all times while eating.

6. Mr A was admitted to Waitakere Hospital with urosepsis[3] and possible pneumonia.[4]

7. On Day 5,[5] while an inpatient, Mr A was given non-puréed food, contrary to his dietary plan with the care facility. Shortly afterwards, Mr A appeared to be choking. He then became pale and unresponsive and subsequently suffered a respiratory arrest and died.

8. The following issue was identified for investigation:

- *Whether Te Whatu Ora Waitematā provided Mr A with an appropriate standard of care in 2021.*

How matter arose

Dietary plan

9. Mr A's dietary plan provided guidelines for all eating and drinking occasions, including mealtimes and snacks. The dietary plan stated:

> 'Risks: I am at risk of choking and aspiration from eating and drinking. If I see food close to me, I could grab it and try to eat it so you must ensure no food is left unsupervised around me.
>
> Supervision: I require full supervision from staff during the whole mealtime …
>
> My food needs to be: Smooth puréed
>
> How to assist me with food: I can self-feed for the most part. I may need you to load my spoon for the last bits of my meal. Sometimes I may need verbal prompts to eat at the correct pace. You need to supervise me at all times.
>
> My drinks need to be: Mildly thickened
>
> How to assist me with drinks: I need verbal prompts and encouragement to ensure I drink enough fluids each day. If I am not drinking enough fluids, then offer me jelly as I will usually eat that. I am at risk of UTI's,[6] so it is important I have lots of fluids …'

Emergency Department

10. By way of background to this particular hospital admission and the ensuing events, Mr A's caregivers at the care facility noticed that Mr A's catheter bag was not draining as usual, and that he had a 'wet sounding cough'. The impression was of a urinary tract infection and a

[3] Sepsis (an extreme reaction to infection) caused by infections of the urinary tract.
[4] Infection of the lungs.
[5] Relevant dates are referred to as Days 1–5 to protect privacy.
[6] Urinary tract infections.

possible chest infection. Mr A's caregivers arranged for him to be taken by ambulance to the Emergency Department (ED) at Waitakere Hospital.

11. A support staff member and the on-call manager of the care facility accompanied Mr A to the ED. On arrival, they provided the hospital staff with Mr A's medical history, including information about his dietary plan.

12. Te Whatu Ora acknowledged that the care facility provided it with all the relevant information about Mr A's dietary plan. Te Whatu Ora stated:

> 'The care facility staff also provided a folder which contained information to support the delivery of care to [Mr A] and was very clear on his dietary (purée diet and thickened fluids) and assistance with eating requirements.'

13. Mr A's dietary requirements were recorded in the ED admission note as follows: 'As per careworker: Is on thickened fluids and puréed food. Needs encouragement with feeding.'

14. Mr A was administered intravenous (IV) antibiotics to treat both the urinary tract and chest infections.

Assessment

15. At 2.58pm, an ED nurse recorded in the clinical notes that Mr A's 'past medical history' included:

> 'Severe Intellectual Impairment … Severe language impairment non communicative (few random words). Dependent on all cares … Dementia with BPSD … Poor liver function, therefore not to take paracetamol.'

16. Despite Mr A's medical history, the ED nurse assessed Mr A as being at 'no risk' of falling, 'independent' for purposes of 'moving and handling', with a 'normal' 'cognitive/mental state'.

Transfer to Assessment and Diagnostic Unit

Days 1 and 2

17. At 4.32pm on Day 1, Mr A was transferred from the ED to the Assessment and Diagnostic Unit (ADU) for a general medical review.

18. The ED nurse completed a 'Transfer From ED to ADU Handover' form. There is no mention of Mr A's dietary requirements in the handover form, but there is reference to Mr A's dietary requirements in the nursing shift notes on both Day 1 and Day 2.

19. At 11.32pm on Day 1, a nurse noted that the care plan included 'thickened fluids and puréed food. Needs encouragement with feeding'.

20. At 4.21am on Day 2, a nurse noted that Mr A was 'on puréed and thickened fluids as per clinical notes'.

21. At 10.11am, Mr A was reviewed by a house officer in the presence of Mr B, Service Manager at the care facility, who was visiting Mr A at this time. Mr A's condition continued to improve. The plan was for Mr A to be discharged the following day (Day 3), provided he was not feverish, and he was improving clinically. The nursing instructions were recorded as 'Soft/Purée Diet[7]'.

22. Mr B confirmed that the care facility provided all of the relevant supporting information to hospital staff. Mr B stated that copies of Mr A's dietary plan were presented to both the ED and the ADU nursing staff, and that the nursing staff 'took notes on the information'.

23. Mr B visited Mr A in hospital on Day 2. Mr B stated:

> 'I spent time with the nurses verbally orientating them to [Mr A's] support needs which included eating and drinking. When I arrived [Mr A] had a smooth puréed meal on his table and mildly thickened fluids. I talked the nurse through how we administer medication and observed her do it correctly. I met with the Doctors before I left and they said that [Mr A] was confirmed for Urosepsis and they were treating via antibiotic. They informed me his blood results show he seems to be responding well …'

Transfer to Ward 1

Day 2

24. At 9.02pm on Day 2, Mr A was transferred from the ADU to Ward 1 (a general medical/stroke ward) as an inpatient to enable the ongoing administration of IV antibiotics.

25. A nursing student completed a 'Transfer From ADU to Ward/Unit Handover' form, but this did not contain any information regarding Mr A's dietary plan or feeding requirements. The handover form was not countersigned by a registered nurse.

26. Te Whatu Ora stated that while Mr A was in Ward 1, a soft mechanical diet[8] was entered into TrendCare[9] and ordered for Mr A, instead of a puréed diet.

27. At 11.11pm, a nurse noted in Trendcare that Mr A required 'full assist with ADL's [activities of daily living] & meals', but there is no mention of Mr A's dietary requirements.

Day 3

28. Mr B visited Mr A again at approximately 1pm on Day 3. Mr B stated:

[7] A soft diet differs from a puréed diet in that foods can be puréed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. A puréed diet consists of food that requires no chewing.
[8] A texture-modified diet that restricts foods that are difficult to chew or swallow. Foods can be puréed, finely chopped, blended, or ground to make them smaller, softer, and easier to chew. It differs from a puréed diet, which consists of food that requires no chewing.
[9] A computer programme that allows staff to input data on the nursing care required by a patient, for each shift. Te Whatu Ora stated that TrendCare is not in use in ED or ADU.

> 'On the table I saw the leftovers of smooth purée diet but noticed he had normal water there. I reminded them that he should have mildly thickened fluids and they said they would make sure that is documented.'

29. At 2.49pm, nursing staff noted that Mr A appeared to be 'agitated when touched, pushing and punching', but the nursing notes (completed by a nursing student and countersigned by a registered nurse) make no mention of Mr A's dietary requirements.

30. The plan was for repeat blood tests to be done and for Mr A to be discharged the following day (Day 4) provided he was stable.

31. At 5.52pm, a nurse noted that Mr A was 'on purée diet & mild thick fluids … Full care, assist with meals & ADL's …'.

Transfer to Ward 2

Day 3

32. At 9.06pm, Mr A was transferred from Ward 1 to Ward 2 (an assessment, treatment and rehabilitation ward) as a medical outlier.[10]

33. Te Whatu Ora stated that the decision to transfer Mr A to Ward 2 was made as Mr A's clinical needs could be met by Ward 2 staff, thereby creating capacity for more acutely unwell patients who were awaiting inpatient beds in the ED and ADU to be transferred to Ward 1.

34. No handover documentation was recorded for Mr A's transfer from Ward 1 to Ward 2.

35. At 10.38pm, a nurse completed an admission assessment form and recorded Mr A's diet as 'Soft mechanical' on the assessment form. This was also recorded in TrendCare.

36. Unlike the previous assessment on Day 1, Mr A was assessed as having a 'history of falls' and requiring assistance with 'moving and handling', and his 'cognitive/mental state' was assessed as 'agitated'.

Day 4

37. At 11.15am on Day 4, Mr A was seen by the medical team on the senior medical officer ward round. Mr A was unable to be examined as he was unwilling to engage with the medical staff.

38. At this point, Mr A was noted to have a high concentration of sodium in his blood.[11] The decision was made to retain Mr A as an inpatient, continue IV antibiotics for a few more days, and to provide Mr A with electrolyte replacement and IV fluids.

39. Apart from a nursing note at 2.54pm noting 'needs [assistance] with feeding, eating and drinking satisfactory', the clinical records on Day 4 make no other mention of Mr A's dietary requirements.

[10] Patients who are treated under the intended medical team, but who are in a different area of the hospital.
[11] 155mmol/L. A 'high' concentration of sodium in the blood is defined as more than 145 mmol/L.

Day 5

40. On the morning of Day 5, Mr A was reviewed on the medical registrar ward round. Mr A's sodium levels were still high,[12] and he remained agitated and resistant, which made it difficult to take blood for testing.

41. The decision was made to administer Mr A with IV lorazepam[13] to enable blood to be taken. Mr A's discharge was postponed until the following day provided his sodium levels improved.

42. Clinical notes throughout the day shift document that Mr A required thickened fluids to take his medications, but that he was refusing all other cares. Staff noted that Mr A was 'moaning and groaning and pushing staff away'.

43. Between 5.45pm and 6.00pm on Day 5, a healthcare assistant (HCA) provided Mr A with his dinner. The HCA sat Mr A in an upright position, placed a food tray in front of him, and left to hand out dinners to other patients. The HCA was unaware of Mr A's dietary requirements. The HCA stated:

> 'As for [Mr A], I prepared him for dinner by sitting him upright on bed for safe feeding, placed his tray on his table. As I need to continue to serve the other trays to the patients, I also informed the nurse allocated to him that I will come back to feed him after I serve all the meals. All I know is that he needed assistance with feeding as he was unable to feed himself. I am not aware of the dietary/plan of each patient in the ward as I only serve trays delivered from the kitchen. I am not aware that [Mr A] is on a constant watch/supervision during his meals and he's high risk of choking.'

44. At approximately 6.20pm on Day 5, a nurse attended Mr A to administer his medication. She noticed that Mr A appeared to be distressed and activated the emergency bell. The nurse stated:

> 'I found him struggling and looked to be trying to cough. He had a meal in front of him. I used a spoon to remove chicken and cauliflower from his mouth. I checked his vital oxygen saturation level (OSL) that showed to be 55%. This was low and very concerning.
>
> I immediately hit an emergency bell to call for a Doctor and applied an oxygen mask to the patient. The Doctor arrived and I sat [Mr A] up and applied [back blows] by hitting him in the centre of the back with [an] open hand. More chicken came from his mouth.'

45. The emergency medical team, which included the on-call house officer, responded to the emergency call. With the assistance of the emergency medical team, Mr A's oxygen levels increased to 97%. A few minutes later, Mr A became pale and unresponsive, and the emergency bell was re-activated.

46. The medical emergency team administered back-blows in an attempt to free up Mr A's airways, but this had no effect. Mr A was administered oxygen, but his oxygen levels

[12] 154mmol/L.
[13] Medication to produce a calming effect.

continued to drop. Mr A's pupils became dilated, and no heart rate or breathing sounds could be heard.

47. Mr A was not for resuscitation, so no such attempts were made by the staff. Mr A was announced deceased at 6.33pm.

48. The house officer stated that he recalled seeing a plate of food with chicken and vegetables on it, in Mr A's room.

49. Following Mr A's death, the general medicine registrar recorded in the clinical records:

> '[I]n hospital there has been some discrepancy over what diet he has been receiving. He was apparently for soft/puréed diet as per ADU PAWR[14] documentation, however these are 2 different diets.'

50. A police constable was tasked by the New Zealand Police to investigate Mr A's sudden death. The constable stated:

> 'During this investigation it was found the Deceased was served solid food when he should have been served puréed or liquid food. This may have contributed towards his death.'

51. The Coroner determined the preliminary cause of Mr A's death to be an aspiration event secondary to a food bolus,[15] with respiratory arrest.[16]

Soft mechanical diet vs puréed diet

52. Te Whatu Ora's Dysphagia[17] — Dietary Texture Modified Food and Liquid Guidelines[18] (Food Guidelines) state that modification of the texture of food and liquids is an important aspect of the safe management of patients with swallowing problems and requires clarity and consistency of concepts/terminology to optimise the quality of patient care and maximise the safety of patients. The Food Guidelines state that puréed food has the following characteristics:

> '
> - It is prepared using a blender. It may require extra liquid to do this.
> - It is smooth i.e. contains no lumps/skins/texture.
> - It requires no chewing.
> - It should be moist, not sticky or dry. These foods should be served or coated with a thick sauce or gravy as necessary to achieve this.
> - It is cohesive, i.e. it must not separate into a liquid and a solid. A thickening agent may be used to achieve this.

[14] Post Acute Ward Round.
[15] A semi-solid mass of food.
[16] Absence of breathing.
[17] Swallowing problems.
[18] Issued in August 2020.

- It should hold its shape on a spoon and slide off in one mass when the spoon is tilted ...'

53. Te Whatu Ora explained that a soft mechanical diet differs from a puréed diet in that it is not of smooth consistency, it can contain 'lumps', and is soft to chew.

54. Te Whatu Ora stated that Mr A received a soft mechanical meal because this was the dietary description that had been entered by nursing staff on TrendCare, in both wards.

Recording and handover of information

Transfer between departments/wards

55. Te Whatu Ora accepted that the information in relation to Mr A's dietary plan was not handed over adequately between staff or documented clearly. Te Whatu Ora stated:

> 'Te Whatu Ora has policies that clearly document how information necessary to provide safe patient care is to be communicated between health care professionals. Handover of information is to occur verbally, visually (patient information board), electronically (e notes) and in written form (Trendcare). In [Mr A's] case information essential to maintaining his safety was not documented clearly or handed over between teams (ADU, [Ward 1] and [Ward 2] Teams) and individually.'

56. Te Whatu Ora stated that the process for ensuring that patients receive the correct diet 'starts at the front door', where the patient and/or caregivers can identify dietary preferences, such as vegetarian, gluten free, soft, and puréed. The nursing staff will notify the kitchen of any individual variances to a standard diet. Te Whatu Ora explained:

> 'On the wards this is done through Trendcare; in ED and ADU it is done either via email or phone call. It is expected special patients' dietary requirements are recorded in the clinical notes, in Trendcare, on the patient information board as well as included in the shift to shift handover.'

57. Te Whatu Ora stated:

> 'The fact that [Mr A] required a purée diet was lost in the handover between ADU and [Ward 1] and the ward staff did not use the folder of care provided by the caregivers to check his care needs, which included a note stating he was to be assisted with all meals. Patient meals are prepared in the hospital kitchen with specific dietary requirements based upon the information entered at ward level on Trendcare.'

Healthcare assistants

58. Te Whatu Ora stated that the responsibility for ensuring that patients receive appropriate food and fluid at mealtimes sits with the nursing staff. Te Whatu Ora said that in Mr A's case, the healthcare assistant was not provided with information about the specific oversight and support that Mr A required during mealtimes.

59. Te Whatu Ora stated that healthcare assistants are often asked to assist patients with meals, and there is an expectation that nursing staff will ensure that healthcare assistants have the information they require in order to provide safe care to patients.

60. Te Whatu Ora said that it is expected that healthcare assistants are included in the shift-to-shift handovers, and that they work under the direction and delegation of the registered nurses at all times.

Handover practice

61. Te Whatu Ora's clinical practices on Handover[19] (Handover Practice) states that effective handover is vital to achieve high quality communication of clinical information and transfer of care, and to protect patient safety. It also states:

> 'Each time clinical information is handed over there is an associated risk for the patient. With subsequent handovers, the magnitude of risk and potential adverse outcomes has been shown internationally to multiply. Inadequate communication of key information, at the time of transfer of care, is often a contributing factor to incidents.'

62. The Handover Practice states that clinical handover refers to the transfer of factual patient information from one healthcare provider to another, including risk assessment priorities. This may occur at the change of shift, and/or where a patient has a change of location or venue of care, being from the ED to another ward/unit.

63. The Handover Practice states that handover at the whiteboard using TrendCare handover sheets should involve all team members, and bedside clinical handover should include the nurses who have provided care, and those who are assuming care.

64. The Handover Practice states that handover of a patient occurs in the following manner:

> '• Verbally, from one person to another e.g. at shift handover;
> • Visually and verbally, including bedside handover;
> • Electronically, including paging, email, E referral via clinical portal where a patient has been verbally handed over e.g. the ADU to the ward; and
> • In written form in the clinical notes e.g. on handover sheets (Trendcare).'

<u>Handover expectations: nurse to nurse across services</u>

65. The Handover Practice states:

> '• Before a patient is transferred to another service, there must be a verbal telephone conversation between the nurse caring for the patient and the nurse expecting the patient in the new area. No patient may be sent without a telephone handover.
> • The nurse receiving the patient should know the patient will be arriving soon, have time to prepare the bed space to receive the patient and meet their needs …

[19] Issued in June 2021.

- Written handover notes should be reviewed to identify on-going care needs.
- When the patient arrives with a transit nurse, there should be a face-to-face handover.'

Handover expectations: team to team at shift changeover

66. The Handover Practice states that the handover expectations at the end of one shift and the beginning of the next shift are as follows:

'• An overall verbal handover of all patients requiring care i.e. all patients for the whole team. Work incomplete that needs to be done.
- A more detailed verbal handover of patients to person taking over direct care i.e. nurse/doctor allocated to these patients. This should include: patient name, age, and gender; current presenting condition; relevant history; patient condition at time of handover and general overall care; clinical risk factors include allergies/alerts; observations/recordings frequency; medications past and present — when next due.
- Visual handover is highly recommended i.e. departing person briefly introduces new person.'

Clinical handover best practice

67. The Handover Practice states that every clinical staff member must understand their role and responsibility for clinical handover. For nurses, there must be a bedside handover where the patient is viewed by the nurse assuming care with the nurse having provided care. The Handover Practice states that best practice is:

'• Handover should be client centred in a way that acknowledges the patient and includes them in the discussion
- Verbal handover is as important to validate the documentation
- Information in the clinical record must be easy to find and read
- All aspects of clinical process should be clear to all involved at all times — referral, assessment, goal setting, care planning, intervention, evaluation and discharge/ transfer of care.'

68. The Handover Practice states in relation to written notes:

'• Written notes must be completed at the end of each shift to which other staff can refer after verbal handover.
- Checklists and written updates provide important sources of information. [They] must be current and up to date.'

Adverse Event Review

69. Te Whatu Ora undertook an investigation of events and completed an Adverse Event Investigation Report. The key findings from Te Whatu Ora's investigation are as follows:

- There was a lack of clear documentation and handover of Mr A's dietary status/ requirements.
- There was a lack of provision of adequate supervision and assistance. Due to other duties, the healthcare assistant was unable to stay to help feed Mr A, leaving Mr A alone with his meal.
- Issues with the functionality of the TrendCare system. Te Whatu Ora found that when a patient moves between wards, a new 'encounter number' is generated on TrendCare. This causes the meal selection to default to a 'normal' meal and does not allow for any prior selected dietary requirements to be carried over to a new ward. Te Whatu Ora stated that 'unless checked by staff this will go unnoticed, as it did in this case'.
- Lack of dietary section on nursing forms. Te Whatu Ora found that a number of the nursing forms, including the 'Patient Transfer Handover' forms, lacked 'space' to enter the dietary requirements for patients. This means that any variation in dietary requirements is reliant on the staff verbally handing over this information.
- Some of the nursing forms have an incorrect dietary selection of 'Soft/Purée Diet', which is not one dietary selection, but two different selections.
- A review by a speech language therapist may have been useful in clearing up the confusion regarding Mr A's dietary requirements, although it should be noted that Mr A's specific dietary needs were longstanding.

70. During its investigation of events, Te Whatu Ora also made a number of incidental findings, which included the following:

- Paracetamol was prescribed when it had been noted at the time of Mr A's admission that due to poor liver function, he was not to take paracetamol.
- On Day 1, the nursing assessment noted that Mr A's mobility status was 'Independent', that he was 'Not a falls risk', and that he had a 'normal cognitive/mental state', when this was not the case.
- During Mr A's time in the ADU, entries in the clinical notes were made by a nursing student and were not countersigned by a registered nurse. This included the Patient Transfer Handover Form ('Transfer From ADU to Ward/Unit Handover' form).
- Due to the COVID-19 restrictions for visitors that were in place at the time of events, Mr A did not have his usual caregivers on site. This could have improved communication with the clinical team and provided further support around mealtimes.

Further information

71. Te Whatu Ora told HDC:

> '[Mr A] was admitted to Waitakere Hospital with a chest and urine infection, he had known disabilities that required support which his usual caregivers provided written information to facilitate the sharing of the required information. [Mr A's] dietary requirements were not accurately handed over from ADU to the inpatient area,

> resulting in an incorrect diet being ordered for him. The level of assistance [Mr A] required to eat was not clearly documented in the clinical notes and was not handed over to the staff delivering day to day care, and [Mr A's] needs were not cross checked with the written information provided by his usual carers. This resulted in a meal with an incorrect consistency being delivered to [Mr A] and inadequate supervision over the mealtime resulting in a bolus aspiration. The care delivered fell short of the expected standards as did the documentation of requirements to keep [Mr A] safe whilst he was in our care. We are sincerely sorry for the distress caused to [Mr A's] whānau and caregivers as a result of the events described.'

Responses to provisional opinion

72. Mr A's nephew and the care facility were given an opportunity to respond to the 'Introduction', 'How matter arose', and 'Changes made since events' sections of the provisional opinion.

73. Mr A's nephew told HDC that the staff at the care facility provided Mr A with 'intensely personal' services over a number of years, and that these events have caused significant distress to the staff at the care facility.

74. No comments were made by the care facility.

75. Te Whatu Ora was given an opportunity to respond to the provisional opinion and had no comments to make.

76. Te Whatu Ora again offered its sincere condolences to Mr A's whānau.

Opinion: Te Whatu Ora Waitematā — breach

77. Mr A was a vulnerable significantly disabled consumer who, tragically, choked and died while in the care of Te Whatu Ora. He was in his eighties at the time of events and had resided in a care facility for most of his life. Mr A had limited communication abilities, required assistance with all activities of daily living and was reliant on others to keep him safe.

78. Notwithstanding the unprecedented situation faced by the hospital during the COVID-19 pandemic (including the restrictions placed on patient visitations), it had a responsibility for supporting Mr A, and this meant meeting both his medical and disability needs within the busy hospital environment, and ultimately for keeping him safe.

Communication and documentation

79. When the care of a patient is being transferred between different individuals and teams, it is essential that clear communication occurs between all persons involved. This is particularly important in situations when patients are not able to advocate for themselves.

80. Mr A's caregivers provided the hospital staff with all of the required information to ensure the safe care of Mr A. This included information about Mr A's dietary requirements (that he

was to receive only a puréed diet, and that he had to be supervised at all times while eating). However, this information was not included in the handover documentation.

81. Mr A transferred wards three times during his relatively brief hospital stay. There was no reference to Mr A's dietary requirements on the handover documentation when Mr A was transferred from the ED to the ADU on Day 1, or when Mr A was transferred from the ADU to Ward 1 on Day 2. No handover documentation was completed when Mr A was transferred from Ward 1 to Ward 2 on Day 3.

82. While Mr A was in the ADU, his diet was inaccurately recorded as a 'soft/puréed diet' in the nursing notes. This is indicative of a communication breakdown during the handover process. It is this inaccurate information that resulted in the incorrect diet being ordered for Mr A in Ward 1 and Ward 2 (a soft mechanical diet instead of a puréed diet).

83. Where a patient transfers wards, and when multiple clinicians and teams are involved in their care, clear documentation and communication is the cornerstone of providing safe and effective care. This is even more important when the patient is as vulnerable as Mr A, and reliant on carers to attend to all needs.

84. Te Whatu Ora's Handover Practice clearly outlines the formal processes to be followed during handovers of care, and the information that should be included in the handovers (which includes 'general overall care; clinical risk factors [including] allergies/alerts'). The Handover Practice also states that handovers 'at the white board using Trendcare handover sheets' should involve all team members. Mr A's dietary requirements were not documented clearly and were not consistently accurate. Information was not communicated effectively when care of Mr A was being handed over between staff members and teams working in different departments/wards.

85. I am critical that there was a widespread failure by Te Whatu Ora staff to follow the Handover Practice, and to communicate Mr A's care effectively, particularly in relation to his dietary requirements. Multiple staff members failed to document Mr A's dietary requirements in the clinical records clearly and accurately, and/or verbally hand over this information.

86. The lack of effective communication and handover culminated in the healthcare assistant who provided Mr A with his last meal being unaware of Mr A's dietary requirements and the level of supervision he needed during mealtimes. This indicates that the healthcare assistant was not provided with the information that was needed to provide safe care for Mr A, and was not supervised adequately, which was not in line with the Handover Practice.

87. Further, I am concerned that staff members failed to identify the discrepancy in Mr A's diet when it was recorded as a 'mechanical soft diet' instead of a 'soft/puréed diet', and that they failed to recognise the distinction between these two forms of diet. In my view, this indicates a lack of understanding and knowledge about dietary requirements among multiple staff members.

88. Mr A's dietary plan with the care facility was clear that he was at risk of choking and aspiration, and that consequently, his food needed to be puréed, and he needed to be supervised appropriately. Mr A's dietary plan with the care facility was not adhered to, as he received non-puréed food, and he was not supervised appropriately. Ultimately, the services provided to Mr A were not consistent with his assessed needs, and I consider that Te Whatu Ora carries responsibility for that failure at a service level.

89. Te Whatu Ora accepted that the care delivered to Mr A fell short of the accepted standards, as did the documentation of the requirements to keep Mr A safe while in Te Whatu Ora's care.

Incorrect assessment and failing to consider medical history

90. On Day 1, Mr A was assessed as being at 'no risk' of falling. Mr A was also assessed as 'independent' for purposes of 'moving and handling', and his 'cognitive/mental state' was assessed as 'normal'.

91. Subsequently, on Day 3, Mr A was assessed as having a 'history of falls' and requiring assistance with 'moving and handling', and his 'cognitive/mental state' was assessed as 'agitated'.

92. As Mr A had intellectual disabilities and dementia with BPSD, and as he was dependent on caregivers for all activities of daily living, it is clear that Mr A was assessed incorrectly on Day 1. This was despite Mr A's medical history being made available to the staff by his caregivers.

93. Further, Mr A was prescribed paracetamol, when it was clearly documented in the clinical records on his admission that he should not take paracetamol due to poor liver function.

94. I am concerned that the staff did not consider Mr A's medical history appropriately during the assessment on Day 1, and when Mr A was prescribed paracetamol. This was important information that was either overlooked by staff or was not considered.

95. It was the responsibility of Te Whatu Ora to ensure that the health professionals caring for Mr A assessed and managed his risks appropriately.

Conclusion

96. Te Whatu Ora has an organisational responsibility to provide a reasonable standard of care to its patients, and to provide services to its patients in a manner consistent with their needs and that will keep them safe.

97. Mr A suffered fatal harm when his dietary plan was not adhered to on Day 5. I have considered whether any individuals should be held to account but conclude that because multiple staff members from different departments (ED, ADU, Ward 1, and Ward 2) failed to follow the appropriate procedures, it demonstrated a pattern of poor care, for which ultimately Te Whatu Ora is responsible at a service level.

98. I consider that Te Whatu Ora failed to provide services to Mr A with reasonable care and skill, and consistent with his needs, for the following reasons:

- Mr A's dietary needs were not documented clearly, and information was not consistently accurate;
- Mr A's dietary needs were not communicated effectively when care of Mr A was being handed over between staff members and teams working in different departments/ wards; and
- Mr A's medical history was not taken into account adequately, resulting in Mr A being assessed incorrectly on Day 1, and being prescribed medication that was contraindicated.

99. Accordingly, I find that Te Whatu Ora breached Right 4(1)[20] and Right 4(3)[21] of the Code of Health and Disability Services Consumers' Rights (the Code).

Other comment

100. This report highlights that hospital staff did not give sufficient attention to Mr A being unwell in an unfamiliar environment, isolated from his usual caregivers and his familiar day-to-day routine. Further, as referenced earlier in this report, Mr A was unable to communicate his needs to the various hospital staff caring for him. All these considerations required staff to adjust their usual practice to accommodate the unique situation they were faced with. I am not confident that this occurred. Understandably, Mr A became increasingly agitated as the days progressed. It does not appear from the information provided that hospital staff considered how Mr A could best be supported to help him adjust to this unfamiliar environment. There is no evidence of an all-encompassing care plan to guide staff in their interactions, and with the provision of cares. The absence of a support plan became even more significant as Mr A's hospital admission extended to the more substantive four days. I note, for instance, the decision to administer the calming medication, IV lorazepam, on Day 5 to enable blood to be taken. While I accept the importance of monitoring Mr A's sodium levels, it is disappointing that the medication was required and that alternative ways of calming Mr A and gaining his compliance for the blood test were not considered. This could have included consulting with disability service staff on strategies typically adopted for calming Mr A in situations like this. There is no evidence that the care facility was approached for advice.

Changes made since events

101. Since the events, Te Whatu Ora has made the following changes:

- The handover documentation has been reviewed and a field has been added so that the dietary needs of patients can be recorded.
- A multidisciplinary group, which includes staff from nursing, dietitian, and speech language therapy services, has been established to identify key learnings, and a programme of education at ward level has been planned.
- The wards that were involved in Mr A's care have been asked to ensure that dietary requirements are part of the shift handover. The wards must also ensure that the patient

[20] 'Every consumer has the right to have services provided with reasonable care and skill.'
[21] 'Every consumer has the right to have services provided in a manner consistent with his or her needs.'

information board correctly reflects both the patient's individual dietary needs, and any assistance they may require.

- The Charge Nurse Manager on Ward 2 has worked with her team to ensure that healthcare assistants are included in shift handovers. The healthcare assistants have been made aware that they need to check the patient information board, as well as with the registered nurses, regarding patient requirements.
- The COVID-19 Policy has been reviewed and updated to include a patient's primary caregiver in compassionate visiting considerations.

Recommendations

102. Taking into account the changes made by Te Whatu Ora, I recommend that Te Whatu Ora:

a) Provide training to all relevant staff (including healthcare assistants) on the handover processes and the handover practice expectations, including an awareness of the associated risks for patients each time clinical information is handed over. Evidence of this is to be provided to HDC within six months of the date of this decision.

b) Provide training to all relevant staff (including healthcare assistants) on the importance of the dietary requirements of patients, so that they are aware of the risks in failing to adhere to any dietary plans and/or restrictions. Evidence of this is to be provided to HDC within six months of the date of this decision.

c) Review the quality of clinical documentation generally across the various departments to ensure there is a robust system in place for staff to record the key disability/support requirements of patients accurately. Evidence of this is to be provided to HDC within six months of the date of this decision.

d) Arrange for Te Whatu Ora Waitematā's Disability Support Services team to consider other system-wide measures or interventions that would more effectively ensure that alerts are both activated and mandatorily followed when consumers/patients with identified disability support needs present to the ED, attend an outpatient setting, or are admitted to hospital. Evidence of any updated policies and/or procedures is to be provided to HDC within six months of the date of this decision.

e) Use an anonymised version of this report as a basis for staff learning at Te Whatu Ora and provide HDC with evidence that this has been completed, within six months of the date of this decision.

Follow-up actions

103. Te Whatu Ora Waitematā will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken. In making this referral, I have had regard to Mr A being a significantly disabled older gentleman who had extremely limited communication and required assistance with all activities of daily living. As such, I consider that Te Whatu Ora had an organisational responsibility for keeping Mr A safe. Over a four-day period, multiple staff members across a number of different hospital departments (ED,

ADU, Ward 1, and Ward 2) failed to provide services to Mr A with reasonable care and skill, and consistent with his disability needs. This ultimately resulted in Mr A choking and dying on Day 5, while in the care of Te Whatu Ora.

104. A copy of this report with details identifying the parties removed, except Te Whatu Ora Waitematā and Waitakere Hospital, will be sent to Te Whatu Ora, Whaikaha|Ministry of Disabled People, and Te Tāhū Hauora|Health Quality and Safety Commission, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.