Patient Journey

J is resident in a care home and suffers from dementia. A review completed by her social worker on 12th May 2020, identified an 8kg weight loss in 8 weeks. When the social worker questioned this, she was Informed by the Home that residents had not been weighed since the COVID-19 outbreak. A referral was made to the dietitian and the food and fluid charts were requested. The social worker was informed at the review that J was on hourly fluid charts, but the charts did not support this, nor did they say if fluids had been offered or declined by the person.

Immediate actions taken:

- A review of the records showed J had in fact lost 11kg since 3 March 2020.
- The social worker expressed her concerns to the deputy manager who identified that the food and fluid charts were not what they should be and were work in progress
- The social worker requested weekly updates from the Home
- The family were notified and told they would be kept updated
- Concerned at what she had found, the social worker reported her concerns via the Portal – an app allowing health and social care staff to report low level concerns to the CCG for the attention of the social care contacting team. An investigation into J's case was instigated.

Investigation findings

Residents are usually weighed weekly however, since lockdown for Covid 19 to ensure all residents remained safe and isolated as much as possible, a decision was made to hold off on weighing weekly unless there was a significant decrease in a residents dementia or a change in their eating habits. On 9th May 20202 it was agreed that J and some other residents needed to be weighed. They were supported to follow social distancing measures to ensure their safety, due to the scales being floor fixed and located in the centre of the Home.

J was weighed and a significant weight loss (8kg) documented. J had not eaten any less than usual and has always had a small appetite. As a result of the weight loss, discussions were had with the dietician, who advised the Home to continue to support J with meals and give a fortified diet, as well as fortified milkshakes. J's weight has continued to decrease despite eating what for J was considered a substantial diet. Food charts were in place; however, these were not always documented to a high standard, and did not include options offered to her when food offered were refused. J was on hourly fluids however, again refusal was not always documented. This appears to be due to the Home having new staff redeployed from day services due to day services being closed because of the pandemic and not being used to the paperwork.

A Multi-Disciplinary Team (MDT) meeting was planned to be organised to discuss future planning due to constant weight loss with, GP surgery, Dietician, Therapy, Social Care and Care Home Management as well as all family members.

As a result of the incident the following actions were undertaken by the Care Home provider:

- Continue with fortified diet as suggested by dietician
- Updates provided to social worker on a weekly basis
- Senior staff team to support with meals and record all meals offered, eaten and declined
- Staff to encourage fluid and record amount consumed and when refused
- Therapy to look at whether specialist seating is needed, so Home can look at how they can support J out of bed for meals
- GP completed a medication review and discontinued some medications
- Referral has been requested for Navigo
- MDT to be arranged to discuss future care planning

As a result of the MDT, which was held via Zoom, further actions were identified, which were:

- Continue weighing J weekly
- Blood tests to rule out any underlying causes
- Family to communicate directly with the Home
- Support to be provided to J for getting out of bed for mealtimes
- A socially distanced visit to be undertaken by the family the following week
- Continue to look at improving the paperwork used by the Home
- Continued support from dietician
- Assessment for specialist seating

At a further review last month, J's weight was more stable, and she remains on food and fluid monitoring, with the dietician still involved. J is now getting out of bed for lunch and remains out in the communal areas until after tea and then goes to bed. A specialist chair has been approved and the provision of this is in hand.

In an e mail received by the home afterwards from daughter, she said 'Excellent review*, I'm glad XX (the home) have confirmed having mam out of bed has improved her physically and emotionally. Which is what we was really wanting. We knew it was causing her to deteriorate. Hopefully mam will continue to be happy. Thanks very much for everything*'

Lessons learnt from this patient journey

- Record keeping is essential in all care settings and this patient story has highlighted the need to ensure that records are accurate and contemporaneous, due to the pandemic this was not observed on a regular basis leading to gaps in paperwork
- The need to review fluid / food balance on residents and to accurately record this on an appropriate chart.
- The need to maintain monitoring of resident's weight where it is required as part of a plan of care and to seek support for the dietician as appropriate
- To be aware of the overall effects of keeping residents isolated in their rooms has on their emotional and physical wellbeing
- To ensure that care home residents have their medication reviewed on a regular basis.

The lessons from the incident are being shared more widely through the bi-monthly Quality Matters bulletin. The contracts officers will build the lessons into their routine monitoring and consider adding to their visiting checklist as appropriate.