HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failings in care provided to a man living with advanced dementia

1. On 8 June 2022, the Health and Disability Commissioner (HDC) received a complaint from Ms A regarding the care provided to her late father, Mr B, by Kamo Home and Village Charitable Trust (Kamo) and Health New Zealand | Te Whatu Ora Te Tai Tokerau (Health NZ). This investigation considers Kamo's management of scabies[1] and its standard of communication with Mr B's family following a scabies outbreak at the facility and a subsequent incident that occurred between Mr B and another resident.

2. The investigation also considers the adequacy of support provided to Mr B when he was admitted acutely in the emergency department (ED) at Whangārei Hospital. At the outset, I acknowledge that there appears to have been a level of confusion about the primary reason for Mr B's transfer to the ED. The referral letter from Mr B's general practitioner (GP) documents that Mr B was being transferred for an ultrasound of his arm and his elevated D-dimer[2] levels, but the incident that occurred between Mr B and another resident evidently confused the clinical picture with concerns being raised about a potential head injury. Regardless of this, Mr B had significant care needs due to his advanced dementia and other comorbidities, and these needs were not well managed by Health NZ.

3. This report highlights the inappropriate management of a vulnerable man in a high-acuity, highly stimulating ED environment for a prolonged length of time. It identified deficiencies in the overall standard of nursing care provided to Mr B and inadequacies in the behavioural assessments and support he received while at Whangārei Hospital.

4. At the outset, I express my sincere condolences to Ms A and her family for their loss.

Information gathered

Background

5. At the time of the events, Mr B, aged 81 years, had advanced dementia, Alzheimer's disease, regular episodes of syncope (fainting) (with a family preference for non-hospital management), prostate cancer (with a decision made in 2020 not to pursue further treatment), and multiple other comorbidities. He was admitted to Kamo's dementia unit on 3 December 2019.

6. Kamo said Mr B's wife was the nominated Enduring Power of Attorney (EPOA) for health and wellbeing at the time of his admission. A discussion between Kamo and Mr B's wife two years later, on 3 December 2021, resulted in her requesting that Ms A be the first point of contact. Ms A stated that she had held the EPOA from the time of admission.

[1] A contagious infestation of the skin caused by mites that spreads through skin-to-skin contact and leads to an itchy rash.
[2] A D-dimer test is a simple blood test that can help determine whether a person has a blood clotting condition.

Management of scabies

Identification of scabies

7. Ms A first became concerned about Mr B having scabies in November 2021 after observing other residents in the dementia unit itching and scratching their skin. Ms A said she raised her concerns that the rash was scabies to staff several times, and each time she was reassured that it was not.

8. Clinical records indicate that Mr B first developed skin integrity issues on 3 October 2021, at which time blisters were noted on his right thigh. However, a scabies diagnosis was not established until 22 December 2021. Kamo said that, between November and December 2021, seven other residents in the dementia unit developed a rash but that each rash was different in its presentation. Those residents were reviewed by GP Dr C, who did not initially think that the rash was associated with scabies. However, by 22 December 2021, Dr C made the decision to prescribe a precautionary scabies treatment to all residents within the dementia unit.

9. Both Kamo and Dr C said it is possible that Mr B did have scabies for some time before his diagnosis on 22 December 2021. However, they suggested that scabies can be notoriously difficult to diagnose accurately, as the condition often mimics several other skin conditions commonly found in older people. Kamo and Dr C said a high index of suspicion is important and that diagnosis of scabies within aged residential care settings often means several residents and/or staff present with signs and symptoms before a definitive diagnosis can be made. Kamo asserted that clinical evidence is needed to commence a scabies treatment pathway.

Treatment

10. Kamo said care staff actively monitored and responded to Mr B's skin concerns, appropriately escalated these to a Registered Nurse (RN) and sought medical input. Clinical records show that Mr B's initial blister on his right thigh was first noted on 3 October 2021 by a caregiver. The caregiver documented that the blister 'needs looking at,' but clinical records do not indicate whether this was escalated to an RN for assessment as required by Kamo's Wound Management Policy (dated September 2021). Subsequent RN and caregiver documentation between 4 October and 16 October 2021 makes no reference to this blister being monitored or assessed.

11. Kamo acknowledged that there were opportunities to enhance documentation but maintained that the care provided to Mr B was responsive.

12. On 16 October 2021, a caregiver noted that Mr B's blister had spread to his groin area and back. An RN was notified, who completed an assessment and noted that Mr B had several blisters on the left and right sides of his thighs, which were filled with pus and had popped. The wounds were photographed, and the RN referred Mr B to Dr C, who diagnosed the blistering rash as bullous pemphigoid.[3] He was subsequently treated with antibiotics and prednisone (a steroid used to reduce inflammation). In addition, Kamo staff commenced antibacterial washes and moisturising of the affected areas of Mr B's skin and initiated a

[3] A blistering rash in older patients with neurological disease.

wound/skin management plan, although it did not document what caregivers should look for or assess. On 30 October 2021, further blisters were noted on Mr B's abdomen and left groin.

13. Clinical records indicate frequent assessments of Mr B's skin being completed during November and December 2021. On 3 November 2021, the Clinical Charge Nurse (CCN) documented that the rash was not improving. A plan was subsequently made for the GP Link Nurse[4] to review the rash on 9 November 2021, before Dr C's review (originally set for 10 November 2021). On 10 November 2021, the rash was noted as being mildly itchy, and it was queried whether the rash was related to Mr B's medications, but the CCN noted that there were no recent changes to his medications and so a pharmacy or medication review was not sought. A GP review did not occur on 10 November 2021 for unknown reasons. The GP Link Nurse attempted to review Mr B's rash on 11 November 2021; however, he was noted as being away from the care home. By 18 November 2021, the rash had spread to Mr B's back and left hand, with swelling in his hand, and he was recommenced on antibiotics and prednisone. On 25 November 2021, the GP Link Nurse noted that the GP had reviewed Mr B's wound chart, including the image of his wound.

14. On 2 December 2021, Mr B developed significant swelling on his left hand, with a large new blister. He was sent to the ED at Whangārei Hospital for a review. Ms A noted that Mr B's wedding ring had become dangerously stuck. A diagnosis was made of a drug reaction related to Mr B's antipsychotic medication (olanzapine), and erythroderma [5] with superimposed cellulitis.[6] Subsequently, the antipsychotic medication was stopped, as recommended by Health NZ. Mr B continued to be treated with antibiotics and prednisone, with a plan for Dr C to review him the next day and, if symptoms worsened, for Mr B to return to the ED. On 3 December 2021, wound photos were sent to Dr C, and Mr B continued with antibiotics and prednisone. On 5 December 2021, Kamo staff noted that the rash was improving. A review by a locum GP on 8 December 2021 also noted that the rash was settling.

15. No nursing assessment or changes to Mr B's long-term care plan were made in relation to the medication changes implemented after he returned to Kamo from the ED. Kamo accepted that no specific care plan was formulated to highlight care and safety needs following Health NZ's decision to withhold the antipsychotic medication. However, Kamo said the change in medication was shared with the care team, and this is evidenced in the progress notes. In addition, Kamo said that Mr B's long-term care plan identified triggers that may impact on his mood and behaviour and provided guidance on de-escalation options.

16. On 10 and 20 December 2021, Mr B's rash was noted as being worse and itchier. A GP review was requested on 20 December 2021. Dr C reviewed Mr B on 22 December 2021, and a

[4] A nurse who acts as a liaison between general practice and other services.
[5] Intense and widespread reddening of the skin due to inflammatory skin disease.
[6] A bacterial skin infection that occurs on top of, or in conjunction with, another condition.

diagnosis of possible scabies was established because by this time several other residents had developed itchy rashes, raising the suspicion that this could be a contagious rash.

17. Kamo's Wound Management Policy stipulates that any wounds that are of concern can be referred to the district nursing service for further advice. However, clinical notes do not show that such a referral occurred. Kamo said a referral to the wound specialist nurse was not indicated, as Mr B's skin condition appeared to be systemic rather than localised and because Dr C was actively engaged in a process of clinical elimination and treatment planning to address the underlying causes.

Notification of outbreak

18. Ms A said she was not alerted to a scabies outbreak within the dementia unit and that she only discovered it by accident on 7 January 2022 after visiting Mr B and acquiring scabies herself. She noted that her mother also contracted scabies. Ms A said this delay in notification meant she had contact with several people in the community and put others at risk.

19. Communication with Ms A regarding the outbreak is not documented in the clinical notes, and Kamo acknowledged that other residents' families were alerted to the scabies outbreak via text message on 23 December 2021, but Ms A was not. Kamo apologised to Ms A for this breakdown in communication. It said Ms A was not alerted because it presumed that she was already aware because of her previous contact with Kamo.

Infection control

20. Ms A is concerned with the infection control practices within the dementia unit. She said she raised concerns about other residents scratching and was concerned Mr B's rash could be scabies. Kamo said these concerns were raised on 26 November 2021 and, at that point, there was no indication of an outbreak. Only one other itchy rash had been reported in August 2021, which had been successfully treated with antibiotics and prednisone. In addition, no other staff members had reported scabies, and no residents reported constant itching.

21. Kamo's Outbreak Management Procedure (September 2021) does not outline specific information to guide staff about different types of outbreaks such as scabies, identification of symptoms, the related care or reporting guidelines, or the communication process with families. However, Kamo said it subscribes to Health NZ's Infection Prevention and Control website, which provides a full suite of comprehensive and up-to-date guidelines and procedures relating to all infections. When an outbreak is confirmed, relevant guidance is obtained from the website and shared with all staff for implementation. The guidance relating to scabies management was not provided to HDC.

22. Kamo's Outbreak Management Procedure states that an outbreak is defined as 'two or more cases of an identical illness occurring in a facility in a relatively short space (2 days) of time'. Kamo said the infection control coordinator was informed of the scabies outbreak on 22 December 2021, who then formulated an outbreak management plan. In contrast, the precautionary outbreak management for scabies document suggests that the infection control coordinator was informed on 23 December 2021. On 23 December 2021, families of

residents were informed about the outbreak by text message, including that residents needed treatment and to avoid skin-to-skin contact when visiting. All visits were facilitated within open spaces to avoid overcrowding. As part of this communication, Kamo staff were also informed of contact precaution measures within the dementia unit and what that involved.

23. Ms A said there was a delay in the scabies treatment. On 24 December 2021, all night clothes and bedding were hot washed, the rooms were decontaminated by the housekeeping staff, and oral ivermectin (an insecticide used to treat scabies) was ordered and administered. The administration of ivermectin requires approval from a clinical microbiologist, who needs to be satisfied that the diagnosis of scabies is likely, and the GP needs to apply for special authority for each patient. In addition, at the time, ivermectin was in short supply nationally. Staff were advised that all residents with a current rash would be re-evaluated in a week's time by a GP, and all new rashes contracted by residents or staff would need to be reported immediately, with any residents subsequently needing to isolate and be treated. Permethrin (another insecticide) was charted and applied on 27 December 2021 as an additional measure to treat scabies. On 5 January 2022, a further round of ivermectin was given, with a plan for any residents remaining itchy after one week after the second dose of ivermectin to receive a topical scabies solution. Mr B was seen by Dr C on 5 January 2022 to review the rash. Dr C documented that a swab of the rashes was to be taken, as well as blood tests.

24. In February 2022, it was considered that the scabies outbreak was over.

25. Mr B continued to have skin concerns, with ongoing rashes and swelling.

Management of adverse event

26. At 4am on 13 January 2022, Mr B was found on the floor. It was suspected that another resident in the dementia unit had pushed him onto the floor and that he had been hit in the head by that person. Ms A raised concerns about how this incident was managed.

27. Kamo said that, immediately after the incident, an RN conducted a thorough assessment of Mr B and repeated it one hour later. Apart from redness around his jaw, no injuries were recorded. The incident report recorded that Mr B had no pain and that he was conscious, verbally responsive, able to follow instructions, and had a full range of motor movement. As the incident was unwitnessed, neurological observations were commenced and found to be normal.

28. At 5am, Mr B's initial blood pressure was recorded as 200/82 mmHg[7] (high) and outside an acceptable range. This did not appear to be escalated to more senior staff. After five hours, his blood pressure improved to 147/72 mmHg (normal), increased at 3.50pm to 175/86 mmHg (borderline high), and then to 229/101 mmHg (high) at 5.30pm. In addition to his erratic blood pressure, Mr B became less responsive and had a slow-to-react left pupil (indicating potential neurological issues).

[7] A systolic blood pressure between 120 and 180 mmHg is normal in adults.

29. A decision was made at around 3.50pm to transfer Mr B to Whangārei Hospital as there were also concerns about a wound on Mr B's arm. Dr C was made aware of the incident that had occurred and Mr B's elevated D-Dimer[8] levels from blood test results reported earlier that day. The contemporaneous referral to the hospital completed by Dr C documented that Mr B was being referred for review of elevated D-Dimer levels and swelling in his upper arm. The referral included relevant details of Mr B's history, including his severe dementia, a persistent rash, and swelling in his arm and thigh. The referral indicates that the purpose of Mr B's transfer was to obtain an ultrasound of his arm in light of the rash and swelling.

30. Mr B was transferred to Whangārei Hospital via ambulance. The ambulance transfer summary records that the ambulance had been called due to Mr B's high D-Dimer results. It documents the incident between Mr B and another resident and that Kamo staff advised that Mr B had been lethargic and 'not acting like himself all day.'

31. Ms A said she did not receive a call from Kamo until around 3.30pm to inform her of the incident between Mr B and another resident close to 12 hours earlier, but she was reassured that Mr B did not have any bruising and that he was 'perfectly ok.' Ms A said that, less than an hour later, she received a second call to say that Mr B was not responding to staff and that an ambulance had been called. Ms A received a further call around an hour later advising that Mr B was on his way to Whangārei Hospital ED in the ambulance and that ambulance staff had been notified of the incident.

32. It is unclear from the progress notes what discussions were had between Kamo and Ms A in respect of the decision to transfer Mr B to hospital as they only document that Ms A was 'made aware of [Mr B] going to the hospital.'

33. Kamo said the reason for the delayed communication with Ms A was because the initial assessment after the incident did not raise any immediate concerns. Kamo said its usual practice in terms of open disclosure is that, if there is no emergency and the incident occurs during the night, contact with family will be made during the following shift.

Care provided in Whangārei Hospital's ED

Summary of care

34. Mr B was transferred to Whangārei Hospital's ED at 5.42pm on 13 January 2022. Mr B was not accompanied by care staff or his family.

35. Mr B was triaged at the hospital at 5.46pm. His incident with another resident and his lethargy were noted along with his raised D-Dimer results. It is documented that Mr B refused initial observations.

36. Mr B was reviewed by ED House Officer Dr D at 5.49pm. Dr D noted that Mr B had been brought in via ambulance after an incident and that he was experiencing increased drowsiness.

[8] Used to assess the presence of blood clots in the body.

37. At 7.13pm, Mr B was documented to be displaying behaviours of stress and distress: had become agitated, had removed his intravenous luer (connector), and was refusing observations and cares from staff. The clinical notes document that Mr B was unable to have a CT scan of his head because he no longer had a connector. A retrospective note from an RN who was assisting states that pressure was applied to stop the bleeding from the connector being removed but that Mr B would not allow staff to assist with changing his bedding or hospital gown.

38. Health NZ said that staff needed to be able to rule out life-threatening injuries so chemical sedation was advised to enable a CT scan of Mr B's head to be performed. Between 8.33pm and 9.10pm, multiple doses of midazolam (a benzodiazepine used to induce sedation and relieve anxiety) and haloperidol (an antipsychotic) were administered to reduce Mr B's agitation.

39. Around 9.54pm, a CT scan of Mr B's head and spine was completed. The CT scan showed no evidence of intracranial haemorrhage or fractures.

40. Mr B was referred to the general medicine team at 10.44pm but remained in the ED overnight. At 11.30pm, Mr B was moved to a different room where he shared a patient watch with another patient. Clinical notes at 1am on 14 January 2022 document that the patient watch was required on another ward and that Mr B was 'fighting but not unsettled or distressed.' At 2am on 14 January, the wounds on Mr B's left hip and groin were documented to have been cleaned and dressed. Clinical records from 7.30am document that the pressure areas were cleaned and redressed.

41. At approximately 8.26am, Mr B was transferred to the ward under the care of the Acute Care of the Elderly team. After transfer to the ward, it was discovered that Mr B had elevated D-dimer and calcium levels, secondary to his malignancy from prostate cancer. Health NZ said that Mr B's ceiling of care was unclear, so staff discussed these findings with Mr B's family, and it was decided that he was not for active intervention and that the focus of care would be on maintaining his comfort and dignity.

42. Mr B was subsequently transferred back to Kamo for hospital-level care at around 5.30pm on 14 January 2022. Sadly, he passed away in mid January 2022.

Monitoring and support

43. There is concern as to whether Mr B was monitored appropriately and supported adequately while in the ED, given his general state of health, dementia, and presenting symptoms. Health NZ acknowledged that Mr B was a vulnerable adult because of his advanced dementia but felt that the care provided to him met accepted standards at the time.

44. Clinical records show that Mr B had various behaviours of stress and distress over the course of his ED stay, such as agitation, pulling out his intravenous luer (connector) three times, aggression, kicking and punching staff, and resisting cares from staff despite needing support. These behaviours were first noted at 7.13pm on 13 January 2022, and multiple doses of midazolam and haloperidol were administered to manage these behaviours.

45. Health NZ's Delegated Patient Observation policy at the time (dated March 2023)[9] states that a comprehensive assessment must be undertaken by an RN when any patient exhibits behaviours of stress and distress. A decision is then made by two RNs about the required level of observation, including whether a patient attendant[10] is needed to support the patient. Clinical records document Mr B's presenting problem, his vital signs, and his symptoms, but no assessment appears to have been undertaken of Mr B's behaviours of stress and distress, including the reasons for them and potential strategies to manage them, as required by Health NZ's Delegated Patient Observation policy. Health NZ said the lack of access to electronic records has been a barrier to best practice regarding documentation.

46. Health NZ's response indicates that a patient attendant was needed and first requested by the ED at around 9.27pm but was not available until 11.30pm. Health NZ said it is not unusual for an attendant to be requested and for nobody to be available because of the limited number of staff. The Delegated Patient Observation policy states that, if there are insufficient patient attendants available to match demand, priority will be given to patients who have multiple behaviours of stress and distress, and this decision is made by the duty manager. Although Health NZ's response indicates that this was the case, clinical records do not document how the decision to prioritise the patient attendant was made.

47. A patient attendant observed Mr B for a total of 90 minutes between 11.30pm and 1am. Health NZ's Patient Constant Observation Management Plan (dated 2016) requires documentation to be completed regarding the level of monitoring the patient attendant needed to provide, the management plan, the behaviours of stress and distress exhibited, and what interventions were undertaken by the patient attendant and their effectiveness. None of this was documented for the period the patient attendant observed Mr B.

48. Health NZ said that the patient attendant had to leave to support another patient, despite clinical notes indicating that Mr B's behaviours of stress and distress continued. Health NZ acknowledged that removing the patient attendant was not best practice but that it was a complex situation and all the ED staff were doing their best to deliver an appropriate standard of care in a busy ED with limited capacity and resources. In addition, it said that Mr B was placed opposite the nurses' station to facilitate visual monitoring and that the ED had high staffing ratios, which allowed for further visibility of him in his room. Health NZ said there is no evidence that Mr B suffered any adverse consequences from not having a patient attendant overnight and stated that staff promptly responded to changes in his condition, attempted appropriate interventions, and made efforts to access additional support.

49. Further to the above, clinical records do not document what pressure area cares (if any), pain assessment, or hydration and nutritional assistance were provided to Mr B over the time he was in hospital. Health NZ agreed that there was a lack of documentation relating to the pressure area cares provided to Mr B but did not make any comments regarding pain,

[9] Health NZ advised that the previous version of this policy had expired in 2018 and therefore the current version, dated March 2023 'represents the closest available reference to the processes that were in place and followed' at the time.

[10] Usually a healthcare assistant and also known as a 'watch.' A patient attendant is appointed to monitor a patient to protect him or her and others from unsafe behaviour.

hydration, or nutrition assessments. Health NZ submitted that Mr B received adequate care during his time in ED to ensure that he was physiologically stable and his dignity was maintained through personal hygiene cares.

Length of stay in ED

50. Ms A is concerned that Mr B remained in the ED for a prolonged period. Clinical records show that Mr B was not transferred to the ward until 8.32am on 14 January 2022 (close to 15 hours after he presented to the ED). Health NZ's ED Standard Operating Procedure at the time (dated 2018) states that patients need to be admitted, transferred, or discharged within six hours of presentation to the ED.

51. Health NZ's response indicates that, although five empty beds were available in a multi-room setting within the first six hours of Mr B's admission on 13 January 2022, a single room was considered preferable because of his behaviours of stress and distress. It is not known whether Health NZ considered moving patients from single rooms to multi-rooms to accommodate Mr B. In addition, Health NZ said the number of single rooms at Whangārei Hospital is low by modern facility standards.

52. Health NZ acknowledged that the time Mr B spent in the ED was prolonged and apologised for this. Health NZ stated that Mr B experienced a long wait to be admitted to the ward because of the medical registrar's high volume of workload overnight and prioritisation of patients with greater acuity and risk of medical deterioration. In addition, it said that 82% of patients on 13 January 2022 and 80% on 14 January 2022 were either admitted, transferred, or discharged within six hours, which was better performance than in other EDs at the time (which was 74.2% on average, nationally).

Response to provisional opinion

Ms A

53. Ms A was given an opportunity to comment on the 'background' section of the provisional opinion. Her comments have been incorporated into the report where relevant. Ms A also provided HDC with photographic and video evidence of her father in hospital.

Kamo

54. Kamo was given an opportunity to comment on relevant sections of the provisional opinion and advised it accepts the findings.

55. Kamo said it wanted to 'again extend our sincere apologies to Ms A for the distress caused. We recognise the impact that the shortcomings identified had on Mr B, Ms A, and her family, and we take full accountability for this.'

56. Kamo said that, although it will fully adhere to the recommendations outlined, it notes that the areas identified have already been addressed through sustained quality improvement initiatives over recent years and that these improvements are well embedded in everyday practice across the organisation. It said that the learnings from these events have been taken seriously and have informed its ongoing commitment to continuous quality improvements.

Health NZ

57. Health NZ was given an opportunity to comment on relevant sections of the provisional opinion, and its comments have been incorporated into the report where relevant.

58. Health NZ offered its apologies to Ms A and her family for the misunderstanding regarding the level of care it provided to Mr B. Health NZ apologised that the family was not fully informed of the extent of care that was provided to Mr B in the ED and for the distress that this has caused.

59. Health NZ agreed that a loud, brightly lit, crowded ED is an environment that is likely to contribute to distress and worsening delirium in a patient with severe dementia such as Mr B. Having reflected on these events, Health NZ said that, given Mr B's comorbidities and circumstances, urgent transfer to ED may not have been in his best interests. Health NZ said timely discussion between Kamo and the care of the elderly team directly, including telehealth assessment if possible, may have avoided attendance at the ED.

60. Health NZ said it has subsequently engaged with a number of aged care facilities in the district and provided telehealth equipment and training to allow urgent telehealth assessments of their residents to assist with decision-making for acutely unwell residents who may require ED assessment. It said that further development of this initiative may decrease transfers of similar patients in the future.

61. Health NZ acknowledged that the long length of stay and the lack of a dedicated patient watch for 13 of 15 hours of Mr B's stay represent a hospital system under pressure.

62. Health NZ noted my expert advisor's comments that the lack of formal pain assessment was a shortcoming in the ED. It responded that a pain assessment would have been compromised and unreliable given Mr B's cognitive status and would not have been prioritised in the context of other needs.

Dr C

63. Dr C was given an opportunity to comment on relevant sections of the provisional opinion.

Clinical advice

In-house clinical advice

64. In-house clinical advice was obtained from Aged Care Nursing Advisor, RN Jane Ferreira (see **Appendix A**). RN Ferreira identified the following departures from accepted standards in the care provided by Kamo:

- Management of skin integrity issues – moderate departure.
- Appropriateness of outbreak management procedure – mild departure.
- Standard of communication with EPOA and adequacy of related policies – moderate to severe departure.

Independent clinical advice

65. The following independent clinical advice was obtained from ED RN Richard Scrase (see **Appendix B**). Mr Scrase identified the following departures from accepted standards in the care provided by Health NZ:

- Appropriateness of Mr B remaining in the ED for 15 hours – mild departure.
- Appropriateness of the monitoring and assessment provided in ED – moderate departure.
- Standard of nursing care in ED – severe departure.

Decision: Kamo – breach

Wound management – adverse comment

66. Ms A is concerned about the management of Mr B's scabies. Clinical records show that Mr B first presented with compromised skin integrity on 3 October 2021; however, a diagnosis of scabies was not established until 22 December 2021.

67. Clinical notes show that when a caregiver first identified blisters on Mr B's right thigh, this was not escalated to an RN for assessment as required by Kamo's Wound Management Policy. Clinical notes between 3 and 16 October 2021 also do not document whether his right thigh was assessed or monitored.

68. However, there appeared to be frequent references in the clinical notes to skin and wound assessments occurring between 16 October and December 2021, albeit these were irregular. Over this period, they show that, when caregivers noted changes in Mr B's skin, they were appropriately escalated to an RN for management. Photographs were taken and input was sought from Dr C when concerns were noted. However, this input appeared to be delayed at times, and there was a lack of follow-up with the GP Link Nurse and/or Dr C when the skin was noted to be worsening. It is also not known what instructions were given to the caregivers in terms of monitoring the wound after the assessment on 16 October 2021. Although no short-term care plan to manage the wounds was commenced, there is discussion of care delivery occurring within the wound/skin management plan.

69. It is also noted that no input was sought from the district nursing service, as required by Kamo's Wound Management Policy or a wound specialist. Kamo said this was because the skin condition appeared systemic, rather than localised, and the GP provided regular input into the treatment process.

70. When Mr B's skin deteriorated in December 2021, he was sent to Whangārei Hospital for further assessment, where it was established that the skin condition was likely the result of an adverse drug reaction from his antipsychotic medication. This medication was subsequently stopped, although Kamo's clinical records do not indicate whether a post-hospital assessment in relation to the impact of stopping this medication on Mr B's care and safety needs and his mood and behaviour occurred. In response to this, Kamo said that the change in medication was shared with the care team, which is evidenced in the clinical notes, with a plan for Dr C to review Mr B the next day and staff on subsequent shifts noting

changes in his behaviour. In addition, Kamo also said that Mr B's long-term care plan identified triggers that may affect his mood and behaviour and provided guidance on de-escalation options, which I acknowledge.

71. RN Ferreira has identified a moderate departure in the standard of wound care provided to Mr B. I accept that, although attempts were made to diagnose and treat Mr B's symptoms, there were clearly short comings in his wound care that meant he experienced periods of discomfort. For instance, there was a delay in escalating Mr B's skin integrity issues to an RN when the blisters were first identified. In addition, I am concerned about the lack of guidance given to caregivers on how to monitor Mr B's skin and when to report changes to RNs. I accept that assessments appear to be frequent after 16 October 2021, although I remain concerned that the escalation in the skin integrity issues was delayed.

Outbreak management – adverse comment

72. There is concern as to whether Kamo appropriately managed the scabies outbreak.

73. Kamo's Outbreak Management Procedure does not outline specific information to guide staff about the different types of outbreaks, symptom identification, the related care or reporting guidelines, or communicating with families. However, Kamo said it subscribes to Health NZ's Infection Prevention and Control website, which provides a full suite of comprehensive and up-to-date guidelines and procedures relating to all infections. When an outbreak is confirmed, relevant guidance is obtained from the website and is shared with all staff for implementation. Kamo did not provide the guidance relating to scabies management to HDC; however, I note the findings of HealthCERT's surveillance audit dated February 2022 and the subsequent full certification audit in January 2024, which found that Kamo had fully attained the infection control standards within the Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (the Standards).

74. In addition, Kamo provided evidence of a scabies outbreak management plan, which showed that the infection control coordinator was informed of the outbreak in a timely manner. The outbreak management plan also showed that the dementia unit was cordoned off, scabies medication was commenced, and other infection-control activities, such as laundering and cleaning, were commenced, along with appropriate communication with staff.

75. However, I am critical about the standard of communication provided to Ms A about the notification of the outbreak and the adequacy of Kamo's visiting protocols. I acknowledge that a text message was sent to the other families informing them of the scabies outbreak, but I am concerned that this text message was not sent to Ms A. This error unfortunately led to Ms A visiting the dementia unit while it was placed on contact precautions, contracting scabies herself, and potentially unknowingly transmitting this to other people in the community. I am concerned that Ms A's visit does not appear to have been documented or noticed by Kamo staff, which raises further questions about the adequacy and monitoring of the visiting restrictions at the time of the outbreak. Kamo accepts that it omitted to notify Ms A of the scabies outbreak.

Standard of communication with family – breach

76. As discussed above, Ms A was not informed of the scabies outbreak. In addition, she is concerned about the timeliness of communication with her about the changes in Mr B's condition after the adverse event on 13 January 2022.

77. Under the Standards, service providers are required to notify EPOAs in a timely manner of any changes in a resident's health condition and inform them of adverse events, and care decisions should be made in partnership with the EPOA.

78. I note that the adverse incident occurred at 4am on 13 January 2022; however, Ms A, as the EPOA at the time, was not informed of it until 3.30pm the following day (close to 12 hours later) when the decision to transfer Mr B to hospital was made.

79. Kamo acknowledged that the communication with Ms A about the adverse event was not timely; however, it said this was because the clinical assessment at the time the incident first occurred did not raise any immediate concerns. In addition, it said that staff in a dementia unit must continually prioritise/reprioritise care to ensure the safety and wellbeing of all residents. I acknowledge the mitigating circumstances Kamo have outlined, but I accept RN Ferreira's advice that a behavioural event that resulted in physical contact with another person is a significant event and that Ms A should have been informed earlier of this. In addition, I note that the clinical records show changes in Mr B's blood pressure that RN Ferreira advised may have indicated a possible head injury, which further highlights the need to have informed Ms A in a timely manner and for her to have been given an opportunity to be involved in how Mr B was managed after the incident.

80. It is unclear exactly what discussions were had with Ms A regarding the management of Mr B's care and whether, as Mr B's EPOA, she was consulted about the decision to transfer Mr B to ED on 13 January 2022. In accordance with the Standards, I would have expected the decision to transfer Mr B to the ED to have been made in partnership with Ms A after a full discussion and consideration of the reasons for Mr B's transfer and the different care management options available. It is unclear whether Mr B had a Ceiling of Care Plan to outline, after discussion with family, the level of medical intervention he should receive. In the absence of such a document, this conversation would have been particularly important to allow Ms A, as EPOA, to consider what care management was in Mr B's best interests in terms of maintaining his comfort and the level of medical intervention that was most appropriate for him.

81. RN Ferreira advised that the standard of communication with Ms A represented a moderate to severe departure from the accepted standards of care. I accept this advice and am critical about the lack of communication about the scabies outbreak and the lack of timely communication regarding the adverse event. I have further concerns about the adequacy of Kamo's communication with Ms A prior to transferring Mr B to Whangārei Hospital on 13 January.

82. Evidence of effective communication with a resident's representatives is a significant aspect of Kamo's responsibility to its residents, particularly in the case of those who have an appointed EPOA to make decisions on their behalf, as was the case for Mr B. I find that the

deficiencies in the standard of Kamo's communication with Mr B's family outlined above amount to a breach of Right 4(2)[11] of the Code of Health and Disability Services Consumers' Rights (the Code).

Decision: Health NZ – breach

83. Mr B was transferred to Whangārei Hospital's ED on 13 January 2022 for further assessment after the adverse event and as a result of concern from his GP regarding the elevated D-dimer levels. Mr B remained in the ED for a total of 15 hours before he was transferred to a bed in the ward. As a healthcare provider, Health NZ was responsible for ensuring Mr B was provided with services with reasonable care and skill under Right 4(1) of the Code. I accept that the hospital was managing a number of conflicting demands and that its ED's performance was better than that of other EDs at the time. Notwithstanding this, with respect to Mr B, RN Scrase has identified multiple departures in the standard of care he received in the ED, which are discussed below.

Standard of nursing care – breach

84. As discussed above, Mr B was in the ED for 15 hours. Although most patients move through the ED relatively quickly, Mr B remained in the ED for a prolonged period.

85. In addition to dementia, Mr B had multiple other conditions that required nursing oversight and intervention. As evidenced by Kamo's clinical records, Mr B had multiple wounds that needed care. These wounds were cleaned, dressed, and swabbed for possible infection. However, they were not documented in the nursing records until 2am, about eight hours after Mr B presented to the ED, and no wound chart was completed while Mr B was in the ED. In addition, Mr B's skin condition placed him at risk of acquiring pressure injuries, particularly in the context of him being less mobile than normal and being a frail, older adult. However, there is no evidence of any pressure area cares or of a risk assessment being undertaken. Health NZ agreed that pressure area cares were not documented.

86. Mr B's dementia and his general frailty meant he needed support to have his basic needs met and to keep him safe. However, there is no evidence of Mr B's fluid and nutritional intake being managed or other basic cares (including pressure area cares) being provided. Lastly, there is no evidence of a pain assessment being completed, which would have been important given the earlier physical altercation Mr B experienced and the behaviours he was exhibiting in the ED (that may have been a symptomatic reaction to pain).

87. RN Scrase commented that, from a nursing perspective, it is not clear whether consideration was given to the other factors that might have contributed to Mr B's behaviours of stress and distress, other than his dementia. I agree with RN Scrase's remarks, and I am concerned at the lack of evidence of monitoring and assessment tools being utilised (in particular a pain assessment tool). I find this particularly concerning in light of the chemical sedation that was administered to manage these behaviours without first considering these other factors.

[11] Right 4(2) states 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

88. I acknowledge Health NZ's view that Mr B received adequate care to ensure he was physiologically stable and his dignity was maintained through personal hygiene cares. I also acknowledge its view that a pain assessment would not have been prioritised because of Mr B's cognitive impairment.

89. However, RN Scrase advised that the standard of nursing care in the ED was a severe departure from the accepted standard of care. I accept this advice and do not agree with Health NZ's explanation that Mr B's care met accepted standards in the context of the resourcing constraints the ED faced. I am critical of the lack of pressure area care, fluid and nutritional management, and pain assessment (noting there are methods to assess pain in a person with cognitive impairment) while Mr B was in the ED. As a frail, older adult with significant cognitive impairment who was displaying behaviours of stress and distress, Mr B was vulnerable and needed close monitoring and support. In my opinion, the resourcing constraints the service was facing do not justify the shortcomings in the provision of basic cares over this extended period of time. As such, I find these deficiencies in care by Health NZ amount to a breach of Right 4(1) of the Code.

Level of behavioural support – adverse comment

90. Mr B had a history of dementia and was exhibiting behaviours associated with stress and distress while in the ED. These behaviours included agitation, pulling out his intravenous luer, aggression, and kicking and punching staff. As RN Scrase correctly points out, patients with dementia often exhibit agitation when they present in acute environments, and they are at risk of delirium. Mr B's clinical records indicate he was distressed, with several doses of sedation administered to manage his agitation. Importantly, these behaviours had the potential to cause harm to Mr B and those around him. Under these circumstances, a fulsome assessment and the development and implementation of a behavioural support plan was needed.

91. My review of Mr B's clinical records does not show evidence of a behavioural assessment and intervention plan having been completed, as required by Health NZ's Delegated Patient Observation policy. However, there is evidence of some interventions, such as sedation, moving Mr B to a more visible area (opposite the nurses' station), and one-on-one support from a patient attendant, albeit only for a short period of time (90 minutes). RN Scrase advised that the response needed to be proactive to achieve the best outcome for Mr B. Although I agree with RN Scrase that the interventions were reactive, I acknowledge that staff were needing to deescalate Mr B's stress and distress at the outset to enable clinical diagnostic tests such as a CT to be undertaken (to rule out any immediately life-threatening injuries). However, I am concerned at the ongoing reliance on sedation to respond to Mr B's behaviour and consider that, at this point, the interventions should have been more proactive and planned.

92. Health NZ's response suggests that a patient attendant was not requested until several hours after Mr B had presented to the ED and that one was not available until two hours after the request was made. Mr Scrase advised that support and monitoring could have been considered earlier. Health NZ said this delay was due to the resourcing constraints at the time, which were beyond the ED's control, and the need to prioritise its resources effectively.

93. Although I am sympathetic to the explanation given for the limited access to a patient attendant, Health NZ's Patient Constant Observation Management Plan requires that a patient's behaviours are documented hourly, including the interactions that have occurred and their effectiveness. However, there is no evidence of this occurring over the time the patient attendant was present, or any evidence of what instructions the supervising RNs gave the patient attendant. There is also no evidence of the assessments that were undertaken by the duty manager with regard to how patient attendants were prioritised.

94. RN Scrase advised that the standard of behavioural monitoring and assessment in this case represented a moderate departure from the accepted standard of care. I accept this advice and note with concern the shortcomings in behavioural support Mr B received.

Length of stay in the ED – adverse comment

95. Health NZ's ED Standard Operating Procedure states that patients need to be admitted, transferred, or discharged within six hours of presentation to the ED. However, Mr B remained in the ED for close to 15 hours, nine hours longer than the Standard Operating Procedure timeframe.

96. Health NZ acknowledged that the amount of time Mr B spent in the ED was prolonged and apologised for this. In addition, it said that although five empty beds were available in a multi-room setting within the first six hours of his admission (on 13 January 2022), a single room was considered preferable because of his behaviours of stress and distress. However, RN Scrase advised that it is not clear whether Health NZ considered moving patients from single rooms to multi-rooms to accommodate Mr B, and I agree that there is no evidence on this point. RN Scrase advised that Mr B's delayed transfer to the ward was a mild departure from the accepted standard of care. I accept this advice and agree more thought should have been given to the relocation of other patients to accommodate Mr B appropriately.

97. In my opinion, acute hospital settings such as EDs are not designed to manage patients with high and complex support needs beyond the initial triage and diagnosis and over an extended period (15 hours). When this happens, as is the case with Mr B, there is a risk of basic cares being missed and adverse events occurring. In my view, the high-stimulus unfamiliar ED environment is likely to have only exacerbated Mr B's agitated state, and for all these reasons I am concerned that Mr B's transfer to an inpatient bed was not prioritised and achieved sooner.

Decision: Dr C – educational comment

98. Ms A is concerned that Mr B did not receive a scabies diagnosis in a timely manner. Dr C was Mr B's GP at the time and was responsible for providing this diagnosis.

99. Nursing staff first escalated their concerns to Dr C in early October 2021. Dr C diagnosed Mr B with bullous pemphigoid and treated him with antibiotics and prednisone. On 2 December 2021, Mr B was admitted to the ED, and a diagnosis of an adverse drug reaction was made. He was treated with prednisone and subsequently seen by a locum GP on 8 December 2021, who noted that his rash was settling. On 22 December 2022, a scabies diagnosis was established after several other residents reported symptoms.

100. Dr C said that it is possible that Mr B did have scabies for some time before his diagnosis but that evidence was insufficient to support this before 22 December 2021. In addition, she said that scabies can be notoriously difficult to diagnose accurately, often mimicking other skin conditions common in older people, and several residents/staff often present with signs and symptoms by the time it is diagnosed.

101. I accept Dr C's explanation that scabies can be difficult to diagnose in older people and that the diagnosis is not clear cut. For these reasons, I am not critical of her care. However, I recommended that Dr C consolidate her knowledge in this area with reference to relevant educational resources as noted in paragraph 108 of this report.

Changes made

102. Kamo told HDC that it has made the following changes since the events:

- implemented regular staff reminders to ensure either that care is documented at the time or that the time of care is clearly stated when notes are entered retrospectively;
- reinforced expectations around timely and transparent communication with family, particularly in situations involving hospital transfers or changes in a resident's condition, including clearer documentation about who is contacted and when and what information is shared;
- invested in staff training and support, including in open disclosure and documentation standards and family engagement;
- updated policies relating to incident reporting, infection prevention and control, and communication with families.

103. Kamo also advised HDC that it apologised to Ms A when she made her initial complaint.

104. Health NZ told HDC that it has made the following changes since the events:

- increased the number of medical and nursing staff in the ED;
- developed better electronic flagging for patients who require patient attendants;
- developed a draft Behavioural Disturbance protocol to guide staff in the management of patients presenting with behavioural challenges;
- developed a Behaviour of Concern stepped guideline for nurses and an associated observation form;
- expedited the process for arranging inpatient beds – the duty nurse manager can initiate procurement of a bed for a patient rather than waiting for acceptance by the inpatient team;
- Whangārei Hospital is currently rolling out electronic notes, including electronic vital signs;

- healthcare assistants are all required to complete the NZQA Level 3 Certificate of Health and Wellbeing, which includes education modules on providing person-centred care;

- the front page of the ED screening documentation booklet now encourages staff to complete the ED Falls and Pressure Injury risks screening tool, which is audited.

105. Health NZ also told HDC that it plans to address the small number of single-room beds in the future with the planned hospital rebuild and that it is planning to create a low-stimulus environment in the ED.

Recommendations and follow-up actions

106. Noting that Kamo was last audited by HealthCERT as part of its certification regimen in March 2026 and that no concerns were identified at this time, I recommend that Kamo:

a. provide training on wound management to caregivers and RNs. As part of this training, Kamo should discuss documentation requirements and when wounds should be escalated to RNs/GPs. Evidence of this education occurring, in the form of training material and staff attendance records, is to be provided to HDC within six months of the date of this report;

b. undertake an audit of 10 random incident reports over the last six months to determine whether communication with the resident's EPOA after the incident was timely. A summary of the findings, along with any corrective actions to be implemented, is to be provided to HDC within six months of the date of this report;

c. survey residents' families regarding their preferred means of receiving mass communication from the facility. Provide HDC with a summary of the findings and any changes made to the current method of communication as a result, within six months of the date of this report.

107. I recommend that Health New Zealand | Te Whatu Ora Te Tai Tokerau:

a. provide a written apology to Ms A for its breach of the Code. The apology is to be sent to HDC within three weeks of the date of this report for forwarding to Ms A;

b. provide a copy of its current Behavioural Disturbance protocol to HDC within three months of the date of this report;

c. undertake an audit of the number of patients who have been admitted and are awaiting a ward bed who have remained in the ED for over six hours in the last six months. A summary of this audit finding, along with any corrective actions to be implemented, is to be provided to HDC within six months of the date of this report;

d. consider developing a pathway that allows for early identification of patients in the ED with cognitive impairment and high and complex support needs. An update on

this consideration is to be provided to HDC within six months of the date of this report.

e. Encourage its clinicians and hospital staff to read the Health and Disability Commissioner's *Disabled People's | Tangata Whaikaha Experiences of Health Services – Report on Complaints to HDC*[12] published in June 2026.

108. In the provisional opinion, I recommended that Dr C review the DermNet guideline on drug hypersensitivity syndrome [13] and the bpac guidelines on scabies diagnosis and management[14] within three months of the date of this report. Dr C confirmed she has done this.

109. A copy of this report with details identifying the parties removed, except Kamo Home and Village Charitable Trust, Whangārei Hospital, Health New Zealand | Te Whatu Ora Te Tai Tokerau and my clinical advisors, will be sent to HealthCERT at the Ministry of Health and Health New Zealand | Te Whatu Ora Te Tai Tokerau and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

[12] Disabled People's | Tāngata Whaikaha Experiences of Health Services: Report on Complaints to HDC — Health & Disability Commissioner
[13] Drug hypersensitivity syndrome. DRESS.
[14] Scabies: diagnosis and management - bpacnz.

Appendix A: In-house clinical advice to the Commissioner

The following in-house clinical 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 Kamo Home and Village Charitable Trust (KHVCT). 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**

I have been provided with the following information to base my review on:

- KHVCT responses and supporting policies.
- [Mr B]'s clinical file.
- Consumer complaint.

3. Complaint

[Mr B]'s daughter and EPOA (Personal Care and Welfare), [Ms A], expressed concern about the care provided to her father in his last months of life. Issues relate to the identification and treatment of scabies, resident care and safety following an altercation in the dementia community, communication processes, and ongoing management of his clinical care.

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, to comment on:

a) The appropriateness of assessment and management (including seeking medical input) of a skin rash.

A review of the submitted nursing documentation indicates [Mr B] first presented with compromised skin integrity in October 2021. Care staff reported areas of redness with pustules in his groin and escalated their concerns to a registered nurse. [Mr B] was referred to his GP for further assessment and commenced on a treatment plan for a skin infection. Skin and wound assessments were completed at different intervals by registered nurses between October and December 2021 and describe ongoing concern with [Mr B]'s skin integrity. Entries in his personal care record describe his skin integrity as '*irritated, inflamed, red, sore, itchy, scaly, rough and dry, affected skin includes back, arms, chest, legs and hands'.*

Photographs of [Mr B]'s lesions and body rash were sent to his GP to inform a virtual consultation, which is a recommended intervention to support clinical assessment and diagnosis. According to nursing documentation, [Mr B] was commenced on further treatment for a skin infection. These actions are evidenced in the medication administration record, progress notes, and wound care management documents; however, there are no supporting GP clinical notes available to provide evidence of clinical assessment and care. There does not appear to be a short-term nursing care plan commenced for the skin and wound infections although there is discussion of care delivery within the wound assessment plans.

[Mr B]'s medications and known allergies were peer-reviewed by the Clinical Manager and GP Link Nurse to determine if the rash may be medication-related; however, there was no indication of recent changes to [Mr B]'s prescribed medications. It is unclear if the RN team requested a medication review by the GP or Pharmacist at this time. It is also unclear from the evidence provided if a referral was sent to an allied health practitioner, such as a wound nurse specialist or dermatologist, for wider consultation about [Mr B]'s atypical skin integrity and ongoing care.

[Mr B] developed significant swelling in his left arm and hand in December 2021, impacting circulation, which required hospital transfer for assessment and the removal of a ring on his left ring finger. According to hospital documentation, [Mr B] was diagnosed with erythroderma and superimposed cellulitis as an adverse reaction to a prescribed antipsychotic. Medications were rationalised and he was transferred back to the care home for ongoing care. It is unclear at this point if [Mr B] was reviewed by his GP on return from hospital. Accepted practice would be for a medical review to occur within two days of return to the care home from hospital, particularly following an adverse drug reaction to ensure an agreed management plan was in place. There is no evidence of a nursing assessment completed on his return to the care home or commencement of a short-term care plan to guide care and safety needs given the medication changes and potential impact to his mood and behaviour. It is also unclear what level of communication occurred with the EPOA and family/whānau at this time.

The personal care record indicates [Mr B]'s skin integrity continued to decline, with reports of blisters, crusted pustules, and body rashes in December 2021. According to an event timeline, other residents in the dementia community were also identified with body rashes. There is evidence of text communication between an RN and the GP regarding clinical concerns. A precautionary scabies treatment plan was commenced as evidenced in the scabies outbreak management plan; however, there is limited evidence of pre- and post-treatment assessment and evaluation in clinical records by the nursing and medical teams at this time.

For this question, I believe the care delivered to [Mr B] was of the minimum and/or lowest level of an acceptable professional standard. There is evidence of assessment, escalation, and collaboration between health colleagues; however, there are opportunities for strengthening the assessment and evaluation of clinical processes. This is a moderate deviation from accepted practice, and it would be viewed similarly by my peers. I have come to that conclusion because it is normal practice for the registered nurse to develop, review,

and update a short-term care plan for skin integrity issues, personal care, and safety needs such as these. Care plans ensure continuity of care across the different shifts and also enable the documentation of a clinical picture over time to be reviewed to determine the effectiveness of the interventions.

- Departure from accepted practice: Moderate

b) Whether the provider's outbreak management procedure is adequate and in line with best Infection Prevention and Control (IPC) practice or not; does this have sufficient information to guide staff (related to specific outbreaks)? Does this entail communication with families/EPOA?

The Outbreak Management Procedure policy provides overarching guidance about the care and management of suspected resident and staff cases; however, the document does not provide specific information to guide staff about the different types of outbreaks, identification of symptoms, nor related care or reporting responsibilities. The Outbreak Management Procedure policy does not provide specific guidance about communicating with the resident, their EPOA, family/whānau to inform them of a suspected outbreak and related plan of care.

Timely communication with residents and their nominated representatives is an essential part of outbreak management and provides an opportunity to share vital information, provide reassurance, and answer questions in a meaningful way.

For this question, I believe the Outbreak Management Procedure is of the minimum and/or lowest level of an acceptable professional standard. It is unclear if this document belongs to a more comprehensive suite of care home IPC policies that aligns to Aged Residential Care (ARC) service provider responsibilities and meets the Ngā Paerewa Health and Disability Service Standards (HDSS) 2022. This may provide an opportunity to review IPC policies, processes and documentation standards to ensure staff are well informed and consumer care and safety needs are maintained. This is a mild departure from the standard of care, and it would be viewed similarly by my peers.

- Departure from accepted practice: Mild

c) Was there sufficient and timely communication by KHV to the EPOA? Particularly when there were changes to [Mr B]'s condition identified (eg, sustained a wound), a change in care pathway or treatment occurred (eg, change in medication).

There is evidence of communication with [Mr B]'s EPOA, wife and family members during their visits recorded in the electronic care record. Entries from care and qualified staff acknowledge family support and input with [Mr B]'s activities of daily living.

[Mr B]'s EPOA, [Ms A], has raised concern about communication delays concerning two significant events.

1. As EPOA for [Mr B], [Ms A] was not informed about the suspected scabies outbreak in the Alice Court dementia community and the clinical decision to commence precautionary scabies treatment for all residents.
2. As EPOA for [Mr B], [Ms A] was not informed in a timely way following a behaviour of concern event that resulted in [Mr B] sustaining a suspected head injury from a physical altercation with another resident – refer (d)

The ARRC Services Agreement and Health and Disability Service Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person in a timely way of any change in the resident's health condition, any identified risk or concern regarding their care and safety needs, or of any adverse event. As the EPOA for [Mr B], [Ms A], as the consumer's decision-maker, has the right to be informed and to give informed consent to proposed changes to an agreed plan of care. Care decisions are made in partnership with the EPOA and registered nurses at the care home, and evidence of these interactions is required to be documented in the resident's family contact record, care plan, progress notes and meeting minutes.

The care home's general manager has acknowledged and apologised for the lack of communication with [Ms A] in the provider response letter and included supporting evidence of this interaction. It is unclear what corrective actions were implemented and what improvement opportunities were commenced in response to the consumer feedback.

For this question, I believe the communication with the EPOA and related evidence of interaction is of the minimum and/or lowest level of acceptable professional standards. Evidence of communication with a resident's nominated representative is a significant part of service provider responsibilities and a fundamental part of the nursing process. This is a moderate to serious departure from the standard of care and would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious

d) The delay in communication by KHV to the EPOA re transfer to hospital (Was transfer to hospital via ambulance in the night not considered an 'emergency'?)

According to the incident report and event timeline, [Mr B] was involved in a physical altercation with another resident and a related fall event at 4am on 13 January 2022. [Mr B] was assessed at the time by a registered nurse who observed redness and bruising to his left jaw but no other apparent sign of injury at this time. [Mr B] was repositioned and transferred back to bed for further monitoring, which is in line with falls event management. Nursing assessment included a skin assessment and monitoring of vital signs. Neurological observations were commenced, which is in line with unwitnessed fall management. This indicated an elevated systolic blood pressure reading of 200/82. This was reportedly above [Mr B]'s baseline range, which may have indicated a suspected head injury; however, the event timeline states that his blood pressure had stabilised an hour later. Additional nursing notes from staff indicate [Mr B] was lethargic and slow to respond. He was assessed by a registered nurse at 3.50pm, who identified that [Mr B]'s blood pressure was elevated and

neurological observations were abnormal. He was then transferred via ambulance to hospital at 5.20pm for further assessment and care. Medical assessment and a CT scan indicated there was no sign of a head injury or identified signs of physical harm. The incident report states that the event occurred at 4am. The GP and EPOA were informed of the resident-to-resident altercation and related fall event at 3.30pm. The general manager and clinical manager have provided a response that, based on their assessment of lower risk, contact was reprioritised.

The ARRC Services Agreement and Health and Disability Service Standards require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in a resident's health condition or of any adverse event. A behavioural event that resulted in physical contact and an unwitnessed fall is significant, and accepted practice would be to contact the EPOA of both parties involved in a timely way as part of the incident investigation processes. Having open communication and a shared understanding of care responsibilities is particularly important for families who are acting on behalf of a resident living with a diagnosis of dementia. Entries in the care record reflect conversations between the family and care home management team, including an apology, with discussion of how best to meet Mr B's care and safety needs following his return from hospital; however, there is no supporting evidence of agreed changes made to the care plan.

For this question, I believe the communication with the EPOA was below an acceptable professional standard. This is a serious departure from the standard of care and would be viewed similarly by my peers.

- Departure from accepted practice: Serious

e) Sufficiency of information provided to the family or whānau/EPOA on challenging behaviours (eg, physical aggression), their management, and likely occurrence of these in a dementia service setting?

The 'Challenging Behaviour Management Procedure' provides information to staff about resident behaviour, support strategies, incident management and event follow-up. The document refers to informing the GP or seeking allied health input after an incident; however, it does not discuss communication with the EPOA, family/whānau or wider responsibilities to care partnerships, open communication and informed consent. There is limited discussion about nursing assessment, identification of risk, safety concerns such as triggers to behavioural changes, and care planning. The document does not refer to incident analysis or identified themes or trends and how this is communicated with consumers, nominated representatives, or other stakeholders to provide reassurance about ensuring resident safety and appropriate care.

It is unclear what orientation was provided to [Mr B] and his EPOA, family/whānau during his admission phase to the dementia community. It is unclear if they were socialised to the new environment, advised of any potential risks while visiting [Mr B], or provided guidance regarding the process for managing the safety needs of residents, staff, and visitors in this setting. It is also unclear from [Mr B]'s care plan if any questions or concerns regarding safety

needs were discussed with his EPOA during the admission period or during the six-monthly resident review process.

For this question, I believe the Challenging Behaviour document does not provide specific guidance for staff regarding reporting responsibilities to the EPOA or nominated representative. This is a moderate departure from the standard of care, and it would be viewed similarly by my peers. There are also opportunities to review policies and processes relating to resident admissions to dementia-level care, the management of resident stress and distress, and related responsibilities to open communication and informed consent.

- Departure from accepted practice: Moderate

f) The adequacy of KHV's *Liaison with Family/Whānau Procedure* to guide their staff? Specifically, to address the communication shortfalls in this case.

Two documents that relate to communication were reviewed. The Consultation – Resident Procedure document states that 'all residents, families or significant others will be consulted regarding the plan for resident care' and 'for matters of concern, resolution is sought and a plan of action recorded in the clinical file.'

The 'Liaison with Family/Whānau Procedure' document outlines the internal process for qualified staff to escalate their concerns about interactions with family/whānau to the care home leadership team. The document does not specifically outline role responsibilities relating to communication with family/whānau. It contains links to a complaints policy and flow chart; however, these particular items were not submitted as evidence for review.

The EPOA has the right to be fully informed about all aspects of care relating to the resident. The EPOA's role is to contribute to resident care planning in partnership with the service provider, to advocate for the resident and provide informed consent to agreed care. Care partnerships are based on collaboration, which involves regular discussion, or consultation, with the EPOA and timely feedback to ensure the appropriate outcomes are achieved.

For this question, I believe the two documents do not provide enough guidance for staff about open communication, informed consent and the related responsibilities.

This is a moderate departure from the standard of care, and it would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

<u>Additional Comment provided 17 December 2024</u>

Thank you for the opportunity to review my clinical advice 25 October 2022 and provide clarification regarding the severity of identified concern for question (g).

The question has discussed sufficiency of information provided to family/whānau or nominated representatives about caring for residents living in a dementia care setting who are experiencing stress and distress. As outlined in the discussion points, the guiding policy

(Challenging Behaviour Management Procedure) does not provide adequate information to inform team actions about communication processes, care partnerships, and informed consent. As discussed in question (c), timely and open communication is an essential part of service delivery, and the care record provides minimal evidence of interactions, such as delivery of health education or improvement initiatives in the circumstances. This would be considered a moderate departure from the standard of care and viewed similarly by my peers.

Additional comments provided on 30 September 2025

Thank you for the opportunity to review the provider's response with supporting information and consider changes to my initial advice.

The provider has shared an apology and discussed comprehensive improvements made to the organisation's systems and processes based on learnings from this complaint. They have acknowledged the need to strengthen communication and documentation standards and have updated policies and quality assurance processes in response to identified practice gaps. Although no evidence was submitted of a completed corrective action plan, the provider has shared feedback clarifying knowledge and skills and has referred to achieved criteria through the external audit process for service providers.

[Mr B] was entitled to receive an appropriate standard of care during his admission to the care home. Based on my review of the nursing information during the timeframes in question, I consider the care and related communication provided to him and his family to be inadequate in the circumstances. I consider there to be mild to moderate departures in adherence to clinical standards, and this would be viewed similarly by my peers. While the COVID-19 pandemic was a trying time for residents, families and care home teams, essential elements of care and communication were still expected to continue.

In summary, I acknowledge the clinical and operational improvements made by the care home since this complaint was received; however, I do not wish to make changes to my initial advice regarding [Mr B]'s care experience at the time.

Jane Ferreira, RN, PGDipHC, MHlth

Nurse Advisor (Aged Care)

Health and Disability Commissioner

Appendix B: Independent clinical advice to the Commissioner

The following independent clinical advice was obtained from ED nurse, Mr Richard Scrase:

Complaint:	**Mr [B]**
Our ref:	**22HDC01392**
Independent advisor:	**Mr Richard Scrase**

I have been asked to provide clinical advice to HDC on case number 22HDC01392. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I started my nursing career in 2000 as a Nursing Auxiliary at Torbay Hospital in Devon, UK. I worked on the general pool, which included working in the ED department. After completing my Nursing Diploma, I started work in 2005 as a Registered Nurse on an acute surgical ward at Torbay Hospital in the UK. In 2006, I moved to New Zealand and worked at Christchurch Hospital on an acute colorectal and general surgical ward. I transferred to Older Persons Health in 2009 and worked as Registered Nurse on a rehabilitation ward before moving across to the Community Team at Older Persons Health in Christchurch, which included working as an RN in a newly formed early supported discharge team. Following this, in 2013, I became a Gerontology Nurse Specialist in a role that supported Aged Residential Care Facilities with areas such as clinically complex residents, education, and care planning support. In 2018, I was appointed as Nursing Director Older People-Population Health for Canterbury and West Coast DHBs. This role focused on supporting nursing in both the Community and Aged Residential Care settings whilst continuing to be direct Line Manager for the Gerontology Nurse Specialist Team. It also involved investigating and reporting on any complaints and concerns raised to the Canterbury DHB and West Coast DHB's about care provided in local Aged Residential Care Facilities. A significant project involved working with the ED department at Christchurch Hospital on how to better support residents from aged residential care when they entered ED. I have completed my postgraduate diploma in Gerontology Nursing, and I have been an author on seven published peer-reviewed articles focussing on health-related issues in New Zealand's frail older population. I was part of the national group

	that has been formulating the ARC Covid Response Plan for New Zealand. I was also Chair of the HQSC National ARC Leadership Group. Since leaving the CDHB in 2023, I have been a designated auditor in the health and disability sector as well as continuing to be involved in health research work.
Documents provided by HDC:	1. Letter of complaint dated 12 May 2022. 2. Health NZ's responses dated 11 August 2022 and 16 July 2025. 3. Clinical records provided by Health NZ covering the period 13–14 January 2022. 4. Delegated patient observation policy and patient constant observation management plan.
Referral instructions from HDC:	1. Whether it was appropriate for [Mr B] to remain in the ED for 15 hours. 2. Whether the level of monitoring provided to [Mr B] in the ED was appropriate. As part of this, please also comment on whether [Mr B] required continuous support from a healthcare attendant. 3. Whether the standard of nursing care provided to [Mr B] was appropriate. As part of this, please comment on the standard of personal cares, wound care and pressure area cares provided to [Mr B]. 4. Any other matters that you consider warrant comment.

Factual summary of clinical care provided complaint:

Brief summary of clinical events:	This clinical advice relates to the care provided to an older adult (Mr [B]) with a diagnosis of dementia, who was taken to the ED at Whangārei Hospital by ambulance with a number of concerns, including having sustained an assault by another resident at his aged care facility. The complainant's concerns relate to both the care provided and the time spent in the ED department following his presentation there on the early evening of 13 January 2022. Family members were not able to go to the ED but kept in contact with staff by telephone. Their expectation was that Mr [B] would be transferred to a ward. Family members were therefore disappointed that Mr [B] was still in the ED the following morning. He was transferred to a ward at approximately 8.30am on 14 January. Mr [B] was described by a family member as being in a

	"catatonic state" and not the person she remembered prior to the assault. Hospital staff also reported to the family that Mr [B] had wounds on his hip, buttock and leg that members of his family were previously unaware of. In addition, Mr [B]'s glasses were found in a hospital property bag underneath his clothes, which were wet with urine. The complainant has asked, "why was a dementia patient left in ED without the proper care and attention required for someone in such a catatonic state." The Health NZ responses to this complaint on 11 August 2022 and 16 July 2025 were extensive and detailed. Although I will look at specific responses in more detail in this report, Health NZ acknowledged that the extended time Mr [B] spent in the ED was not best practice but that this was due to the unavailability of a bed in a single room on a ward. Their responses can be broadly summarised as stating that Mr [B] was medically reviewed in the ED within a reasonable time frame and that interventions and cares provided were reasonable and timely, given Mr [B]'s behaviours of concern and his resistance to cares being provided. They stated that Mr [B] was incontinent on several occasions but that he was cleaned and changed in a timely manner but that there was no evidence that Mr [B] was left in soiled clothes. Furthermore, the Health NZ response states that the wounds referenced above were present on his arrival to the ED. The response from Health NZ states that Mr [B] did initially have either a hospital watch or a shared watch, but this had to be removed at approximately 1am on 14 January because of a requirement for them elsewhere in the hospital. Following a review of this particular case, a number of service improvements have been made or initiated by the hospital to improve the care provided to patients and in particular those with a diagnosis of dementia.

Question 1: Whether it was appropriate for Mr [B] to remain in the ED for 15 hours.	
List any sources of information reviewed other than the documents provided by HDC	The Ngā Paerewa Health and Disability Service Standard NZS 8134:2021 came into effect on 28 February 2022 and in this context replaced Health and Disability Services Standards NZS 8134:2008. Although

	the current standards came into force shortly after the events discussed here, it is my view that the principles highlighted are transferable, are – from a consumer perspective – clearer, and, importantly, align well with relevant sections of the previous relevant standards.
Advisor's opinion:	The clinical documentation provided states that Mr [B] arrived in the ED at 5.42pm on 13 January 2022 and arrived on the ward at 8.26am on 14 January 2022. Mr [B] therefore remained in ED for approximately 14 hours and 45 minutes. The health target for length of stay in New Zealand EDs is (and was in 2022) that 95% of patients are to be admitted, discharged or transferred within six hours of arrival in the ED. The purpose of this target is to improve hospital flow, and for individual patients to receive the most appropriate care, in the right place in a timely manner. Although there are times when individuals will [stay] for more than six hours, in this instance the stay in the ED was significantly more than the aforementioned target. In my professional opinion, it would therefore be reasonable to state that it was not appropriate for [Mr B] to remain in the ED for as long as he did. That said though, it is also important to consider the real-life context at the time this event occurred. The responses from Health NZ highlighted that; • The department was busy on the evening of 13 January 2022 and the early morning of 14 January 2022. • They did not appear to have received a handover document from the aged care facility and so there was a lot to piece together, particularly in terms of Mr [B]'s baseline level of function. • Mr [B] had a diagnosis of dementia and was resistive to cares in what was to him an unfamiliar environment. • The ED had endeavoured to have Mr [B] transferred to a ward on 13 January but there was no single room available, which they considered the most appropriate environment for him.

	In other words, Mr [B] arrived in a busy environment, and it would have taken some time to get a full picture of what the primary issues were for this man. Added to this, it appears that there was not an appropriate bed space on the ward for this man once a decision was made about what the next steps needed to be. Having reviewed all the notes available to me and given my professional knowledge of supporting individuals with a diagnosis of dementia in a stimulating hospital environment, I would agree that endeavouring to ensure that Mr [B] had a single room would be a priority to ensure stimulation was kept to a minimum. However, I note from the Health NZ response that although there were no single rooms available, there were five empty beds, although I have no knowledge of their configuration. Given this, and reflecting on my own professional experience of similar situations, it would be reasonable to ask to what extent discussions were had between senior nursing staff about how existing patients, including those in single rooms could be moved in order to accommodate Mr [B]. It is possible that these discussions were had, and not documented, and that it couldn't happen because of the impact of those already in a side room and other patients, including consideration of male/female mix. However, given the lack of documentation in this regard, I am also led to consider whether the immediate lack of a side room was the end of the discussion without any further critical thinking or problem solving involved. I note from the documentation provided that Mr [B] arrived on the ward at approximately 8.30am on 14 January. It is not clear to me from the documentation provided whether Mr [B] went into a side room on the ward. It is also not clear to me what factors changed that made it possible to transfer Mr [B] early that morning, when it wasn't possible the previous evening. There may well be a reasonable explanation and a number of reasons why a bed becomes available when it wasn't earlier. However, with the information I currently have available, the explanation isn't clear.

What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and, in particular, section 3, Pathways to Wellbeing. The Health NZ target for EDs is that 95% of patients are discharged, transferred or admitted within six hours. Health targets performance – Health New Zealand | Te Whatu Ora
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Here, I am specifically considering the appropriateness of Mr [B] remaining in the ED for an extended period of time. The matter of the actual care provided is considered elsewhere. Overall, I found the lack of documented evidence a recurring theme when reviewing this case. The letters of response made several areas clearer to me, but the documentation at the time events occurred was significantly less detailed. I accept the challenges that the department faced in terms of the business of the hospital and the difficulty in obtaining an appropriate bed space for Mr [B]. However, the fact remains that Whangārei ED kept Mr [B] in the department for a period of time well beyond the target figure of up to 6 hours. Unsatisfactory though it was, in the event that Mr [B] was unable to be moved to a bed on a ward, then accepted practice would be to keep him in the ED until he could be safely moved to an appropriate bed space, simply because there was no safe and appropriate alternative. However, I do need to consider the points raised above in terms of what discussions were had with respect to how to best accommodate Mr [B]. Therefore, in view of the lack of documentation with respect to the decision-making concerning the delayed transfer to the ward, I consider this to be a mild departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I discussed this case without disclosing the names of parties or hospital involved with both a senior clinician of a busy ED department and also an experienced nurse specialising in dementia care. Both parties agreed with my opinions throughout this report.

Please outline any factors that may limit your assessment of the events.	I acknowledge that I am unfamiliar with Whangārei hospital and the layout, size and configuration of the ED department or the wards. I also acknowledge that I am unaware of the acuity of patients both in the ED and the wards for the period in question.
Recommendations for improvement that may help to prevent a similar occurrence in future.	In view of the limited documentation available, specifically with respect to the decision about keeping Mr [B] in ED, I would consider a written procedure about transfers from ED. For example, is a single room necessary and available, Yes/No. If no, can a patient in single room be moved without impacting their care/wellbeing, Yes/No, etc. Then staff can document for example, "followed transfer pathway, no side room available, patient to remain in ED." In this way, there is a logical equitable and consistent way of dealing with an issue that is likely to arise again.

Question 2: Whether the level of monitoring provided to [Mr B] in the ED was appropriate. As part of this, please also comment on whether [Mr B] required continuous support from a healthcare attendant.	
List any sources of information reviewed other than the documents provided by HDC:	Ngā Paerewa Health and Disability Service Standard NZS 8134:2021 Handley M, Theodosopoulou D, Taylor N, et al. The use of constant observation with people with dementia in hospitals: a mixed- methods systematic review. *Aging & Mental Health*. 2023;27(12):2305–2318. Gee S, Bergman J, Hawkes T, Croucher M. Think delirium: Preventing delirium amongst older people in our care. Tips and strategies from the Older Persons' Mental Health Think Delirium Prevention project Christchurch, New Zealand: Canterbury District Health Board; 2016.
Advisor's opinion:	In answering this question, I have considered monitoring as both physical and behavioural support of Mr [B] during his time in ED. The clinical notes provided state that Mr [B] declined to have his observations taken when he first arrived in the ED. The letter of response from Health NZ dated 11 August 2022 states that the House Officer saw the

	patient at 5.49pm, which was shortly after his arrival. I have been unable to identify any documentation relating to this initial assessment, although the Health NZ response dated [11 August] 2022 quotes the assessment (although no time is given) and includes "seems sore, mark right temple. Tender right ribs/abdomen.? reduced air entry right side, tender right abdomen." A CT scan of the head and bloods were completed that evening. Initially, Mr [B] was placed in a room close to the nurse's station to aid closer observation. Mr [B] then declined observations and cares at 7.13pm. The first recorded blood pressure on the documentation provided was taken in the ED at 9.27pm. Mr [B]'s blood pressure was documented as 213/104. Other observations were within a normal range. The next set of recordings were completed at what appears to be midnight according to the handwritten observation chart. These observations, including blood pressure, were within a normal range. Ideally, it would be a reasonable expectation to repeat Mr [B]'s blood pressure given the recorded reading at 9.27pm within an hour. However, repeated observations to an individual that is already confused and distressed is quite likely to exacerbate matters and thereby risk increasing his blood pressure as well as escalating behaviours of concern. I therefore feel that the frequency of clinical observations was reasonable under the circumstances documented. Mr [B] was also incontinent on several occasions during his time in ED, but the documentation provided does not indicate that he was left in a soiled or wet bed for an extended period of time. That said, I am of the opinion that there were some significant gaps in terms of documented nursing assessments and interventions for this man while in the ED, and I will address these in more detail in the next section. I acknowledge that the use of medication was an attempt to essentially aid Mr [B] becoming more settled in order that support and input could be more safely given, but that in itself also has risks, such as increasing the likelihood of falls as a result of sedation. However, Mr [B] may have been better supported and monitored by having one-on-one support at an earlier

	stage than was the case. This support may have reassured Mr [B] early in his stay and discouraged him from removing his IV lines, which he did on several occasions. This one-on-one support doesn't always work as we would hope, but it needs to be considered at an early stage. Therefore, support for Mr [B] may have been aided by him having some one-on-one support when arriving or soon after arriving in ED. The family couldn't be there and therefore the next best option is a hospital aide. When an older adult with dementia arrives in hospital on their own, the most likely outcome is that they will be distressed, and all the literature on this subject suggests that it is highly likely that they will initially become more agitated. Therefore, it is about providing support, not as a response but as a proactive way of increasing the likelihood of achieving the best outcomes for an individual such as Mr [B] and in addition also reducing the risk of him acquiring a delirium. The use of continuous support from a healthcare assistant as soon as possible and if possible before things have escalated can be of value if this resource is utilised in the correct way and it can add to improved monitoring and assessment by building trust and familiarity between the patient and staff. The focus though should not be on keeping the patient quiet, but on supporting their wellbeing and meeting their needs. However, I acknowledge that, although this scenario would be ideal, in terms of accepted practice in a busy hospital environment with all the constraints on resources that this brings, the approach detailed above is extremely challenging to achieve. In addition, given that I need to consider matters without the benefit of hindsight, it was likely that when Mr [B] first arrived there was an expectation that he would be moving through the department relatively quickly rather than him staying for an extended period of time. Once Mr [B] did have additional support, the clinical notes state that this was for the period of 90 minutes between 11.30pm on 13 January to 1am on 14 January and that Mr [B] was one of two patients being supported by the same staff member. The hospital's

	Patient Constant Observation Management Plan that covers the role in question requires that patient activities are documented hourly and that there is a patient management plan. During the period he was under supervision there is nothing documented that states what Mr [B]'s behaviours were, what interactions were had and their effectiveness. The reason for this omission is unclear. Overall, it is my view that additional support and monitoring could have reasonably been considered earlier than was the case.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 and, in particular, section 3, Pathways to wellbeing.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Having reviewed all the available documented evidence, it is my professional opinion that, although it was a challenging situation, continuous healthcare assistant support by someone with a clear expectation of their role to support Mr [B] would have been appropriate for earlier and significantly longer than was the case, both prior to and after the time Mr [B] actually had this support. I acknowledge that accepted practice is that support needs be prioritised to where the need is greatest when staffing is limited. However, in my view, it would also be reasonable to expect documented evidence concerning a request for healthcare assistance support earlier than was the case. Therefore, on balance, I consider the documented monitoring and assessment to be a moderate departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I discussed this case without disclosing the names of parties or hospital involved with both a senior clinician of a busy ED department and also an experienced nurse specialising in dementia care. Both parties agreed with my opinions throughout this report.
Please outline any factors that may limit your assessment of the events.	I acknowledge that I am not conversant with the staffing ratios in the department and nor do I have an awareness of the other patients and any challenging behaviours or clinical concerns that they may have had

	in the department on the night in question, which may have impacted on time available and decision-making.
Recommendations for improvement that may help to prevent a similar occurrence in future.	I acknowledge and support the new interventions that the department is putting in place with respect to better supporting patients with a diagnosis of dementia, which they have outlined in their letters of response. In addition, it may be useful to consider further education for healthcare assistants, so that they are better able to support those patients with a diagnosis of dementia and better meet their needs. In this way, there is greater opportunity for positive interaction rather than what in my experience is often the default, whereby the support person is a silent observer. To consider a pathway that allows early identification of patients with dementia and, in particular, those arriving without support so that healthcare assistant support can be considered at an early stage. The document "Think Delerium" referenced above may also be of value.

Question 3: Whether the standard of nursing care provided to [Mr B] was appropriate. As part of this, please comment on the standard of personal cares, wound care and pressure area cares provided to [Mr B].	
List any sources of information reviewed other than the documents provided by HDC:	Ngā Paerewa Health and Disability Services Standard NZS 8134:2021
Advisor's opinion:	Once the decision had been made to keep [Mr B] in the ED, there needed to be a focus on the fact that it was highly probable that he was likely to be staying there until the next morning when hospital flow would allow ward beds to become available. This being the case, particular documented attention needed to be given to hydration, pressure injury care, and pain assessment. That is not to say that these areas should not normally be given attention in the ED, it is more that the extended stay makes them even more significant.

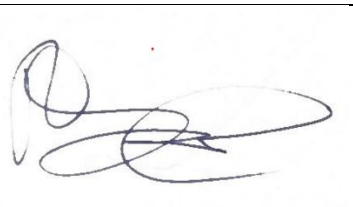
	I have already mentioned that, in my view, the documentation was at times limited. It is, however, important to give this comment context. EDs are busy, fast-paced environments, and, although it was not the case in this instance, patients generally move through the department relatively quickly. Furthermore, patients are not necessarily brought into the ED to be admitted; in fact, it is usually the case that the minority of patients presenting to ED are actually admitted to hospital. It is therefore not appropriate to compare the level of documentation completed in the ED with that undertaken in, for example, an aged care facility or on a ward. The documentation therefore needs to be professional and complete and appropriate for the environment and the patient concerned. However, the added factor to consider is the length of time an individual remains in the ED. Broadly speaking, the longer an individual is in the ED before transferring to a ward, the more significant any gaps in documentation are likely to be. The primary areas of concern are as follows: The wounds that Mr [B] had on his upper thigh were swabbed for possible infection and then cleaned and dressed. However, these were not documented in the nursing notes until 2am, which is approximately eight hours after Mr [B]'s arrival in the ED. The only wound chart I was able to locate was one completed following his arrival on the ward on 14 January 2022. In addition, there is no documented evidence of any fluid intake during the extended period of time Mr [B] was in the ED. Whilst I acknowledge that Mr [B]'s time in the ED was largely overnight and staff were endeavouring to settle him, there is a balance to be had, particularly given he couldn't receive IV fluids as he had removed his IV lines. I do note that the clinical observations are not immediately reflective of dehydration. There was no documented evidence of pressure area cares or risk assessment being undertaken. As a frail older adult, Mr [B] would have been a strong candidate for acquiring pressure injuries while in hospital, particularly given he was likely to be less mobile than normal. The fact that he didn't acquire any pressure

	injuries during his time in hospital doesn't preclude the fact that there should be documented evidence of an assessment and, if identified as appropriate, documented evidence of pressure-relieving equipment being utilised. Furthermore, aside from his dementia, it is not clear from a nursing perspective what considerations were given to what other issues might be driving or adding to his challenging behaviours. This would in my view include a pain assessment, which would not be an unreasonable consideration given he had apparently been punched while back in the rest home, and the issues highlighted in the doctor's initial assessment. It is my professional view that there were some significant gaps in Mr [B]'s nursing care where a focus on managing his challenging behaviour may have been prioritised over other important elements of nursing care. However, it is also important for me to consider the lived experience of the staff involved and the challenges that they faced in trying to support a patient with dementia who was on his own in an unfamiliar environment. In my professional experience, it is sometimes very difficult to de-escalate a situation so that a patient is comfortable with a member of staff examining them. When supporting individuals with dementia, there is sometimes a difficult balance between achieving good nursing care and giving an individual space to calm down and to actually show them respect and to acknowledge that they have a voice. However, ultimately, it is the lack of evidence with respect to fluids, pressure injury prevention, and pain management and the relatively late documentation and management of his wounds that were of concern to me.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Ngā Paerewa Health and Disability Service Standard NZS 8134:2021 and, in particular, sections 3.2 and 3.5.

Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	I would consider the lack of documented evidence of some significant areas of nursing care to be a severe departure from accepted practice.
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	I discussed this case without disclosing the names of parties or hospital involved with both a senior clinician of a busy ED department and also an experienced nurse specialising in dementia care. Both parties agreed with my opinions throughout this report. There was an agreement that the extended stay in the ED was not planned but evolved because of other circumstances. However, once this extended stay had been actioned, the nursing care in particular needed to change accordingly, challenging though that would be for an ED environment.
Please outline any factors that may limit your assessment of the events.	I acknowledge that cares may have been provided but were not documented correctly. I also acknowledge that I am unaware of the staffing ratios and experience of those on duty at the time of this event.
Recommendations for improvement that may help to prevent a similar occurrence in future.	Improved education for ED nursing such that, in the event that a patient has a prolonged stay in ED, all appropriate assessments and interactions are undertaken and documented, particularly with respect to pressure injury prevention, wound care and fluid intake. Documentation and assessments in the ED are often different to that on the ward. When patients are moving out of ED within the expected time frame, this works. However, when they have a prolonged stay, then there may need to be a look at what documentation is used, particularly in a case such as this when it appears likely Mr [B] was going to remain in the ED overnight once a bed could not be found for him. In some respects, he could be considered as a medical outlier in the ED. It is how this is better supported that may benefit from some further work.

Question 4: Any other matters that you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	
Advisor's opinion:	I have no further concerns with respect to Mr [B]'s time in hospital.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.


Name: Richard Scrase
Date of Advice: 1 October 2025

The following further advice was provided on 3 November 2025:

Thank you for the opportunity to reply to the response from Health NZ dated 29 October 2025.

Question 1: Whether it was appropriate for Mr [B] to remain in the ED for 15 hours.

Thank you to Health NZ for their comments with respect to this question. I acknowledge and apologise for my oversight when I referred to health targets that were not actually in effect at the time of the incident in question. I also acknowledge the mitigating factors that impacted this man's extended stay in the ED. However, in my view, these factors do not alter the fact that it was not appropriate for Mr [B] to remain in the ED for an extended period. Consequently, my findings with respect to this question remain unchanged.

Question 2: Whether the level of monitoring provided to Mr [B] in the ED was appropriate. As part of this, please also comment on whether Mr [B] required continuous support from a healthcare attendant.

Thank you for the additional details supplied by Health NZ. I should be clear that my comments about handwritten notes were really about some of them being slightly difficult to read, particularly in copied form rather than an expectation that they should be electronic. I fully support the additional Level 3 training being given to healthcare assistant (HCA) staff in the ED. This is likely to be beneficial in terms of better supporting patients, including those with a diagnosis of dementia.

The findings in my initial report relating to this question remain unchanged.

Question 3: Whether the standard of nursing care provided to Mr [B] was appropriate. As part of this, please comment on the standard of personal cares, wound care and pressure area cares provided to Mr [B].

The ED Falls and Pressure injury risks screening tool, which is also audited, is an important introduction to help improve health outcomes in the department. So too are the changes made to the policy regarding behaviours of concern and the additional training being provided to HCAs previously mentioned.

The findings in my initial report relating to this question remain unchanged.

Ngā mihi,

Richard Scrase