Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

A Decision by the Aged Care Commissioner

(Case 20HDC02394)

Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner.

2. The report discusses the care provided to Mrs A (aged in her nineties at the time of events) by Oceania Care Company Limited by Otumarama Care Centre (Otumarama) and Whareama Care Centre (Whareama). Both care centres were owned by Oceania Care Company Ltd at the time of the events.

3. Sadly, Mrs A died at Whareama in 2020.

4. This Office received a complaint from Mrs B about the care provided to her mother, Mrs A, at Otumarama Care Centre and Whareama Care Centre.

5. The following issues were identified for investigation:

- *Whether Oceania Care Company Limited (trading as Otumarama Care Centre) provided Mrs A with an appropriate standard of care from Month1[1] to Month3 (inclusive).*

[1] Relevant months are referred to as Months 1–5.

Names have been removed (except Oceania Care Company Ltd, Otumarama Care Centre, Whareama Care Centre, and the advisor) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *Whether Oceania Care Company Limited (trading as Whareama Care Centre) provided Mrs A with an appropriate standard of care, from Month3 to Month5 (inclusive).*

Background

6. Mrs A had several co-existing conditions, including extra-axial meningioma, [2] hypopituitarism, [3] gastro-oesophageal reflux disease (GORD), [4] macular degeneration, [5] osteoporosis,[6] dorsolumbar scoliosis,[7] recurrent falls, urinary tract infections,[8] lower limb cellulitis,[9] hearing loss, weight loss, anxiety, and frailty.

7. Mrs A's daughter, Mrs B, held an activated Enduring Power of Attorney (EPOA)[10] for Mrs A's personal care and welfare. Mrs B had been Mrs A's primary caregiver and support person prior to Mrs A requiring long-term care.

8. At 10.06pm on 13 Month1 Mrs A presented to the medical unit of the public hospital accompanied by Mrs B. Mrs B reported that her mother had been less responsive and had had increasing confusion over the past five to six weeks. Mrs A was admitted to hospital, and it was decided that because of her increasing needs, she could no longer live at home under Mrs B's care and should be transferred to a care home at a hospital level of care.

9. On 28 Month1, Mrs A was admitted to Otumarama for hospital-level care. At this time, as a result of COVID-19, isolation precautions were still being practised in care homes for new admissions.

Falls risk management

Falls Management policy — Oceania (issued 2012 reviewed Month2)

10. The purpose of the Falls Management policy is to 'minimise the occurrence of falls by identifying the risk of a resident falling and then managing that risk'. This policy covered both Otumarama and Whareama. The policy documents that all residents are assessed using interRAI,[11] and the falls risk is determined by a triggered CAP[12] or a registered nurse's observation of risk. A personalised falls management plan is developed following

[2] A type of brain tumour.
[3] Deficient production of growth hormones by the pituitary gland.
[4] A condition in which the acid from the stomach leaks up into the oesophagus (gullet) and causes symptoms such as heartburn.
[5] An eye disease that can blur central vision.
[6] A disease that weakens the bones, making them thinner and less dense than they should be.
[7] A condition in which the spine curves sideways in a C- or S-shaped curve.
[8] Infections in the urinary system.
[9] A common and potentially serious bacterial skin infection.
[10] A legal document in which a person (the donor, in this case Mrs A) appoints another person (the attorney — Mrs B) to make decisions on their behalf if the donor becomes incompetent. A doctor is required to provide a medical certificate outlining the consumer's mental capacity in order to invoke or 'activate' the EPOA. Mrs A's EPOA had been activated on 8 Month3.
[11] An interRAI is a suite of clinical assessments that is used to build a picture of a person's health and wellbeing needs.
[12] Clinical Action Protocol.

assessment. When a resident falls, they must be assessed for injury by the most senior health professional on duty prior to the resident being moved. The family and GP must be notified 'whether there is an obvious injury or not'. This may not be required immediately post fall but should be in the follow-up plan and the Falls Risk Assessment Tool (FRAT) [13] and an incident report completed. In an unwitnessed fall, or a fall that involves injury to the resident's head, this must be documented, and neurological observations must be taken for 24 hours, and a pain assessment undertaken for the following 48 hours.

Falls risk assessment — Otumarama

11. Mrs A was admitted to Otumarama on 28 Month1. As part of her admission, a FRAT was used to assess Mrs A's risk of falling. Mrs A's FRAT score was 9/20. Although this score indicates a low risk of falls, it was noted that due to the '[r]ecent change[s] in [Mrs A's] functional status and/or medications affecting safe mobility' she was instead assessed to be at a high risk of falling.

12. Additional information was taken from Mrs A's previous interRAI assessment, which noted her falls risk factors such as confusion due to hypoactive delirium, her need for assistance to mobilise, and her poor vision.

13. Falls prevention tools were thereby implemented, such as the use of sensor mat,[14] the use of a walking frame, suitable lighting, and ensuring that Mrs A's personal effects were within reach (including her call bell).

14. Progress notes on 18 Month2 document that risk-taking was observed by the physiotherapist, who noted that Mrs A was found to be standing unsupervised in her room adjusting the curtains, but the sensor mat had not been activated. Mrs A was directed back to her chair. The physiotherapist reinforced to her to use the call bell and that she was not to get up to walk without assistance as she was at a high risk of falling. The physiotherapist put the sensor mat in place and checked that it was working before leaving Mrs A's room.

Fall on 6 Month3 — Otumarama

Neurological observation guidelines (2014)

15. According to the guidelines, neurological observations are to be performed and recorded half-hourly for 2 hours, then hourly for 4 hours, then 6-hourly thereafter. The guideline does not specify whether there needs to be proof of a head injury. If neurological deterioration occurs, for example if the resident develops a severe or increasing headache or vomiting, this should prompt urgent reassessment by a registered nurse and then referral to hospital.

16. At 8.45pm on 6 Month3, Mrs A's sensor mat was activated, and a carer observed that Mrs A was standing next to her bed, unsupervised. It appeared that Mrs A had tried to get into bed but had lost her balance and had fallen, hitting her head. The registered nurse was informed, and Mrs A was assisted off the ground with the use of a hoist. Mrs A had sustained

[13] This tool identifies three levels of falls risk and gives an associated score. A score between 16 and 20 indicates a high risk of falls, whereas a score between 5 and 11 is considered a low risk of falls.
[14] An alarm is triggered to alert staff when the person stands on the mat.

a small bruise on the top of her head and a bruise on her left elbow. Neurological observations were performed and appeared normal. Mrs A did not vomit or complain of nausea. An ice pack was applied to her head. Mrs B was notified of her mother's fall at 9.05pm. In response to the provisional opinion, Mrs B stated that it 'was **not** a small bruise and caused [her] mum great discomfort' (Mrs B's emphasis).

17. Mrs A was commenced on a short-term care plan for the bruise on the top of her head. The size of the bruise was to be monitored and ice packs applied as tolerated.

18. Immediately following the fall, Mrs A's FRAT score was reassessed as 13.[15] Mrs A was commenced on regular neurological observations over a 24-hour period.

19. After Mrs A's fall, six entries in the progress notes over two days show that Mrs A appeared to complain of head pain:

- On 7 Month3 the progress notes document that Mrs A was 'a bit restless after 11am and [complained of pain] on her head'.
- On 7 Month3 at 1.22pm progress notes document that Mrs A looked 'weak and restless, nauseated and holding the front head …'
- On 7 Month3 at 4.48pm progress notes document that Mrs A appeared alert and oriented but refused to touch her head and verbalised pain. She was given paracetamol for pain relief.
- On 8 Month3 at 3.58am progress notes document that Mrs A was restless and showed discomfort but could not define her exact problem.
- On 8 Month3 at 10.48am the physiotherapist noted that Mrs A was 'not responding consistently or clearly to questioning and appears to grimace with movement'. When Mrs A was asked about her pain, she answered that she had bumped her head.
- On 8 Month3 at 11.45am progress notes document that Mrs A was drowsier than usual and was unable to hold her head upright.

20. In response to the provisional opinion, Mrs B queried: 'After 6 entries … why was no one more concerned?' Mrs B stated: 'I find that the whole period of observing mum in such pain and discomfort to be extremely concerning … How cruel to allow her to be in such pain, with a head injury.'

21. On 8 Month3, an ambulance was ordered to take Mrs A to hospital for further review, and Mrs B was informed.

22. Following Mrs A's fall, Mrs B had asked for her mother to be reviewed by the GP, in particular to check Mrs A's forehead, and for an X-ray to be taken to see whether her mother had sustained a fracture. Progress notes document that the registered nurse discussed Mrs B's concerns with the Clinical Manager. The Clinical Manager decided to keep Mrs A at the care

[15] Previously her FRAT score had been 9/20 but due to other factors she had been assessed as a high falls risk.

home and instructed the nurse to continue the neurological observations, as they were still within normal range, but to send Mrs A to the hospital if there were any further concerns. Mrs A was added to the list for a GP review on 8 Month3.

23. In response to the provisional opinion, Mrs B stated that she was not informed that her mother was unwell, or of her condition. She said that had she known, '[she] would have been more insistent for hospital'.

Emergency Department (ED) presentation and hospital admission 8 Month3

24. Mrs A presented to the Emergency Department (ED) at the public hospital at 12.12pm on 8 Month3 following her fall (at Otumarama on 6 Month3). ED notes state: '[Nursing staff] at [care] home unsure of situation — no one can tell me what happened.' Mrs B stated that she was told that Mrs A had been mobilising without assistance and had fallen and had complained of pain in her left elbow and forehead, and generally she had been unwell for the past week. Mrs A was diagnosed with long-standing delirium and a superficial head injury following a fall.

25. At 3.43pm on 11 Month3 hospital progress notes document that Mrs B did not want Mrs A to return to Otumarama as she felt that Mrs A's needs were not being met. A bed was found at Whareama, and Mrs A was discharged to hospital-level care there on 15 Month3.

Falls risk assessment at Whareama

26. There is no evidence that a FRAT was completed, or a short-term care plan developed when Mrs A was admitted to Whareama, given that she had just been discharged from hospital following a fall at the previous care home. There is also no evidence that other appropriate falls risk assessments were completed by staff at Whareama.

Nutrition and weight management — Otumarama

Oceania's Nutrition and Hydration policy (issued 2011)

27. Oceania's Nutrition and Hydration policy and procedures note that all residents are to be weighed on admission and at least monthly, or more frequently if clinically indicated. Weights are recorded on the Weight Monitoring Chart on eCase within a week of being weighed, and any abnormalities need to be investigated and noted in the progress notes. Before the end of each month, the Clinical Manager determines the residents at risk of malnutrition and delegates a registered nurse to follow up with these residents. Residents identified as a high risk of malnutrition are those with unintentional weight loss of more than 2% bodyweight in one month. According to this policy, each resident should have a specific weight range identified, as specific weight goals help staff to evaluate monthly weighs. If weight loss is greater than 2kg in one month, or the BMI is less than 18.5, this must be documented clearly, and family and the GP notified and a referral to the dietitian completed. Supplements such as Fortisip[16] can be considered and/or weekly weighs.

[16] A nutritional supplement in the form of a ready-made milkshake-style drink.

28. On 23 Month1, during her admission to hospital, Mrs A was assessed by a hospital dietitian. The dietitian noted that since her admission 10 days previously, Mrs A had lost 3.3kg and now weighed 44kg. The dietitian documented that this was a 'significant' weight loss and recommended that Mrs A be commenced on Fortisip twice a day, have weekly weighs, and continue to have assistance with her meals.

29. On her admission to Otumarama, specific care plans were created to address Mrs A's nutritional needs.

30. Mrs A's 'swallowing difficulties' care plan documented that she required a puréed diet and thin fluids, and that she required 'partial assistance' with her meals along with supervision and prompting throughout eating of the meal, and at times physical assistance. The care plan noted that she needed to be positioned correctly and that she could take a long time to chew her food and sometimes would pocket it in her mouth.

31. Mrs A's 'dietary' care plan documented that she was at a high risk of malnutrition because of her unsteady hands, poor coordination, poor vision, and confusion, and therefore she required supervision and prompting throughout eating of her meal, and at times physical assistance. To aid in supervision, she was also to be encouraged to have her meals in the dining room. This care plan also noted her allergies to onion and garlic, which caused vomiting and angioedema.[17] The goal in her dietary care plan was that she would 'maintain a healthy weight by continuing to consume food and fluids as provided'. Mrs A's medication chart contained an alert regarding her allergies to onions, garlic, and leeks and noted angioedema as the result if given these foods.

32. On 30 Month1 Mrs B informed the Clinical Manager in Otumarama that Mrs A had lost weight prior to her hospital admission.

33. On 9 Month2 Mrs A weighed 45.5kg (having lost 1.2kg in 10 days) and was commenced on a short-term care plan for weight loss. The goal of this short-term care plan was for Mrs A to maintain a healthy weight range, which was determined to be 44–47kg. The care plan noted interventions such as Fortisip, weekly weighs, and to follow the dietitian's instructions.

34. On 23 Month2, progress notes document that Mrs A had lost 1.8kg in one month and that the weekly weighs and food monitoring were to continue.

35. On 6 Month3, Mrs A was noted to have had further weight loss. She now weighed 41.1kg, and the GP was notified.

36. On 7 Month3, Mrs A was started on a 3-day food chart.[18] As of 8 Month3, when Mrs A presented to ED following her fall, the food chart had not been completed.

[17] Swelling under the skin rather than on the surface (similar to hives).
[18] A food chart is used to record quantitatively all food and drinks consumed as accurately as possible.

37. Mrs A's weight was tracked by Oceania over four months from 29 Month1 to 7 Month5 and is included as Appendix A. The table includes information about when and where Mrs A was weighed, whether the type of scales used was noted, and her weight difference between dates.

38. As reflected in the table, out of the 11 recorded weights, the following was noted:

- Otumarama weighed Mrs A eight times between 29 Month1 and 6 Month3.
- Whareama weighed Mrs A twice between 25 Month3 and 7 Month5.
- The type of scales (chair, hoist, or floor scale) was recorded once.
- Mrs A was not weighed at a consistent time and was weighed anytime between 7.30am and midnight.
- Mrs A's weight at postmortem was 35.5kg, a total loss of 7.9kg since 29 Month1.

Nutrition and weight management — Whareama

39. Following her hospital admission on 8 Month3, Mrs A was transferred to Whareama on 15 Month3.

40. A staff member who worked in the kitchen at Whareama stated that when a new resident is admitted, the registered nurse fills out a dietary profile for that resident. A copy of these profiles is kept in a folder in the kitchen. Staff are then verbally informed of the profiles and this information is also written on a whiteboard in the kitchen for all staff to see. A monthly allergen audit is completed for each resident with food allergies.

41. A carer from Whareama stated that Mrs A's meals came from the kitchen in separate containers with her name on them, as she had food allergies.

42. Progress notes from Whareama document that Mrs A had a small appetite, needed to be encouraged with food, at times was fed by her daughter, Mrs B, and was on the dietary supplement Fortisip. In response to the provisional opinion, Mrs B observed that at times, the Fortisip was 'too thick to drink', and '[f]or a person malnourished, there was little oversight to ensure the [Fortisip] was drinkable'.

43. The interRAI assessment on 20 Month4 documented that Mrs A was at a high risk of undernutrition. However, no evidence of any short-term care plans to manage her risk of weight loss have been provided to HDC. In response to the provisional opinion, Mrs B stated that she found this 'deeply concerning', and she was 'unaware of [her mother's] condition/weight being so bad'.

44. Following Mrs A's admission to Whareama on 15 Month3, her first recorded weight was 10 days later on 25 Month3, and one other weight was documented on 7 Month5. There is no evidence that Mrs A was weighed in Month4.

45. Oceania stated that Mrs A's marked loss of weight was not highlighted on the public hospital's discharge summary.

46. In response to the provisional opinion, Mrs B told HDC: '[P]lans around [Mum's] food were of a HUGE concern to me. I believed that to get mum the foods she was familiar with was important.' (Mrs B's emphasis.)

Communication — Otumarama and Whareama

Person Centred Care Planning Policy — Oceania (May 2010)

47. This policy recognises the resident's right 'to have family or a nominated support person to participate in the care decisions on their behalf'. The policy covered both Otumarama and Whareama. In response to the provisional opinion, Mrs B said that trying to participate in care decisions related to her mother was 'very trying' for her as she did not want 'to be accused of micromanaging the staff'.

Multi-Disciplinary Review Policy — Oceania (May 2010)

48. This policy notes that 'Oceania Healthcare actively encourages residents and/or their family/whānau or representative to have input into multi-disciplinary reviews'. The policy covered both Otumarama and Whareama. In response to the provisional opinion, Mrs B told HDC: 'At neither care home was I ever invited to go over this and discuss and finalize with anyone, although I was expecting to be invited to do so.'

49. The Age-Related Residential Care (ARRC) Services Agreement is a contract between Health NZ|Te Whatu Ora and aged residential care providers for delivery of services to older people. Oceania told HDC that both Otumarama and Whareama held an ARRC agreement with Health NZ. Section D4.1 (d) of the ARRC Services Agreement provides that 'each Resident … or the Resident's family/whānau or nominated representative [will be] involved in decisions affecting the Resident's life …'.

50. Progress notes indicate that Mrs B visited her mother frequently and was active in her care. Mrs B told HDC that she was concerned about the lack of communication from Otumarama and so expressed to the nursing care team at Whareama that she wanted more communication from Whareama regarding any significant changes to her mother's health, and any medication changes, test results, etc. On review of Mrs A's progress notes, there is evidence that Otumarama and Mrs B were in very regular contact with each other. Out of the 47 days Mrs A was a resident at Otumarama, there are 47 entries relating to communication with Mrs B, via either email, telephone calls, visits, or family meetings. In response to the provisional report, Mrs B said that in her opinion:

> 'Regular communication **does not** mean efficient or effective communication. It INDICATES some communication took place … Communication may have happened, but it was **NOT** always **EFFECTIVE**.' (Mrs B's emphasis.)

51. Mrs B told HDC that at times she felt that some of the nursing team at Whareama were not listening to her and would 'cut [her] off' if she tried to provide information about her mother. She also noted that she felt she was being 'fobbed off' and that some staff did not

want to hear her concerns, and she had the impression that the staff felt that they 'knew what was best' for her mother. Mrs B said that at times she felt she had to remind staff that she had been Mrs A's primary caregiver for at least 10 years prior to her admission and therefore had a good understanding of her mother's needs. In response, Oceania stated that its staff 'felt that they were providing the care appropriate for [Mrs A]' and noted that there is evidence in her progress notes that staff ensured that Mrs A's needs were being met and she was settled. A statement from a staff member noted that Mrs A was 'still capable to let [the staff] know her preferences, concerns, and other things' and that they 'always wanted the best for [Mrs A]'. In response to the provisional opinion, Mrs B noted: 'There were good staff, doing great care for mum, and I am truly thankful.'

Person-centred care planning — Otumarama and Whareama

Person-centred Care Planning policy (January 2020)

52. Oceania's Person-centred Care Planning policy documents that the person-centred care plan (PCCP) is based on 'comprehensive clinical assessments', and these assessments are used '[a]s the basis to discuss, define and document care strategies that are thorough, accurate, systematic and clear'.

53. An initial assessment is completed within 24 hours of a resident's admission. In the initial three-week period, a comprehensive interRAI is undertaken, which adds more information into the person-centred care plan. The person-centred care plan is then developed within three weeks of the resident's admission. Oceania stated that the person-centred care plan 'forms the foundation for the provision of the service delivery', and this process 'focuses on the uniqueness and individuality of each resident by placing the resident in the centre of the care process'.

54. Oceania confirmed that assessments and care plans in Otumarama were completed in a timely manner, in consultation with Mrs A and Mrs B. A review of Mrs A's clinical notes while she was a resident at Otumarama supports this assertion, with evidence of these assessments and care plans having been completed promptly.

55. However, as identified by Oceania, it could not provide any evidence that on her admission to Whareama any assessments occurred for Mrs A, or that a person-centred care plan was completed. Oceania said that this should have occurred within three weeks of her admission to Whareama and noted this to be a 'serious deviation from standard practice'.

Events on 9 Month5 — Whareama

Incident/Accident and Sentinel Event policy (March 2020)

56. Oceania's Incident/Accident and Sentinel Event policy provides that following an incident, all reasonable steps are to be taken to ensure that the situation is safe, and the resident is treated, and then the most senior person on duty and on call is to be contacted (if a registered nurse is not on duty). The event is then to be documented and the resident's family informed. Regarding sentinel events (an example of such being the sudden or unexpected death of a resident), an investigation is to be commenced as soon as possible

within 24 hours, and the process is to be completed within 20 working days and a corrective action plan created.

57. Mrs A's Advanced Care Directive noted that in the event of a gradual or sudden deterioration in her health, she would want to be kept comfortable and to die naturally with dignity in the care home.

58. Mrs A was at risk of Addisonian crisis, which is a life-threatening situation that requires the person to have a hydrocortisone injection as soon as possible if an oral dose of hydrocortisone has been missed. Mrs A was prescribed 20mg of oral hydrocortisone at breakfast and 10mg at lunch time. Her medication chart contained an alert noting: '[I]f unable to take oral Hydrocortisone **transfer immediately** [to] ED to avoid Addisonian Crisis [emphasis added].'

59. The GP reinforced this and noted that in the event of Mrs A being unable to take her oral hydrocortisone, she should have '**immediate** medical review with [**intravenous**] **hydrocortisone** being provided [emphasis added]'.

60. Progress notes document that the nursing staff had received a standing order[19] from the GP to transfer Mrs A to hospital immediately if she was unable to take her hydrocortisone tablet.

61. The progress notes also document that Mrs B informed nursing staff about the need to escalate Mrs A's care to the hospital for an intravenous dose of hydrocortisone if she was unable to take it orally.

62. According to Mrs A's medication administration chart, her breakfast-time dose of hydrocortisone was given around 8.00am and her afternoon dose around 1.30pm.

63. Mrs B and Mrs A's grandson visited Mrs A on the morning of 9 Month5 and expected to see her out in the lounge or dining room. When Mrs A was not there, Mrs B and Mrs A's grandson proceeded to her room where they were surprised to find her still in her room for breakfast instead of out in the dining room. Mrs B was informed about a note in the diary that read: 'Please leave [Mrs A] in her room [this was underlined] this morning — no church (requested by [d]aughter.' Mrs B agreed that she did not want Mrs A to attend church, but she told HDC that there was miscommunication, and that it was 'not usual practice' for her mother to be in her room for breakfast. Mrs B believes that Mrs A was 'forgotten about' in her room.

64. In response to the provisional opinion, Mrs B told HDC: 'This is WHY there needs to be a communication avenue for family members to [healthcare assistants] … It was a monumental stuff up!' (Mrs B's emphasis.) Mrs B said that she had suggested adding a communication book in Mrs A's room, with notes written by her 'to communicate [her] wishes when [Mrs B] was not there to speak for her, or if she was unable to speak for

[19] A written authorisation issued to staff by Mrs A's GP.

herself'. Mrs B stated: '[I]t may have prevented the miscommunication on [9 Month5] that ultimately saw my mum left in her room for breakfast, instead of breakfast in the dining [room] as usual …'

65. Progress notes on 9 Month5 documented that Mrs B was very concerned that Mrs A may have vomited up her morning dose of hydrocortisone over her breakfast tray. Mrs B told HDC that she almost had to 'beg' for a nurse to assess her mother. When she was attended to, she felt that the nurse was 'defensive' and 'not taking the matter seriously', and she noted that the nurse brought in the meal-tray paper and showed it to her to 'prove' her wrong. Mrs B was still concerned about her mother and asked for observations to be taken, which appeared to be within her normal limits. In its Serious or Sentinel Event investigation form, Oceania recorded that Mrs B stated that Mrs A had 'vomited her pills all over the breakfast tray'. The registered nurse spoke to staff and assessed that there was no vomit but some mucous. In response to the provisional opinion, Mrs B told HDC that she 'did not state anything about vomit all over [Mrs A's] breakfast tray … actually it was over her breakfast and [Mrs A]'. Mrs B stated that it was not mucous so much, as it was 'a lot of water [and] brown stuff'.

66. Mrs B was still very concerned about her mother and placed her in the lounge at around 1pm and then left the building. When a carer checked on Mrs A, she said that she was very hungry and so was given her lunch-time meal. Progress notes document that Mrs A was shaking, but her temperature was within normal limits.

67. At approximately 3.35pm, progress notes document that a carer asked the registered nurse to look at Mrs A as she was not responding to her verbally. The nurse assessed Mrs A, who could not answer when she was spoken to, and her skin appeared very pale. Mrs A was still breathing during this assessment. The nurse instructed the carer to stay with Mrs A and left to call an ambulance. The nurse returned 15 minutes later to record Mrs A's vital observations, but unfortunately Mrs A had passed away. Mrs A was then placed in her room and Mrs B was informed of her passing.

Further information

Oceania

68. Oceania told HDC that staff could access resident information across both care homes, via the shared eCase client management system. Oceania said that as Whareama and Otumarama were in close proximity to one another, some staff also worked across both care homes. Oceania expressed its 'deepest condolences to the family' and apologised for the experience Mrs A had at Otumarama and Whareama.

69. Oceania said that following receipt of Mrs B's complaint, it had the opportunity to review the clinical care provided at both Otumarama and Whareama. Oceania noted that it reviewed its policies to reflect best practice guidelines, and it is committed to improving and developing its clinical staff through dedicated aged-care education and training.

Responses to provisional opinion

Mrs B

70. Mrs B was given the opportunity to respond to the 'information gathered' section of the provisional opinion and her comments have been incorporated into this report where relevant.

71. Mrs B told HDC:

> '[I believe I] was judged [and] wrongly pigeon holed as a bothersome daughter, over protective, fussy … when in actual fact, [it] was about trying to get my mum the best care, and navigate a system in trying times of a pandemic. It was always my intention to empower my mum as best as I could … I was looking forward to a partnership with Whareama, so I COULD step back.' (Mrs B's emphasis.)

Oceania

72. Oceania was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations. It submitted that staff 'frequently updated [Mrs B] on any changes [in relation to Mrs A] but found overall communication difficult as [Mrs B] was unaccepting of some situations and therefore it was difficult to gain a true care partnership'.

73. Oceania also noted:

> '[I]t is accepted practice within our Oceania care [centres] that residents can choose to eat meals in their rooms. When they require overall supervision, it is expected that [a healthcare assistant] will provide in-room supervision and assistance in this instance.'

74. Oceania accepted the proposed findings and recommendations and said that it hopes that Mrs B 'can find resolution to her complaint' through this process.

Opinion: Oceania Care Company Limited (trading as Otumarama Care Centre) — breach

75. First, I acknowledge the distress that these events have caused Mrs A's family and offer my condolences for the loss of their loved one. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Otumarama Care Centre was appropriate, I considered in-house clinical advice from registered nurse (RN) Jane Ferreira (Appendix B).

Care provided at Otumarama Care Centre 28 Month1 to 8 Month3

Falls risk management

76. At the time of events, Mrs A was in her nineties and had several co-existing conditions, including macular degeneration, osteoporosis, dorsolumbar scoliosis, recurrent falls, urinary tract infections, hypoactive delirium, and frailty. She had been cared for at home by her daughter, Mrs B, but due to Mrs A's increasing needs, Mrs A was transferred to long-term

hospital-level residential care. She was assessed as a high falls risk, and several falls minimisation strategies were used to keep her safe, such as a sensor mat, ensuring that her personal effects (including her call bell) were in reach, and regular wellbeing checks by carers.

77. The Falls Management policy stipulates that if a resident is assessed as at risk of falling, then a personalised falls management plan is to be developed.

78. RN Ferreira advised that the appropriate falls assessments were completed for Mrs A in a timely manner, and that Mrs A's falls management care plan reflected the fall minimisation strategies in place.

79. RN Ferreira considered that there was no departure from accepted care in relation to falls risk assessments at Otumarama. I agree.

Fall on 6 Month3

80. The Falls Management policy notes that if a resident falls, they are to be assessed for injury by the most senior health professional on duty before they are moved. A falls risk assessment is to be completed post fall and, if it was an unwitnessed fall, or a fall that involved an injury to the resident's head, then neurological observations are to be commenced for 24 hours.

81. According to the neurological observations guidelines, if the resident shows signs of neurological deterioration, such as developing a headache, then an urgent reassessment of the resident is made and then they are to be referred to hospital.

82. After her fall, Mrs A sustained a bruise to the top of her head. Following her fall, over the next two days, Mrs A appeared to decline cognitively. Over those two days, Mrs A is recorded as complaining of pain on her head, appearing most restless, more drowsy, unable to respond clearly to questions, and then not being able to hold up her head. She was transferred to hospital and diagnosed with a superficial head injury.

83. RN Ferreira considered that the management of Mrs A's fall was appropriate in the circumstances, but the failure to recognise her gradual decline, post her fall, constituted a moderate to significant departure from accepted practice. RN Ferreira noted that while there were policies to guide nursing action, the nursing team did not consider Mrs A's underlying health and wellbeing factors in their post-fall management.

84. I agree and am critical that Mrs A's observed and reported decline over the two days after her fall did not trigger escalation to the hospital sooner.

Nutrition and weight management

85. Prior to her transfer to Otumarama, Mrs A had been admitted to hospital. While she was in hospital, the hospital dietitian noted Mrs A's poor oral intake and subsequent 'significant' weight loss. Her recommendations were to assist Mrs A with her meals, use Fortisip as a nutritional supplement, and do weekly weighs.

86. On her admission to Otumarama, Mrs A was assessed as a high risk of malnutrition due to physical deficits such as poor vision and poor coordination, and cognitive deficits due to confusion.

87. Care plans were developed to address these issues and included strategies such as assisting Mrs A with her meals, continuing a high-energy, high-protein diet, and commencing her on Fortisip. Mrs A's allergies to chives, leeks, and garlic were noted and the kitchen was informed.

88. According to the Nutrition and Hydration policy, residents are to be weighed on admission and at least monthly, or more frequently if clinically indicated. Mrs A was in Otumarama for just over five weeks and was weighed eight times.

89. RN Ferreira advised that Mrs A's nutritional and weight loss needs were assessed on admission to Otumarama in line with organisational policies, with evidence of various assessments and care plans to manage this.

90. RN Ferreira identified no departure from the accepted standard of care. I agree. It appears that the appropriate assessments were done, the dietitian's suggestions were followed, and Otumarama was responsive when Mrs A lost weight.

Communication

91. Mrs B was Mrs A's EPOA and previously had been her primary caregiver at home. According to the Person-centred Care Planning policy, family or a 'nominated support person' could participate in the resident's care decisions on their behalf.

92. This aligns with the Age-Related Care Agreement, which notes that the resident's family or 'nominated representative' can be involved in decisions regarding the resident's care.

93. Mrs B expressed that she wanted more communication from Otumarama regarding her mother's care. However, on assessment of Mrs A's progress notes, it is evident that out of the 47 days Mrs A was a resident at Otumarama, there were 47 entries relating to communication with Mrs B, either via email, phone calls, visits, or family meetings.

94. RN Ferreira advised that the level of communication met the minimum standard in the circumstances, and I agree. It appears that Otumarama was responsive to Mrs B's queries and concerns, and the care team included additional personalised strategies to assist the team to meet Mrs A's needs in a meaningful way. However, I acknowledge Mrs B's comments in response to the provisional opinion that in her view, while there was communication, this was not always effective.

Person-centred Care Planning policy

95. A person-centred care plan is to be developed within three weeks of a resident's admission, taking into account the initial assessment and a comprehensive interRAI.

96. RN Ferreira advised that Otumarama completed timely nursing assessments and developed a personalised care plan in partnership with Mrs B. RN Ferreira identified no departure from accepted practice. I agree.

Cortisone management

97. Mrs A was at risk of Addisonian crisis, which is a life-threatening situation that requires a hydrocortisone injection as soon as possible. Mrs A had been prescribed oral hydrocortisone twice a day, and the GP had documented clearly that if there was a suspicion that Mrs A had not been able to take her oral tablet, or may have vomited it up, then she was to be transferred to hospital immediately for a hydrocortisone injection.

98. As Mrs A's primary caregiver, Mrs B had understood this risk and had informed Otumarama. Mrs A's medication chart contained an alert with the instructions to transfer her to ED immediately if she was unable to take her hydrocortisone tablet.

99. RN Ferreira advised that the appropriate safety alerts and relevant clinical guidelines were in place at Otumarama, and therefore she identified no departure from accepted practice. I agree.

Conclusion

100. Following Mrs A's fall on 6 Month3, several entries in the progress notes indicate that Mrs A had pain in her head and was deteriorating. However, her care was not escalated to hospital until two days later, on 8 Month3. For this reason, I consider that Oceania Care Company Limited (trading as Otumarama Care Centre) did not provide an appropriate standard of care to Mrs A.

101. Accordingly, I find that Oceania Care Company Limited (trading as Otumarama Care Centre) breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[20]

Opinion: Oceania Care Company Limited (trading as Whareama Care Centre) — breach

102. I have undertaken a thorough assessment of the information gathered in light of the concerns raised. To determine whether the care provided by Whareama Care Centre was appropriate, I considered in-house clinical advice from RN Ferreira (Appendix B).

Care provided at Whareama Care Centre 15 Month3 to 9 Month5

Falls risk management

103. A FRAT is used to assess a person's risk of falling and categorises the person into low, moderate, or high risk of falls. This assessment then forms the basis of the falls risk care plan.

[20] Right 4(1) states that '[e]very consumer has the right to have services provided with reasonable care and skill'.

104. RN Ferreira advised that it is unclear whether the appropriate falls risk assessments were completed by the staff at Whareama. There is no evidence that a FRAT was completed, or a short-term care plan developed, given that Mrs A's recent fall had resulted in hospitalisation. There is also no discussion of safety strategies, given that Mrs A had been moved into a new environment, she had hypoactive delirium, she was frail, and she had had a recent fall.

105. RN Ferreira identified weaknesses in the nursing processes at Whareama and considered these to be a moderate to significant departure from accepted practice.

106. I agree and am critical that a vulnerable resident who had just been discharged from hospital following a fall had no appropriate falls assessments or planning in the form of a FRAT or a short-term care plan. In my opinion, this was a serious oversight by Whareama.

Nutrition and weight management

107. The interRAI on 20 Month4 documented that Mrs A was at a high risk of undernutrition. However, there is no evidence that a short-term care plan was developed to manage this risk.

108. Mrs A was admitted to Whareama on 15 Month3 and was a resident until 9 Month5. During this eight-week period, she was weighed only twice — once on 25 Month3 (10 days after her admission), and once on 7 Month5.

109. RN Ferreira advised that there is no evidence that appropriate nutrition assessments were completed on admission to Whareama, and although the interRAI on 20 Month4 documented that Mrs A was at a high risk of undernutrition, there is no evidence that a short-term care plan was developed to address this.

110. RN Ferreira advised that the management of Mrs A's nutritional needs during her time at Whareama was a significant departure from accepted practice, and the management of her weight loss was 'not in line with recognised admission and ongoing care responsibilities'.

111. I agree. I note that Oceania submitted that Mrs A's marked weight loss was not highlighted on the hospital's discharge summary. However, the progress notes from the hospital would have indicated this, and it is likely that Mrs A was visibly frail and underweight. I am critical that her weight was measured only twice at Whareama and that the first weight was 10 days after her admission. Again, in my opinion, this was very poor care of a very vulnerable resident.

Communication

112. Mrs B told HDC that at times she felt that she was not listened to by nursing staff and was 'fobbed off'. She said that she had to remind staff that she had been Mrs A's primary caregiver prior to her admission into the care home, so she had a good understanding of her mother's needs.

113. RN Ferreira advised that the level of communication between Whareama and Mrs B met the minimum standard in the circumstances, with opportunities for Whareama to improve its consumer engagement, care partnership, and documentation standards. While I accept RN Ferreira's advice, I am critical that it appears that Whareama did not endeavour to work in a more collaborative way with Mrs B, given her previous experience caring for her mother and that she was Mrs A's nominated representative.

Person-centred Care Planning policy

114. The Person-Centred Care Planning policy notes that an initial assessment should be completed within 24 hours of a resident's admission into the care home, and within the initial three-week period a comprehensive interRAI is to be developed and a person-centred care plan completed.

115. RN Ferreira noted that 'care plans provide guidance to the care team to ensure continuity of care delivery across shifts and are an essential part of the nursing process'. She advised that it is unclear how the nursing team could provide coordinated care to meet Mrs A's unique healthcare needs without a current person-centred care plan.

116. RN Ferreira noted that there is evidence that there were delays in meeting the timeframe of this policy, including delays in assessments and in some care plans being developed for Mrs A.

117. RN Ferreira identified a significant departure from accepted practice. I accept this.

Events on 9 Month5

118. Mrs A had been prescribed oral hydrocortisone to be taken twice a day, once in the morning and then again at lunch time. It was noted that if she was unable to take this tablet then she was to be transferred to hospital immediately to receive intravenous hydrocortisone, as she was at risk of Addisonian crisis.

119. The GP instructions on Mrs A's medication chart were that if she was unable to take her oral hydrocortisone then she was to be transferred to hospital immediately.

120. On the morning of 9 Month5, Mrs B was surprised to find Mrs A alone in her room, with her breakfast in front of her. Usually, Mrs A was fed in the dining room as she required supervision and at times assistance with her meals. Staff noted that Mrs B had asked that Mrs A be left in her room and not attend church. Mrs B asserted that this was a miscommunication, and that Mrs A was not to be left on her own in her room for breakfast.

121. Mrs B was also concerned that her mother may have vomited up her hydrocortisone tablet and asked a registered nurse to assess Mrs A. Although the vital observations were within normal limits, Mrs B still verbalised her concern that Mrs A did not take her oral hydrocortisone.

122. Mrs B told HDC that she felt that her concerns were not taken seriously, and she left Whareama reluctantly. Sadly, a few hours later Mrs A was found unresponsive in the lounge, and subsequently she passed away.

123. RN Ferreira identified some departures from accepted practice in relation to this incident. She advised that it was a significant departure from accepted practice for Mrs A to have been left alone in her bedroom for breakfast, given that Mrs A required assistance and supervision with her meals and should have been in the dining room so that she could be monitored more easily. I agree. Although Mrs A did not wish to attend church, she still should have been taken out to the dining room, as this was her normal routine.

124. Regarding Mrs B's concern that Mrs A vomited up her hydrocortisone tablet and therefore needed to be sent to hospital urgently, RN Ferreira advised that it appears that although Whareama staff were aware of the hydrocortisone alert, there does not appear to have been a care plan in place to guide staff in this situation. RN Ferreira considered this to be a significant departure from accepted standards. I agree. Given that there was an alert on Mrs A's medication chart indicating that she should be transferred to hospital immediately if she did not ingest her hydrocortisone tablet, I am concerned that staff appear to have been reluctant to follow this order. In my opinion, Mrs B's concerns were not taken seriously, and the correct procedure was not followed by Whareama.

125. When Mrs A was found to be unresponsive in the lounge, the carer immediately sought out the registered nurse. The nurse assessed Mrs A and then instructed the carer to stay with her. Unfortunately, while the nurse was calling for an ambulance, Mrs A passed away. RN Ferreira noted that the care team recognised that Mrs A was deteriorating and acted in a timely way to escalate her care to the hospital. However, RN Ferreira also noted that there is no evidence that first aid principles were applied, or an emergency bell activated, and it is unclear why Mrs A was left in the lounge and not moved to her bedroom for privacy. RN Ferreira considered these omissions to constitute a mild to moderate departure from accepted practice. I agree.

Conclusion

126. In summary, I consider that Oceania Care Company Limited (trading as Whareama Care Centre) did not provide an appropriate standard of care to Mrs A between 15 Month3 and 9 Month5, for the following reasons:

a) No falls risk assessments or a falls risk care plan were completed, despite Mrs A having just been in hospital following a fall.

b) Although Mrs A was identified as being at a high risk of undernutrition, no nutrition assessments or a short-term care plan were developed at Whareama to address this risk.

c) Mrs A had experienced significant weight loss prior to her admission to Whareama and required her weight to be monitored by weekly weighs. However, over the eight weeks she was in Whareama, she was weighed only twice.

d) According to Oceania's Person-centred Care Planning policy, new residents require a comprehensive assessment within 24 hours of admission, and a personalised care plan within three weeks of admission, to guide staff to provide consistent care and meet the unique needs of the new resident. However, this did not occur for Mrs A.

e) On 9 Month5, Mrs A was left in her room for breakfast, when her usual routine was to eat breakfast in the dining room, as she required supervision and assistance with her meals.

f) On 9 Month5, Mrs A was found unresponsive in the residents' lounge. However, there is no evidence of first aid having been given or an emergency bell activated, and it appears that no consideration was given to moving her to her room immediately for privacy.

127. Accordingly, I find that Oceania Care Company Limited (trading as Whareama Care Centre) breached Right 4(1) of the Code.

128. In addition, it was well documented that Mrs A was at risk of Addisonian crisis if she did not take her oral hydrocortisone, and therefore she was be sent to hospital immediately for intravenous hydrocortisone if her oral dose was missed. On 9 Month5 Mrs B expressed concern to staff that her mother may have vomited up her hydrocortisone, but Mrs A was not sent to hospital.

129. Accordingly, I find that Oceania Care Company Limited (trading as Whareama Care Centre) breached Right 4(4)[21] of the Code for failing to provide Mrs A with services in a manner that minimised potential harm to her and optimised her quality of life.

Changes since events

130. In early 2022 Whareama Care Centre was closed permanently. Otumarama Care Centre was closed permanently in August 2023.

Recommendations

131. I recommend that Oceania Care Company Limited (previously trading as Otumarama Care Centre and as Whareama Care Centre) use an anonymised version of this report as the basis for future training in its other care homes across New Zealand.

132. In the provisional opinion, I recommended that Oceania Care Company Limited provide a written apology to Mrs A's family for the issues identified in this report. The apology has now been sent to HDC and forwarded to the family.

[21] Right 4(4) stipulates that '[e]very consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer'.

Follow-up actions

133. A copy of this report will be sent to the Coroner.

134. A copy of this report with details identifying the parties removed, except the advisor on this case and Oceania Care Company Limited (trading as Otumarama Care Centre and Whareama Care Centre), will be sent to Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Timeline of recorded weights for Mrs A

Date and time	Location	Weight scales used	Weight	Weight difference
29 Month1 at 11.00am	Otumarama	Not recorded	46.7kg	
5 Month2 at 6.15pm	Otumarama	Not recorded	45.4kg	- 1.3kg
6 Month2 at 1.30pm	Otumarama	Not recorded	45.1kg	– 0.3kg
9 Month2 at 10.50am	Otumarama	Not recorded	45.5kg	+ 0.4kg
16 Month2 at 11.30am	Otumarama	Not recorded	44.9kg	– 0.6kg
23 Month2 at 6.00pm	Otumarama	Not recorded	44.6kg	– 0.3kg
30 Month2 at midnight	Otumarama	Not recorded	43kg	– 1.6kg
6 Month3 at 7.30pm	Otumarama	Not recorded	41.2kg	– 1.8kg
25 Month3 at 1.30pm	Whareama	Chair scale	43kg	+ 1.8kg
7 Month5 at 7.30am	Whareama	Not recorded	43.4kg	+ 0.4kg
11 Month5 at 1.00pm	Post-mortem examination	Not recorded	35.5kg	– 7.9kg

Appendix B: In-house clinical advice to Commissioner

The following advice was obtained from RN Jane Ferreira:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Oceania Healthcare. 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.

2. **Documents reviewed.**

Consumer complaint received 24 December 2020

Provider responses dated 3 May 2021 and 2 May 2023

Clinical file information including nursing assessments, care plans, monitoring forms, progress notes, GP records, medication prescription, health directives, and significant event investigation information.

Organisational policies including falls management, COVID-19 management, and related protocols.

Additional information received 3 May 2023 including clinical records, incident records and investigation reports, nursing assessments, care plans, observation records, equipment checks, medication prescription and administration records, communication records, meeting minutes, shift rosters, education, and training records, revised organisational policies with evidence of improvement initiatives.

3. **Complaint**

[Mrs A's] daughter [Mrs B] has raised concern regarding the care provided to her mother between 28 [Month1] and 9 [Month5] while resident at Otumarama Care Home and Whareama Care Home. Her concerns relate to delayed treatment, falls management, nutritional needs, clinical care, and communication.

4. **Review of clinical records**

For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future. In particular, comment on:

- Falls management, weight management and nutritional needs, medication management, communication, education and training.
- Any additional areas for comment.

Background

[Mrs A] was admitted to Otumarama Care Home on 28 [Month1] at hospital level of care. Her medical history included extra-axial meningioma, hypopituitarism, gastro-oesophageal reflux disease (GORD), macular degeneration, osteoporosis, dorsolumbar scoliosis, recurrent falls, urinary tract infections, lower limb cellulitis, hearing loss, weight loss, anxiety, and frailty. Prior to her admission [Mrs A] had experienced a recent respiratory tract infection and was diagnosed with a related hypoactive delirium, minor adrenal crisis, and acute kidney injury. File information shows that [Mrs A] required regular assistance from carers to meet activities of daily living. She had a very supportive family who were actively involved in her care. [Mrs A] experienced a fall event on 6 [Month3], and was transferred to hospital on 8 [Month3] with a suspected head injury. On 15 [Month3] she was discharged to Whareama Care Home for ongoing care and passed away on 9 [Month5]. I extend my condolences to [Mrs A's] family at this time.

A) Was [Mrs A's] falls risk adequately assessed with appropriate measures put in place to manage and/or mitigate her risk of falls.

Preadmission health information indicates that [Mrs A] had been assessed as a high falls risk due to her health history, noting variable levels of mobility and function. The interRAI assessment 16 [Month1] discussed associated falls risk factors which included posture and vision, a hypoactive delirium with altered mental state, and an unfamiliar in-patient care environment, noting that [Mrs A] required assistance at all times for safety.

[Mrs A] was admitted to Otumarama care home on 28 [Month1] and her falls risk was assessed by a registered nurse (RN) in line with the organisation's Falls Management policy. The Falls Risk Assessment Tool (FRAT) provided an initial risk score of 9/20, with recognition of additional risk factors resulting in a High falls risk status. An interim care plan was commenced which included a range of generic falls minimisation measures, which would be considered appropriate in the circumstances.

The Person-Centred Care Plan (PCCP) policy and Falls Management policy state that an interRAI clinical assessment will be completed within 21 days of admission, with data used to inform a long-term nursing care plan. File evidence shows that [Mrs A's] interRAI assessment was completed on 14 [Month2], which is within recommended timeframes. The Falls management care plan (section 10) reflects that falls minimisation strategies were in place, with evidence of input from [Mrs A's] daughter and EPOA, who was her primary carer while living in the

community. These include the use of a sensor mat, suitable lighting, the application of walking frame and bed brakes, and ensuring items of importance, including a call bell, were within reach.

The clinical record shows that [Mrs A] was regularly seen by a general practitioner (GP) or nurse practitioner (NP) during her admission. GP notes from the virtual admission assessment 29 [Month1] report a high falls risk status noting strategies were in place. File information reflects evidence of regular physiotherapist assessment and involvement in [Mrs A's] care. Physiotherapy notes 4 [Month2] acknowledge COVID-19 isolation requirements for new care home admissions, in line with pandemic measures at the time, with a proposed assessment timeline. [Mrs A] was seen by the physiotherapist on 18 [Month2] and assessed as a high falls risk. Physiotherapy notes describe observed risk-taking, noting [Mrs A] was standing unsupervised in her room to adjust curtains, and that the bell mat had not activated. [Mrs A's] care plan refers to completion of regular wellbeing checks by carers, in line with interventions in the Falls Management policy (5.2). The policy (5.5) provides guidance regarding the care and management of sensor mats, including mat safety checks per shift, actions, and reporting responsibilities for identified faults. It is unclear if these interventions were reviewed by the RN team following the identified risk and what additional safety measures were put in place to ensure call bell functions and safety needs were maintained.

[Mrs A] experienced a fall event in her bedroom on 6 [Month3]. File information shows [Mrs A] was assessed post-fall by an RN in line with the organisation's policy for the post-fall management of witnessed and unwitnessed fall events. There is evidence that neurological observations were commenced, and that communication and reporting requirements were completed, in line with recommended incident management responsibilities. As outlined in the manager's incident follow up, [Mrs A's] falls risk was reviewed by an RN on 6 [Month3] with suitable post-fall interventions in place and seen by a physiotherapist on 8 [Month3], prior to hospital transfer for assessment of identified decline.

The care record reflects that [Mrs A] was admitted to Whareama Care Home from hospital on 15 [Month3]. The provider has advised that [Mrs A's] continuous electronic care record was transferred from Otumarama care home to Whareama care home at the time. The PCCP policy (6.4.1) states that the care team are guided by the instructions in the care plan which is the basis for all care delivery. It is unclear what was communicated to the care team on admission regarding [Mrs A's] medical history, level of frailty, associated nursing care needs, and safety requirements.

Progress notes discuss [Mrs A's] arrival in the care home, outline her dietary needs and state she was a high falls risk however it is unclear from the submitted evidence whether nursing assessments were completed, or care planning

reviewed and updated, in line with organisational policies. It appears that baseline observations, specific dietary requirements and allergies were recorded however there is no evidence that a FRAT was completed, pain, mobility or skin integrity assessed, or a safety risk management plan considered given the recent fall event resulting in hospitalisation. An interRAI assessment was completed on 20 [Month4] and refers to the fall event 6 [Month3] which resulted in hospital admission, but there is no discussion of reassessed falls risk or reviewed safety needs, which would be considered accepted practice given [Mrs A's] identified frailty and associated health conditions. As outlined in the provider response, there does not appear to be a review of falls management and risk prevention strategies in care planning which would be accepted practice in the circumstances. In addition, there is no discussion of specific care and safety strategies offered to support [Mrs A], considering another change in her environment, diagnosed hypoactive delirium, recent fall, and frailty. Given the identified risk factors, accepted practice would be to develop a personalised, short-term care plan to support care and safety needs during the settling-in phase to the new care home. This is outlined in the organisation's admission processes, and Clinical Manager's Orientation Manual.

[Mrs A] was seen by a physiotherapist on 16 [Month3], with assessment comments referring to a markedly flexed C-spine, noting difficulties with posture and positioning. There is limited discussion in care planning regarding changes to her mobility plan, including associated nursing responsibilities to skin integrity and pressure injury risk assessments, pain management and related health needs. Progress notes indicate that [Mrs A's] level of mobility was improving, and physiotherapy notes 25 [Month3] discuss a trial of stand practice using a walking frame, but there is no evidence that a short-term care plan was commenced at this time to outline specific interventions and safety considerations.

From the evidence reviewed to respond to this question it appears that falls assessment and care planning processes met the required standards at Otumarama Care Home however there are identified weaknesses in nursing processes at Whareama Care Home. There appear to be opportunities for improvement in clinical processes and documentation standards regarding the completion of holistic and timely nursing assessments, care planning, and evaluation, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to significant.

b) Do the clinical notes indicate how often [Mrs A's] falls risk was assessed? When [Mrs A] fell in her room on 6 [Month3] at Otumarama Care Home, was the RN post-fall assessment adequate?

The PCCP policy states that nursing assessments (including falls risk) will be completed on admission, six monthly as part of the resident review process, and repeated as indicated, which is in line with accepted practice standards (HQSC,

2019). As outlined in question (A), file evidence shows [Mrs A's] falls risk was assessed by an RN on admission to Otumarama Care Home as part of the admitting nurse's responsibilities and reviewed again following her fall event on 6 [Month3]. GP notes from the virtual medical admission assessment 29 [Month1] record that [Mrs A] was a high falls risk, noting prevention strategies were in place. [Mrs A's] falls risk was also assessed by a physiotherapist at both care homes, with physiotherapy notes reporting that [Mrs A] was at high risk of falls.

The falls management policy provides guidance regarding post-fall responsibilities, which includes the review of a resident's falls risk. [Mrs A's] falls risk was reassessed by an RN on 6 [Month3] with a risk score of 13/20 (medium risk), noting that she had no previous fall history recorded. While checklist risk factors were selected, automatic high-risk factors were not selected on the tool, which presents a coaching opportunity regarding holistic nursing assessment. Post-fall neurological observations were completed across 6, 7 and 8 [Month3] in line with organisational policies in place at the time. Short-term care plans were commenced for the identified bruising which would be considered appropriate nursing practice in the circumstances.

A nutritional monitoring form was in place at the time due to weight-loss concerns, with evidence provided of limited oral intake during the timeframe in question. There does not appear to be evidence that pain assessments were completed at this time, however progress notes discuss the administration of prescribed as-required (PRN) pain relief (Paracetamol). File information shows care concerns were escalated by the nursing team to the GP with a post-fall review scheduled for 8 [Month3], and that a physiotherapist assessment occurred on 8 [Month3], which would be considered accepted practice.

From the evidence reviewed to respond to this question it appears that the post-fall assessment and related actions completed by the RN team on 6 [Month3] were appropriate in the circumstances.

- Departure from accepted practice: Nil

c) Was the delay in seeking treatment from the hospital appropriate? Please review the organisation's "falls" policies, "clinical incident/accidents sentinel events" policy, and "clinical escalation pathway" document and advise if staff actions aligned with policies at the time of the event.

The Falls Management policy in place at the time of the event provides discussion of falls risk assessment steps and care planning processes, with clear guidance about how to manage fall events and post-event responsibilities. The policy references the Health Quality and Safety Commission's (HQSC) Frailty Care Guidelines Falls Prevention resource which outlines steps for witnessed and unwitnessed falls (HQSC, 2019). The organisation's Falls Risk Assessment Tool (FRAT), located within the electronic care record, appears to provide relevant

prompts to guide event assessment, escalation, and reporting. The Falls Management policy provides reference to the Clinical Escalation Pathway, noting if changes are causing concern, to phone the GP/NP or 111 for an ambulance. The policy discusses post-event processes such as completion of falls analysis, corrective actions, benchmarking, and quality improvement interventions, in line with incident management and clinical governance requirements.

The Clinical Incident/Accidents Sentinel Events policy (2020) appears to provide guidance in line with relevant sector legislation and contractual requirements. The policy outlines organisational expectations for incident management standards, role responsibilities, reporting, education, and training requirements. The policy includes decision steps for event escalation and investigation with reference to timeframes, corrective actions, and event feedback.

As outlined in the provider response, the Clinical Escalation Pathway (2022) is a new process implemented in response to this complaint. The document references the revised Nga Paerewa Health and Disability Sector Standards, and the HQSC Frailty Care Guides, which are recognised clinical resources (HQSC, 2019).

From the information reviewed it appears the policy guidance in place at the time was appropriate to guide clinical decision-making in the circumstances. There is evidence that steps were commenced by the RN team to monitor [Mrs A's] post-fall status, however it is unclear if her underlying health status was considered as a contributing factor to the fall event, and subsequent decline.

The Falls Management policy states that if the post-fall assessment or neurological observations do not raise any concerns, that GP/NP notification may not be required immediately. Progress notes 7 [Month3] indicate that [Mrs A] was monitored overnight post-fall and appeared comfortable. However, an entry from the morning shift on 7 [Month3] states "*looks weak, restless, nauseated and holding the front of her head. RN assessed"*. The entry states that [Mrs A] was assisted with meals and ate a small amount, as evidenced on the nutritional record form. RN entries on 7 [Month3] refer to a bruise located on [Mrs A's] head, left frontal aspect, but report that [Mrs A] was alert, orientated and that neurological observations were within normal range. The entry states that [Mrs A] was restless after 11am, complained of pain and was given prescribed paracetamol tablets, however there is no discussion of a pain score, or evidence that a pain assessment was completed at this time. RN progress notes reflect that [Mrs A's] daughter expressed concern regarding falls-related injury and requested hospital transfer for an X-ray. The entry refers to RN escalation to the CM for senior nurse guidance which would be considered accepted nursing practice. Nursing entries reflect that a GP visit was scheduled for 8 [Month3], with a plan to continue observations and if signs of head injury or concern to send to hospital, which is in line with policy guidance.

A PM shift entry on 7 [Month3] states "*very less food, fluid intake".* The PM shift RN entry reports "*no complaints of nausea or vomit(ing), alert, talking normally, walking well in bedroom* ..." An RN entry from the nightshift reported that [Mrs A] presented with restlessness, showed discomfort, no reports of pain but that she was "*unable to define her exact problem".* There is no evidence that a pain assessment or wider nursing assessment was completed at this time. The entry states that a prescribed PRN antipsychotic medication (Quetiapine) was administered, however the rationale for this action is unclear. Prescribed pain relief (Paracetamol) may have been an appropriate intervention when considering associated risk factors, however medication administration records were not provided in the evidence bundle to inform further comment. It is unclear if [Mrs A's] vital signs, hydration status or elimination patterns were reviewed which would be considered accepted practice in the circumstances.

File information reflects that the incident report was reviewed by the business and care manager and an event summary completed, in line with incident management responsibilities. The event statement reports that the team were alerted (by a call bell) and found [Mrs A] standing on her sensor mat, saw her lose balance, fall, and hit her head. Post-fall steps are reflected, noting family and the GP were informed. Physiotherapy notes 8 [Month3] state that [Mrs A] presented with reported and observed pain, was unable to attain or maintain a sitting position, and was unsafe to attempt stand transfers. The incident report was updated the same day stating that [Mrs A] was drowsy, unable to sit unaided, and sent to hospital for assessment with query dehydration or injury-related concerns.

Progress note entries reviewed prior to the fall event indicate that the care team were concerned about [Mrs A's] health and wellbeing, discussing frailty, mood, reduced oral intake, irregular bowel patterns and safety concerns. An entry on 2 [Month3] refers to finding [Mrs A] kneeling on the floor and on 4 [Month3] that sensor mats were positioned on both sides of the bed, however it does not appear that monitoring frequency was increased at this time. Contributing factors selected on the event report include medical diagnoses, call bell not used, did not wait/ask for assistance. It is unclear whether the care record was reviewed by the leadership team for additional signs of concern, such as constipation, dehydration, or infection, to inform post-fall actions. There is no evidence of wider analysis of contributing factors or that a corrective action plan was considered, particularly relating to pain management and recognition of resident decline, which would be considered accepted practice.

From the evidence reviewed to respond to this question it appears that while relevant policies were available to guide team actions, it appears the RN team did not recognise signs of gradual resident decline as a contributing factor to [Mrs A's] fall event or consider underlying health and wellbeing factors in post-fall management. There appear to be concerns with post-event clinical leadership,

nursing assessment and pain management which would be viewed similarly by my peers.

The STOP AND WATCH tool partnered with the clinical reasoning guide would be considered a recommended resource to support RN assessment steps and related decision-making (HQSC, 2019). I note this has since been integrated into the organisation's new Clinical Escalation Pathway (2022).

- Departure from accepted practice: Moderate to significant.

d) Please review the notes, and comment if the communication between care home staff (in both care homes) and [Mrs B] (complainant) was appropriate and adequate, and why/why not?

File information reflects that [Mrs A's] daughter, [Mrs B], was her primary carer, advocate, and support person prior to admission to long-term care. As outlined in clinical assessment comments, [Mrs A] was well known to community health teams and her goal in [Month1] was to return to her home for ongoing care. Assessment comments discuss the challenges experienced during [Mrs A's] acute-care admission which impacted her wellbeing, referring to the COVID-19 pandemic and associated care and isolation measures, separation from family and health decline, followed by transitioning to a long-term residential care setting.

The Age-Related Residential Care (ARRC) Agreement and Health and Disability Service (HDSS) Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. The submitted organisational policies and procedures reflect the provider's responsibilities to ensure family/whānau were involved in resident care. The PCCP policy and Multidisciplinary Review Policy (2020) refer to admission responsibilities and resident review process, acknowledging collaboration between the care team, resident, their nominated representative, and family/whānau. File information indicates that usual care home admission interactions were disrupted due to COVID-19 pandemic measures in place at the time, and that restricted visiting impacted the care and relationship process.

The family/whānau communication record and progress note entries reflect that [Mrs B] regularly visited her mother and provided feedback to the care team regarding her mother's needs. [Mrs A's] care plan reflects EPOA review and input in [Month2], with the inclusion of additional personalised strategies to assist the team to meet [Mrs A's] needs in a meaningful way. There is evidence that case conferences were held on 22 [Month3] and 3 [Month4] following [Mrs A's] admission to Whareama Care Home however there is no evidence of further care plan review which would be considered accepted practice in the circumstances.

Email communications and the care record provide evidence of interaction between both care home teams and [Mrs B], as [Mrs A's] nominated

representative. Entries in the care record indicate the nursing team escalated concerns to the care home leaders, however, it is unclear if meetings were held between [Mrs B] and care home managers to discuss concerns and find resolution, in line with accepted communication and complaint management processes. There is discussion within the care record that case conferences occurred, however there is no evidence provided of meeting minutes shared with [Mrs B] in response to her concerns to outline agreed approaches to care decisions, plans or reviews, in line with the PCCP policy (7.2; 9).

As discussed in question (J), [Mrs B] expressed concern regarding the safe administration of prescribed medications on 9 [Month5]. Given her knowledge and experience as [Mrs A's] previous primary carer, it is unclear why the RN team did not respond to her request as EPOA, to seek medical advice or transfer [Mrs A] to hospital for further assessment, in line with appropriate service standards. [Mrs B] has discussed her experiences about interactions with care home team. The provider response has acknowledged [Mrs B's] concerns regarding professional standards of communication and conduct and discussed improvements made to organisational policy and processes. It appears the organisation's communication policy and complaint's management policy were not provided in the evidence bundle which would inform further comment.

From the evidence reviewed to respond to this question it appears the level of communication met the minimum standard in the circumstances. There appear to be opportunities for improvement with consumer engagement, care partnership and documentation standards in line with PCCP policy requirements, which may be viewed similarly by my peers.

- Departure from accepted practice: Mild to moderate

e) Was [Mrs A's] weight properly measured on admission to the different care homes, and regularly after, and is there a clear record of her weights? Do the clinical notes indicate which weigh scale was used each time her weight was measured, and is this documented in the notes in accordance with their "setting weight goals and interventions" document (such as time weighed, scale used etc)? If weight loss was recorded, did the staff take action, and if so, what?

File evidence shows that [Mrs A] was at risk of undernutrition as outlined in pre-admission assessments, and medical admission notes refers to weight loss. File evidence shows that [Mrs A] weighed 46.7kg on admission to Otumarama Care home. A short-term care plan to address weight loss was in place, 9 [Month2], with a goal to maintain a healthy weight range, in line with the organisation's "Setting weight goals and interventions" guidelines (Feb 2019). The weight monitoring chart reports that she was weighed six times during [Month2], noting her weight had declined to 43kg on 30 [Month2]. She was weighed again on 6 [Month3] with a further decline to 41.2kg reported. There is evidence of

evaluation provided, noting that a nutritional supplement was charted with weekly weighs in place per dietician instructions.

The long-term care plan refers to a goal to maintain a stable weight, noting that [Mrs A] will be provided with enough food and fluid of her choice, and be monitored for further weight loss. The care plan includes a list of likes and dislikes noting meal size as small due to a poor appetite, and that [Mrs A] was prescribed a nutritional supplement (Fortisip) twice daily. It notes that dietician input was not indicated at that time. There is no reference to the frequency of weighing, use of weight records and daily intake monitoring forms, or discussion of an evaluation plan. There is no discussion in care planning regarding the preferred use of weighing devices, however physiotherapy notes 25 [Month3] state that [Mrs A] was able to sit on a weigh scale (chair) which may indicate the approach used at the time. It does not appear that nursing information was reviewed or updated in response to the physiotherapist's mobility assessment at the time which would be accepted practice.

[Mrs A] was admitted to Whareama Care Home on 15 [Month3] however there is no evidence that an admission weight was recorded as part of nursing responsibilities. The weight tracker indicates that [Mrs A's] weight was first recorded on 25 [Month3] at 43kg, and again on 7 [Month5] at 43.4kg. There is no evidence provided that [Mrs A] was weighed during [Month4], which would be considered below acceptable standards when providing care for a vulnerable resident.

While progress note entries discuss nutritional intake, there is minimal discussion of weight management interventions or evidence of weight review by the RN team. The short-term and long-term care plans within the electronic care record commenced by Otumarama Care Home do not appear to have been reviewed post-hospitalisation by the admitting team at Whareama Care Home. There is no evidence that a short-term care plan was commenced by the admitting team in response to identified weight management concerns which would be considered accepted practice, as outlined in organisational policies.

[Mrs A] had been assessed as requiring hospital level care. Her care plan (1,10), 19 [Month2], reviewed 6 [Month3], outlined her mobility and transfer needs, noting [Mrs A] mobilised with a low walking frame and carer assistance. There is no discussion within the short-term or long-term care plans or physiotherapy notes about assessed preference for chair scale or hoist scale use as part of weight management.

The provider has submitted evidence of annual medical equipment checks completed by a service provider which includes performance tests of hoists, chargers, and batteries. File information shows that equipment at Otumarama Care Home, listed as a chair scale, hoist scale, and analogue floor scale, was

performance verified on 12/7/19, 28/7/20, 12/7/21. Equipment at Whareama Care Home, listed as a chair scale, hoist scale, digital scale was performance verified 16/7/19, 29/7/20, 12/7/21.

From the evidence reviewed to respond to this question it appears that the management of [Mrs A's] weight was not in line with recognised admission and ongoing care responsibilities while resident at Whareama Care Home. There appear to be opportunities for improvement in the clinical oversight of resident weight management, nursing assessment, care planning and evaluation, and documentation standards which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to significant

f) Whether [Mrs A's] diet and nutritional needs were properly assessed with an appropriate meal plan in place and was this in accordance with their "nutrition and hydration" policy? Were her food allergies properly documented and communicated to the staff?

Care home information indicates that [Mrs A's] nutritional needs were assessed on admission to Otumarama Care Home in line with organisational polices and processes. Her allergy status was reflected in E'Case information, relevant care plan sections, and on her medication prescription information in Medimap. Preadmission information in the home care interRAI assessment flags dehydration risk, with assessment comments reporting that [Mrs A] needed encouragement with all fluids and intake, required modified equipment, a nutritional supplement and was under the care of a hospital dietician. Nursing admission information reports that [Mrs A] was described by family as known to eat very small meals and received a high energy, high protein (HEHP) diet.

[Mrs A's] interRAI information reflects a risk of undernutrition with a BMI score of 19. The Nutrition and Hydration policy outlines care responsibilities with weight management, and guidance regarding unplanned weight loss with recognised interventions, in line with the HQSC Frailty Care Guide resources (HQSC, 2019). The care plan indicates that [Mrs A] was offered a HEHP diet with a nutritional supplement and file information reflects that her daughter was supportive with meal alternatives. The care plan (12) refers to food allergies and information-sharing with the kitchen team. The nutritional requirements form reflects allergies, noting a preferred small meal size with a weight-gain goal. Likes and dislikes were listed.

File information reflects that [Mrs A] was admitted to Whareama Care Home on 15 [Month3]. There is no evidence provided of nursing assessments completed on admission nor commencement of a short-term care plan to guide care and safety needs post-hospitalisation, during the settling-in phase to the new care home.

The interRAI assessment was reviewed 20 [Month4], which is outside of PCCP policy timeframes, and the long-term care plan was not updated in response to interRAI assessment findings, which raises concern regarding care planning practice and service delivery responsibilities. The interRAI assessment 20 [Month4] states that [Mrs A] was at high risk of undernutrition. There is no evidence that a new short-term care plan was commenced to manage her risk of weight loss. There is no evidence that further nursing assessment occurred, the GP was informed, or a dietician consulted. Given the identified nutritional risk it is unclear why the frequency of weight recording was not increased and associated monitoring forms commenced per policy guidelines.

The care plan (11, 12) states that [Mrs A] was allergic to onion and garlic causing vomiting and angioedema, and that kitchen teams had been informed of health and safety risks. Statements provided by kitchen personnel discuss the process of collecting resident nutritional information and communication of relevant data, such as published on a white board, which appears to be in line with policy guidelines.

File information reports an incident occurred on 23 [Month2] where [Mrs A] received the wrong meal. The manager's comment on the incident event reported that [Mrs A] had been monitored by an RN, remained well and that risk mitigation steps had been put in place. The care record 3 [Month3] reflects incident follow-up by the clinical manager. The entry states that a new process had been implemented by the kitchen manager to ensure correct meal service, however the care plan was not updated to reflect what this safety measure was. The PCCP policy (6.4.1) Handover: states that "*any changes to the resident care are the basis for all handovers. All care staff are guided by the instructions in the care plan which is the basis for all care delivery"* with reference to points (D10.1, D10.2, 16.3) of the ARRC agreement. It is unclear if a safety alert was communicated to the care home teams, if kitchen and nursing information was updated or if improvements were shared with [Mrs A's] EPOA, in line with policy and incident management processes.

From the evidence reviewed to respond to this question it appears the care provided to [Mrs A] was below the accepted standard in the circumstances. There appear to be departures in clinical oversight, nursing assessment, care planning, communication and documentation standards for at-risk residents which would be viewed similarly by my peers.

- Departure from accepted practice: Significant

g) Please review notes and comment what assistance [Mrs A] required in terms of giving herself meals. Was this properly recorded and adhered to by staff? Please review notes dated 9 [Month5] (day [Mrs A] passed away), and comment on the appropriateness of her being left alone in her room for breakfast.

The nursing care plan (12), 19 [Month2], states that [Mrs A] had an assessed malnutrition risk of 4, indicating High Risk. Care plan information refers to a six-month history of dysphagia (swallowing difficulty) noting that [Mrs A] ate very slowly with personalised equipment, that meals were a purée texture and that she required full assistance and prompting with food and fluid intake. The care plan (12) lists physical difficulties with eating and drinking including unsteady hands, poor coordination, and low vision but does not specifically mention [Mrs A's] stooped posture or provide guidance regarding safe, individualised positioning as identified in the physiotherapy assessment. The care plan (12) states that [Mrs A] will be positioned in bed or chair in readiness to eat, with food placed within reach, utensils placed in her hand with a prompt to start eating. The care plan states that during eating [Mrs A] "requires supervision and prompting throughout eating of meal", noting she may require physical assistance at times.

Assessment comments in the medical admission state "chin on chest, pocketing food", and to refer to Speech and Language Therapy (SLT) for advice on positioning, eating, and drinking. A specific care plan (2), 19 [Month2], was in place which provided further information about dietary requirements and safe swallow care. The assessment refers to a need for meal and drink assistance, noting some food spillage, pocketing of food in the mouth and long chew times. The care plan strategies state that during meals [Mrs A] required "supervision, prompting, and at times physical assistance", which is also reflected in care plan (12). Care plan (2) refers to assessed swallowing difficulties with generic risk strategies discussed such as upright positioning, offering a purée diet, thin fluids, and time, however there is no discussion of specific safety measures introduced to reduce [Mrs A's] risk of choking or aspiration, such as individualised positioning given her marked kyphosis, specific guidance regarding isolation and choke risk, call bell access or first-aid measures. Care plan strategies state to "go back and check on her, provide assistance as needed", however there is no evidence that interventions were reviewed between 19 [Month2] and 9 [Month5].

File information shows that [Mrs A] had been assessed as requiring close supervision and assistance with all meals, and progress notes and communication records indicate that [Mrs A] usually had all her meals in the residents' shared dining room where she could socialise and be safely supported. [Mrs B] has advised that during her visit on 8 [Month5] she informed the on-duty team that a family visit was planned for 10am 9 [Month5], and asked that [Mrs A] remain in the dining room after breakfast. Progress notes reviewed for the time in question do not reflect evidence of this communication request. It is unclear how information was handed over to the next shift in line with the PCCP policy, if a communication book or handover form was in use at the time or a verbal discussion was held between the teams on the day.

[Mrs B] has stated that she found her mother in her bedroom on the day in question and not in the dining room as requested. She has expressed concern at

finding [Mrs A] positioned facing away from the doorway, with no call bell available and her breakfast tray still present. It is unclear what shift planning occurred given the change in [Mrs A's] breakfast location, and what care and safety measures were discussed between the RN and care team as part of shift management responsibilities to ensure safe and appropriate service delivery. Recommended RN practise would be to ensure that a high-risk resident was supervised and well supported, as had been clearly outlined in [Mrs A's] care plan 19 [Month2], and that all unmet needs had been safely addressed prior to the planned family visit.

[Mrs A's] Advance Care Directive form, 22 [Month3], outlined her goals for care, which stated to have dignity, and included personalised information with prompts regarding her care needs such as 'I am not good at ringing my bell, be sure to check on me'. Orientation manuals and role resources refer to the PCCP policy and the Health and Disability Commissioner's Code of Rights, noting that care provided will be consistent with what is written in the person-centred care plan. The provider has acknowledged the lack of care planning in place at the time and apologised, with discussion of improvements made in response to learnings from this complaint.

From the evidence reviewed to respond to this question there appear to be significant concerns with clinical leadership, communication, documentation standards, and delivery of safe and appropriate care to [Mrs A] during the timeframe in question, which would be viewed similarly by my peers.

- Departure from accepted practice: Significant

h) Please review the incident forms from Whareama and comment if there was a choking incident that happened in the dining room recorded, which staff were involved, and any details about this incident.

The submitted incident record lists three reported events during [Mrs A's] admission which occurred in [Month2] and [Month3] while resident at Otumarama Care Home. There is no evidence of any reported incidents or associated discussion of a choking event within care record entries between 15 [Month3] and 9 [Month5] while [Mrs A] was resident at Whareama Care Home.

As a comment, care plan (2) provides strategies to reduce the risk of choking events, however there is no guidance provided regarding potential event management such as the application of first aid measures, incident reporting processes, and related nursing responsibilities to care and safety needs in line with organisational policies which presents an improvement opportunity.

i) Please review the "person centred care planning" policy, was this adhered to by the staff?

The Person-Centred Care Planning (PCCP) policy provides organisational guidance regarding resident assessment and care planning responsibilities with reference to sector legislation. The policy lists sources for data collection with timeframes for nursing assessment, goal setting, personalised care plan development, and evaluation in line with contractual requirements. The PCCP states that where progress is different than that expected, changes are made to supports in the care plan, in partnership with the resident and their family. The policy refers to the case conference review process, noting that the conference form and discussion points require a signature of acknowledgment from the resident or family members, and uploading to the electronic care record.

From the evidence reviewed it appears that Otumarama Care Home followed the policy guidelines, completed timely nursing assessments, and developed a personalised care plan in partnership with [Mrs A's] EPOA, however, as identified by the provider there appear to be delays in meeting organisational processes in line with the PCCP policy at Whareama Care Home. As outlined in the PCCP policy, care plans provide guidance to the care team to ensure continuity of care delivery across shifts and are an essential part of the nursing process. Progress notes within the care record evidence care occurring and entries provide examples of person-centred care delivery at both care homes, however it is unclear how the RN team were able to safely lead and provide coordinated care without a current care management plan, in line with evidence-based nursing principles.

- Departure from accepted practice: Significant

j) Whether the need for [Mrs A] to urgently go to the hospital if there was a suspicion that she did not ingest her cortisone tablet was well documented and communicated to staff? Was there an appropriate alert set up?

The care record reflects that [Mrs B] expressed concern to the RN team regarding the administration of Hydrocortisone medication and related care and safety responsibilities in [Month2]. An email dated 19 [Month2] was sent by the CM to the GP for clarification of a care pathway in the event that oral medication was not tolerated. Communication was received from the GP referring to the risk of an Addisonian crisis if Hydrocortisone was not administered. A GP letter dated 20 [Month2] stated that if [Mrs A] was unable to take oral hydrocortisone that she should have an immediate medical review and receive the medication intravenously. Alerts with this information were present on [Mrs A's] prescription in Medimap, the electronic medication system, with instructions to "*Take Hydrocortisone tablet with milk"* and *"If unable to take oral Hydrocortisone transfer immediately to ED (*emergency department*) to avoid Addisonian Crisis"*. Medical notes state to contact the GP if [Mrs A] was unable to take oral hydrocortisone to arrange alternative administration. This information is reflected in the care plan (11) that states "*[Mrs A] must have her Hydrocortisone doses at the precise times. Her daughter advises that if she is unable to take the*

hydrocortisone orally that she must go to ED to have it administered IV. She states that there is an alert on her hospital file for staff there to know what to give her".

The provider has advised that the care teams were all aware of [Mrs A's] allergy status, however it is unclear if they received any specific education regarding their clinical responsibilities. As identified, there is no evidence of care plan guidance commenced while [Mrs A] was resident at Whareama Care Home to support the RN and care team with safe decision-making.

From the evidence reviewed to respond to this question, it appears that safety alerts and relevant clinical guidance was in place while [Mrs A] was resident at Otumarama Care Home, however these documentation standards were not evidenced at Whareama Care Home. While alerts were noted in Medimap, medical notes and E'case information pages, there was no evidence of current care planning to guide [Mrs A's] healthcare needs. This would be considered a deviation from safe clinical practice, care responsibilities and accepted documentation standards, and viewed similarly by my peers.

- Departure from accepted practice: Significant

k) Please review the clinical notes and comment on whether the actions of the staff on 9 [Month5], where the complainant was concerned that [Mrs A] had vomited and therefore possibly not ingested her hydrocortisone tablet, were appropriate?

File information reflects that [Mrs B] expressed concern about unsupervised mealtimes, health presentation and safe medication administration to the duty RN on 9 [Month5], and questioned if [Mrs A] had received her prescribed dose of Hydrocortisone. Medication administration records 1–8 [Month5] show that [Mrs A] routinely received prescribed breakfast medications between 0804 and 0852hrs each day. Records show she received her prescribed dose, which included Hydrocortisone, at 0857hrs, on 9 [Month5]. The prescription shows that timing for the second dose of Hydrocortisone was ordered at "1300–1500hrs". Medication administration records 1–8 [Month5] show this dose of Hydrocortisone was routinely given after 1400hrs, and that she received the charted dose at 1427hrs on 9 [Month5].

[Mrs B] has discussed delayed nursing assessment and interventions. A carer entry from the AM shift on 9 [Month5] reports that [Mrs A] had some discomfort from the morning, ate very little food and that the RN was informed. RN progress notes reflect [Mrs B's] concern with [Mrs A's] wellbeing, discuss RN consultation with the care team regarding accounts of vomiting, with evidence that vital signs were recorded, however there appear to be discrepancies in the completion of a holistic nursing assessment and recognition of resident decline.

As discussed in question (J) medication records had a safety alert to prompt RN actions regarding Hydrocortisone management, however it is unclear if the duty RN was familiar with [Mrs A's] original care plan and associated interventions. Given [Mrs B's] previous background and knowledge as [Mrs A's] primary carer and her expressed concern regarding the possibility of a missed dose of hydrocortisone, it is unclear why the duty RN did not seek GP/NP guidance as outlined in [Mrs A's] plan of care ([Month2]) or consult the on-call clinical lead for support, in line with organisational policy.

From the evidence reviewed to respond to this question it appears the care provided to [Mrs A] was below the minimum standard in the circumstances. While progress notes provide event comment, there is no evidence of risk assessment, supportive interventions, care collaboration or escalation which would be considered accepted practice in the circumstances.

- Departure from accepted practice: Moderate to significant.

l) When [Mrs A] appeared to be deteriorating on 9 [Month5], were the actions of the staff appropriate? Were their "clinical incident/accidents sentinel events" policy and "clinical escalation" pathway documents adhered to?

Clinical file information reflects that a carer alerted an RN at 1535hrs that [Mrs A] was not responding verbally and sought support, which is in line with recommended practice for signs of acute deterioration, organisational policies, and procedures (HQSC, 2019). RN progress notes state that [Mrs A] appeared very pale, was breathing but was not responding to spoken word. It is unclear if the emergency bell was activated for team assistance, in line with incident management processes. There is no discussion of first aid principles applied or assessment of vital signs at this time.

Progress notes indicate that an ambulance was urgently called, and a second RN assisted in preparing transfer documentation. It is unclear why [Mrs A] was not transferred from the resident lounge directly to her bedroom for privacy, further nursing assessment and care at this time. Progress notes state that the RN returned to the lounge to record [Mrs A's] vital signs at 1550hrs and found that [Mrs A] appeared to have passed away.

[Mrs A's] Advance Care Directive form, 22 [Month3], elects that 'in the event of gradual or sudden health deterioration, which is deemed irreversible, to be kept comfortable and … allow me to die naturally with dignity and without pain or distress'. Progress note timeframes indicate the event evolved quickly which can be challenging to coordinate. It appears the RN promptly sought paramedic and peer support, and file information indicates that a carer remained with [Mrs A] until her family could be present which shows respectful care.

The Incident/Accident and Sentinel Event policy that was in place at the time (March 2018–2020), included guidance for managing serious events and investigation process. It appears the RN team informed [Mrs A's] EPOA, GP and care home leaders who commenced a significant event investigation. The policy

states that a corrective action plan will be written, implemented, and evaluated until "closed", with a requirement for post-event evaluation, however a completed corrective action plan outlining the agreed improvement steps was not submitted in the evidence bundle. The provider has advised that the adverse event investigation process undertaken at the time was not robust with no specific actions identified. The organisation's clinical processes have reportedly been reviewed and the Clinical Escalation Pathway was implemented in May 2022, in response to learnings and improvement related to this complaint.

From the evidence reviewed to respond to this question I consider the care provided to [Mrs A] by the afternoon team on 9 [Month5] to be acceptable given the timeframe in the circumstances. It appears the team recognised signs of decline and acted in a timely way. There are identified opportunities for strengthening acute care decision-making, communication and end of life care processes which would be viewed similarly by my peers.

- Departure from accepted practice: Mild to moderate

m) Please review any information regarding what education is provided for care staff and RNs surrounding acute incidents and medication management.

The Professional Development Policy and Procedure for Clinical Staff (2021) provides discussion of organisational responsibilities to education and training with a list of background documents. The supporting Education policy was not provided in the evidence bundle. The provider has submitted copies of orientation manuals for the clinical manager and carer roles only, which refer to Inservice education and training, and professional development opportunities, but there is limited discussion of specific nursing topics. The CM orientation manual outlines responsibilities for incident management but does not specifically discuss education and training opportunities for team roles. The document discusses sentinel event reporting and reporting steps, and relevant polices are listed in the orientation checklist. The manual provides a list of clinical competencies and comprehensions that qualified nurses are required to achieve annually, which includes Medication Management. The Medication Administration Comprehension RN/EN (2020) provides a quiz for nurses in partnership with the Medication Management policy (not submitted), with a requirement of a pass score of 80%. The CM orientation manual states that the CM is responsible for ensuring team competencies are assessed and recorded in relevant work records.

The provider response has discussed improvements to organisational policies, orientation processes and staff training days, and included an agenda of monthly clinical education sessions for 2022–2023. No supporting content was provided. Clinical topics listed include professional requirements for nurses, the code of conduct, professional boundaries, and direction and delegation, however there is no discussion of specific training provided regarding incident and medication management. The CM orientation book indicates these sessions are delivered

online via the organisation's intranet, however again topic content was not provided.

Based on the evidence reviewed I am unable to respond to this question as it appears that limited information has been submitted by the provider to inform further comment. The provider has referred to a lack of robustness in the sentinel event report process with no evidence of a corrective action plan at the time to identify improvement opportunities. Given the range of discussion points raised, I would also consider falls management, pain management, nutrition and hydration, weight management, nursing assessment, care planning and documentation standards, communication, and complaint management as relevant clinical topics for reflection and learning.

n) Please comment whether you consider the issues identified (above) to be systemic issues at Whareama and Otumarama or whether it was more attributable to an individual, or both?

From the information reviewed I consider the raised discussion points to be related to care home leadership, systems and processes in place at the time, which appear to have influenced the quality of care delivered to [Mrs A], and her whānau.

Clinical advice

I note that the events occurred during the COVID-19 pandemic period 2020–2022 and would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams and health service providers during this time.

Based on this review I recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. To support this approach, I recommend that the care home team complete the HDC online modules for further learning — https://www.hdc.org.nz/education/online-learning/.

Jane Ferreira, RN, PGDipHC, MHlth
Nurse Advisor (Aged Care)
Health and Disability Commissioner

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