HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate care provided to vulnerable consumer in aged care home

Background

1. This report discusses the care provided to the late Mr [B] by Bupa Care Services NZ Limited (Bupa).

2. Mr B was aged in his early 70s and had a history of vascular dementia[1] with hypoxic brain injury,[2] atrial fibrillation,[3] osteoarthritis,[4] hyperlipidaemia,[5] hypertension,[6] gout, and anaemia. During an acute admission to Auckland City Hospital following a fall at another care home, he was diagnosed with primary subdural haemorrhages, with behavioural and psychological symptoms of dementia[7] (BPSD). He was assessed as requiring psychogeriatric care and admitted to the Bupa specialist dementia unit on 23 January 2023, where he passed away in April 2023.

The complaint

3. Mr B's whānau raised multiple concerns relating to Bupa's management of Mr B's care, including the following:

- Overall care planning, including oral hygiene and beard removal
- Nutrition/hydration management
- Weight loss
- Pain management
- Falls management

4. The overall purpose of the whānau raising this complaint is to attempt to improve the living situation for current and future residents at the Bupa facility.

Bupa's response

Oversight and care

5. Bupa responded that, on admission, a variety of assessments are completed by a registered nurse (RN) and a general practitioner (GP) based on the information provided by the referring clinician and by examining the resident. Bupa noted that all the paperwork for Mr B was completed within standard set timeframes. Mr B saw the GP on 15 occasions during his residency of almost three months. Following completion of the initial assessments, the

[1] Decline in memory and other thought processes.
[2] Injury to the brain when it is deprived of oxygen.
[3] An irregular heart rhythm.
[4] Inflammation causing pain, stiffness, and swelling in joints.
[5] Abnormal levels of fats in the blood.
[6] High blood pressure.
[7] BPSD consists of a wide range of non-cognitive symptoms, including agitation, aggression, depression, anxiety, psychosis (delusions and hallucinations), apathy, wandering, and sleep or appetite disturbances.

clinical team continue to capture the resident's abilities and needs through data collection and additional monitoring, such as fluid balance and behaviour sheets, which is used to develop the resident's long-term care plan (LTCP). Bupa expects that the LTCP is developed and shared with the resident and whānau at the three-week review meeting within 15 days of admission, which occurred via phone with Ms D, Mr B's wife and EPOA.[8]

6. In response to concerns raised about Mr B's beard being removed, Bupa acknowledged that Mr B had a beard on arrival and stated:

> '[W]e have been unable to identify when or who shaved off his beard. Again, we apologise as this does not reflect our organisational values to support person-centred, individualised care.
>
> …
>
> Mr B was supported to complete his own hygiene cares — including his mouth and oral cares. We appreciate that a more objective consideration of the condition of Mr B's mouth and teeth, especially when he was noted to have reduced oral input, would have allowed for further intervention and support to be provided.'

7. Bupa said that Mr B's BPSD symptoms often presented in uncooperative, resistive, and sometimes aggressive behaviours, specifically around personal care. The plan included that the care team should try to support Mr B to complete his cares and, if unsuccessful, try again later.

Nutrition/hydration

8. Bupa said that on admission, each resident's preferences are captured in several ways. Mr B's preference for a vegetarian diet was captured accurately in the nutritional requirements form 'Map of life' and sent to the kitchen. Bupa stated:

> 'We have been unable to definitively establish if Mr B was mistakenly provided with non-vegetarian meals. We appreciate any such occurrence would have been upsetting for Mr B's whānau. Providing Mr B with a non-vegetarian meal would not be in line with our expectations of person-centred care delivery and we apologise.'

Weight

9. Bupa stated that all residents are weighed and have their vital signs recorded at a minimum of once monthly. According to the Bupa weight spreadsheet, Mr B gained 6kg from February to March 2023.

Pain

10. Bupa stated that Mr B had regular Panadol charted on admission, and, as he entered his last days, morphine was prescribed. Pain assessments were completed from time to time but were not considered to be required for longer periods. Bupa stated:

[8] Nowhere in the response was it stated that due to Mr B's dementia the initial assessments/plans were made in collaboration with, or should have been/were discussed with, Ms D as the EPOA, before being completed.

> 'The team initially incorrectly utilised an Iowa pain scale assessment form. However, as Mr B lived with a diagnosis of dementia, a modified Abbey pain scale tool was more appropriately used latterly.'

11. Bupa said that there is no documentation that suggests that Mr B's teeth or mouth were a source of pain for him or contributed to his decreased food and fluid intake.

Falls

12. Bupa stated:

> 'Mr B was able to mobilise independently and was known to like to walk within the safe environment of […] [Park]. Mr B had a history of falls prior to his admission to the Bupa Care Home. On admission, his falls risk was assessed, and he was noted to have a HIGH falls risk. The risk assessment finding takes into consideration his history of falls, medical diagnoses, physical condition, and prescribed medications … Strategies supportive of reducing Mr B's risk of falling are noted in his LTCP … including environmental considerations, orientation … appropriate footwear, regular checks on his whereabouts, and use of a sensor mat when in bed.'

Operating environment

13. Bupa described the challenging environment in which it was providing aged residential care over the last few years, which had included the COVID-19 pandemic, a shortage of staff/recruitment, Auckland floods, and pay parity issues, which had had an impact on its workforce.

14. Bupa concluded by extending an invitation to meet with Ms D and/or other members of Mr B's whānau to address their concerns and to support Ms D's purpose.

Resolution proposal

15. On 11 August 2025 I notified Bupa of HDC's investigation of this matter. I proposed that HDC find Bupa in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[9] based on a review of the complaint and Bupa's response. Clinical advice regarding the care Bupa provided to Mr B was received from Dr Isabella Wright, Nurse Practitioner (NP), which was enclosed with the notification. NP Wright's advice identified shortcomings in Bupa's care in a number of key respects and supported my reasoning for proposing this finding.

16. On 8 September 2025 Bupa agreed to the proposed finding of a breach of the Code.

Responses to provisional decision

17. Bupa and Mr B's whānau were given an opportunity to respond to the relevant parts of the provisional decision.

18. Bupa advised that it had no further comments to make.

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

19. Mr B's whānau provided a substantive response to the 'information gathered' section of the provisional decision, which criticised Bupa's response for failure to take into account the contradictions in their own records or experience of the whānau. Other comments have been incorporated into the report where applicable, and the whānau submission has been sent to Bupa.

20. In their closing remarks in response to the provisional decision, Mr B's whānau said:

> 'If we, after very limited time in the facility, can see issues [] we would have expected a competent manager based in the facility to not only see them but to be actively resolving the issues.
>
> As a whānau, we would expect to see how more senior managers within the BUPA structure are responding to these issues and a clear plan to resolve them to ensure this facility meets the standards BUPA expounds.'

21. It is important that Bupa take heed of this feedback and embed the necessary changes to remedy the shortcomings in care identified through this investigation process.

Decision

Bupa Care Services NZ Limited — breach

22. Bupa has a duty of care to ensure that its vulnerable residents receive an adequate standard of care and support in line with their individual needs, whilst meeting contractual obligations and adhering to the Code. Although I acknowledge Bupa's statement that it had been a challenging environment due to the COVID-19 pandemic, Auckland floods, and staff shortages, the onus is on Bupa to plan and manage the service provision accordingly.

Clinical advice regarding standard of care provided to Mr B

23. The full clinical advice is attached to this decision as Appendix A.

Care planning

24. NP Wright advised:

> 'From the evidence reviewed, it appears the clinical documentation did not accurately guide the safe delivery of nursing care and would be viewed similarly by my peers. A lack of consistent assessments and gaps in the care plan is considered a moderate deviation from accepted practice. Departure from accepted practice: **Moderate**'

25. I accept NP Wright's advice and am critical that there is minimal documentation about oral care, considering the state of Mr B's teeth. I acknowledge that Mr B's BPSD symptoms were a barrier, although further intervention and support should have been offered by Bupa when it was noted that Mr B had reduced oral input, which did not occur. I am also critical that Mr B's care plan identified that he preferred a daily shave, which was at odds with Mr B having a beard. I acknowledge that Bupa is unaware of how this occurred and apologised for this. Nonetheless, the consequence of removing Mr B's beard may have caused him a 'loss of self'.

26. I consider it appropriate to involve the consumer and, if applicable, their whānau in the care planning from the beginning of the consumer's residence in a care home. Specifically, Mr B and his wife/whānau should have been able to voice person-centred individualised preferences, such as continuing to maintain Mr B's beard and to provide him with only vegetarian food. This was a missed opportunity for Bupa to gain valuable information, especially as Mr B's BPSD diminished his contribution to assessments and care planning.

Nutrition and hydration

27. NP Wright advised:

> 'From the evidence reviewed, it appears nutrition and hydration management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of clear identification, assessment and regular review of nutritional and hydration needs is considered a moderate deviation from accepted practice. Departure from accepted practice: **Moderate**'

28. I accept NP Wright's advice and am critical that Bupa's nutrition and hydration management did not meet accepted standards. I note that Bupa stated that Mr B was provided with vegetarian food, which was disputed by Mr B's whānau, who witnessed that on at least two separate occasions Mr B was served non-vegetarian food, such as meat pizza and fish. I accept the whānau account and am critical that on at least two occasions, despite Mr B being a lifelong vegetarian, he was served non-vegetarian food.

Weight management

29. NP Wright advised:

> 'From the evidence reviewed, it appears weight management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of clear assessment and interventions of weight loss is considered a moderate deviation from accepted practice. Departure from accepted practice: **Moderate**'

30. I accept NP Wright's advice and am critical that, despite Mr B being on fluid restrictions and eating moderately, according to Bupa he seemingly gained 6kg between February and March 2023. Bupa did not investigate this reasonably significant change over a brief timeframe to ascertain the cause of the weight gain or if it was correct. Similarly, I am critical that, when Mr B suffered a significant weight loss of 12kg from March to April 2023, there is no evidence of a comparison between Mr B's weight gain and weight loss or further investigation, as the rapid gain was at odds with the following months' significant loss. In addition, there are no records of a short-term care plan or records of further planned interventions despite the GP having prescribed nutritional supplements.

Pain management

31. NP Wright advised:

> 'From the evidence reviewed, it appears pain assessment and management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of timely assessments and administration of analgesia is considered a moderate deviation from accepted practice. Departure from accepted practice: **Moderate**'

32. I accept NP Wright's advice and am critical that although sometimes when Mr B was in pain, the pain was assessed and treated, this occurred inconsistently.

Falls management

33. NP Wright advised:

> 'From the evidence reviewed, it appears falls assessment and management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of clear identification, assessment and regular review of falls risk is considered a moderate deviation from accepted practice. Departure from accepted practice: **Moderate**'

34. I accept NP Wright's advice and am critical that there are serious inconsistencies in documentation regarding Mr B's level of risk of falls, which may have influenced his falls prevention strategies.

Conclusion

35. In most respects, Bupa's response to this complaint has suggested that Mr B's vascular dementia and BPSD needs were taken into consideration and were responded to appropriately during the relatively brief period of time he was a resident at the Bupa specialist dementia unit. However, with reference to whānau observations of Mr B's circumstances over this period and with reference to the expert advice and findings from my clinical advisor, NP Wright, I am not satisfied that Mr B received an adequate standard of care, and I am critical of Bupa. I consider that Bupa Care Services NZ Limited breached Right 4(1) of the Code, which states that '[e]very consumer has the right to have services provided with reasonable care and skill'. I note that Bupa Care Services NZ Limited has accepted this finding.

Concluding Remarks

36. In the opening section of this report, I referred to the reasons for the whānau raising their concerns with the Health and Disability Commissioner. They said they wanted changes to be made so that the living situation of current and future residents of the Bupa specialist dementia unit could be improved. The advocacy demonstrated by Mr B's whānau in raising their concerns is commendable. By highlighting the shortcomings in Mr B's care, it is critical that Bupa ensure that the various insights gained over the course of this investigation process are acted upon. I acknowledge that supporting older people with complex neurological conditions such as vascular dementia and BPSD can be challenging, but this case has only served to emphasise the importance of ensuring fulsome assessment and care planning processes are undertaken that are responsive to the evolving needs of the individual and, equally importantly, that staff providing care are adhering to the documented care plans in place. It is apparent from whānau observations of Mr B that his LTCP was not consistently followed by support staff and, as a result, Mr B's needs were not appropriately met and his condition deteriorated over the brief three months he resided at Bupa. This investigation process has confirmed that greater effort should have been made to ensure Mr B received an appropriate standard of care.

Changes made as a result of this event

37. Bupa stated that it promotes 'person-first care', which means that incorporation of an individual's likes and collaboration of care is integral. The Bupa care team has completed the 'Person-First training' and intends to incorporate changes to the current environment.

38. Currently Bupa is implementing a staggered rollout for electronic records across all care homes (VCare). This has been utilised by the Bupa Care Home since 3 April 2023, and, as part of this, daily care records can be created, including care records that specifically note oral care completion.

Recommendations

I recommend that Bupa:

a) Provide a written apology to Mr B's whānau for the breach of the Code identified in this report. The apology should be provided to HDC, for forwarding to Ms D, within three weeks of the date of this decision.

b) Undertake an audit of 10 resident clinical files from the Bupa Care Home, to determine whether there has been an adequate standard of documentation with respect to admission and care paperwork, including initial and long-term care plans. The review should identify whether:

   i. Care plans have consistent assessments without gaps
   ii. Nutritional and hydration needs have been assessed and reviewed regularly
   iii. Patients with significant weight gain or weight loss have had comprehensive assessments and interventions
   iv. Patients with pain have had timely assessments and administration of analgesia
   v. Patients with falls risks have been identified, and assessments and regular reviews have occurred
   vi. VCare records have been utilised, including daily care records
   vii. 'Person-first care' is evident throughout the care plans and assessments
   viii. There are other significant findings.

39. Please highlight in the audit when family/whānau/welfare guardians, etc were involved in the admission process. A summary of the findings, along with corrective actions to be implemented, is to be provided to HDC within six months of the date of this decision.

Follow-up actions

A copy of the final report with details identifying the parties removed, except Bupa Care Services NZ Limited and the advisor on this case, will be sent to Health NZ and HealthCERT and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Ms Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from Dr Isabella Wright, nurse practitioner:

'**CLINICAL ADVICE — NURSING**

CONSUMER : [Mr B]

PROVIDER : Bupa Specialist Dementia Unit

FILE NUMBER : C23HDC01555

DATE : 27 May 2025

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1. Thank you for the request that I provide clinical advice in relation to the complaint from Ms [D] about the care provided by Bupa Specialist Dementia Unit. 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**
   All clinical documentation provided by Bupa and Health New Zealand | Te Whatu Ora Te Toka Tumai Auckland.

3. **Complaint**
   Complaint received regarding multiple concerns relating to inadequate and inappropriate treatment and care of the late Mr [B] on 15 June 2023 from EPOA, wife — [Ms D].

   In-house nursing advice has been requested to determine whether the following clinical practice was in line with accepted practice standards and guidelines:

   1. Pain assessment and management
   2. Falls assessment and management
   3. Weight management
   4. Nutrition and hydration
   5. Care planning — in particular [Mr B's] care formulation and provision of care and treatments, particularly on restraint, showering and beard shaving.

4. **Provider response(s)**
   Review of response from Bupa on 11 August 2023 — […], Senior Clinical Service Improvement Coordinator.

5. **Review of clinical records**
   <u>Background</u>
   Mr [B] was a 72-year-old man with a medical history of vascular dementia with hypoxic brain injury, atrial fibrillation, osteoarthritis, hyperlipidaemia,

hypertension, gout and anaemia. He was admitted to Auckland City Hospital on 30 Dec 2022, following an unwitnessed collapse at another care home with injuries to head — bilateral mixed-density subdural collection. During this acute admission, [Mr B] had a primary diagnosis of subdural haemorrhages and secondary diagnosis of behavioural and psychological symptoms of dementia (BPSD). He was assessed as requiring psychogeriatric care and was admitted at Bupa specialist dementia unit on 23 January 2023. [Ms D] is concerned about the care that was provided to [Mr B] at Bupa from the time of his admission in January 2023 to the time of his death in April 2023.

Pain management

On admission (Jan 2023), [Mr B] was assessed as having intermittent pain due to eczema. This was documented on a care plan, and the identified pain management intervention was to monitor pain regularly and administer medications for pain as needed. There is no documented evidence of regular pain assessment with appropriate assessment tools, when [Mr B] was noted to have an itchy rash related to eczema. At the end of March 2023, [Mr B] had increased agitation, reduced oral intake and experienced recurrent falls. There is no documented evidence of regular pain assessments, to establish if pain could have been a possible contributing factor to the increase in agitation.

On 9 April 2023, documented evidence suggests [Mr B] experienced further deterioration marked by lethargy, decreased level of alertness, reduced oral intake and mobility. [Ms D] was updated on 10 April, and her decision was that [Mr B] was not for active treatment or acute hospitalisation.

The GP was informed of [Mr B's] deterioration on 12 April 2023, and he was prescribed morphine injection, 2.5–5mg to be administered subcutaneously when required on the same day. This was administered at 2pm with good effect. Following this, he was administered paracetamol on 13 April at 4.30pm, 14 April at 3.57pm, and 1 April at 4.26pm for generalised pain after falls. It is not clear why there was a delay in updating the GP about [Mr B's] deterioration.

While there is evidence of some pain assessments on 11 April at 9am, 13 April at 7.53am, and 15 April at 1am, there are no records that suggest that [Mr B] was offered pain-relieving medications despite pain assessments indicating that he was experiencing mild to severe pain. Documentation by a healthcare assistant […] on 13 April at 8.59pm suggests that [Mr B] may have been experiencing pain, "*seen on bed, restless and appear on pain".* There is no documented evidence that this was followed up with further assessments by a registered nurse.

On 14 April, [Mr B] was reviewed by a GP after a fall; however, there is no evidence that his deterioration was discussed and planned for during this consultation. Documented evidence on 16 April at 8.40pm indicates that [Mr B] may have been in pain, "*seen on bed. Appear to be in pain"*. There is no evidence that this was followed up with further assessments. His next dose of morphine (pain relief) was

administered on 17 April at 5.04am. The documented evidence does not indicate that [Mr B's] pain was assessed and addressed during this time.

On 17 April, [Mr B] was reviewed by the GP, the oral morphine prescription was changed to morphine injection to be administered via a syringe driver subcutaneously. This was commenced on the same day at 6.33pm, and there are no records of syringe driver medication administration or monitoring records provided.

The documented episode of the care provided to [Mr B] was last recorded [along with the] date and time of [his] death. The gap in documentation may suggest a transfer to the hospital wing referred to by [Ms D] in her complaint.

From the evidence reviewed, it appears pain assessment and management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of timely assessments and administration of analgesia is considered a moderate deviation from accepted practice. **Departure from accepted practice: Moderate**

Falls management

[Mr B] had recurrent falls during his admission in Bupa — with a total of six falls, five of which were unwitnessed. These were documented on 01.02.23, 24.02.23, 03.03.23, 10.04.23, 11.04.23, and 13.04.23.

There is documented evidence of post-fall assessments and timely updates about the falls to [Ms D] except for 24 February, where there is no documented evidence of a family update in the progress notes or family communication records. Two of the six falls had documented GP follow-up (review dates 03.03.23 and 14.04.23). The provider's policy on Falls Prevention and Management, Post-Fall Assessment requires residents to be reviewed by a GP after a fall. However, the timeframes for the review are not clear. I note on 17 February, [Mr B] was reviewed by the GP for ongoing hypotension; it's not clear if this was related to the fall event on 1 February.

There are inconsistences in documentation regarding [Mr B's] level of risk of falls. Initial admission falls assessment identified that he had a high falls risk, while a physiotherapist assessment identified him as having a low risk of falls. [Mr B's] falls risk was not documented on the care summary. There is evidence of conflicting documentation regarding [Mr B's] level of risk of falls on the long-term care plan summary, in the mobility section it is documented as a moderate, while the alert was documented as high risk.

The lack of clarity about [Mr B's] level of falls risk could have influenced his falls prevention strategies. Documented strategies included staff to ensure a clutter-free environment, safe footwear, that floors were dried adequately when wet and ensure that there was adequate lighting.

[Mr B] was noted to be hypotensive on 17 February, with a blood pressure reading of 88/58; there is documented evidence of medication review, with the discontinuation of diuretic on 6 March 2023. However, there is no evidence that suggests that his falls prevention interventions were reviewed, despite the recurrent falls.

Documented evidence in the falls report and progress notes on 13 April suggests that there was a sensor mat in place; however, it is not clear when this strategy was implemented. I note that [Mr B] was identified as at risk of falls as an inpatient at Auckland City hospital, and this was included on his discharge summary, which Bupa care home may have reviewed during admission. The falls risk was not clearly identified, and this raises questions of whether his falls risk was adequately assessed, and appropriate interventions were implemented.

From the evidence reviewed, it appears falls assessment and management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of clear identification, assessment and regular review of falls risk is considered a moderate deviation from accepted practice. **Departure from accepted practice: Moderate**

Weight management

Documented evidence demonstrates that [Mr B] had a weight loss of 12kg in one month (Mar–Apr 2023), from 88.8 to 76.5kg, representing weight loss of 14%. There are some instances during the decline in April that [Mr B] refused food and fluids.

GP reviewed the weight loss on 3 April and prescribed a nutritional supplement (Ensure powder). However, there is no evidence of a short-term care plan or records for further interventions/follow-up.

[Ms D] requested that [Mr B's] diet texture be changed from normal to soft diet on 13 April. This change was documented on 15 April and, possibly, kitchen staff were made aware then. This raises questions of whether of [Mr B's] nutritional needs were assessed adequately in view of the significant weight loss.

From the evidence reviewed, it appears weight management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of clear assessment and interventions of weight loss is considered a moderate deviation from accepted practice. **Departure from accepted practice: Moderate**

Nutrition and hydration

[Mr B's] vegetarian preference was noted on the … Map of Life document. While this information was available, documented evidence suggests this may not have been used to guide his dietary needs. Diet was identified as normal on his interRAI assessment and care plan with no reference to the vegetarian diet. It is not clear from the progress notes and food intake monitoring charts that he was offered vegetarian food. Part of his nutritional interventions on his care plan was for staff to "*offer a variety of foods and fluids*". Oral intake monitoring records from

admission until 16 April indicate that [Mr B] maintained adequate food intake, with evidence of significant decrease in oral intake from 9 April.

From the evidence reviewed, it appears nutrition and hydration management did not meet accepted standards of practice and would be viewed similarly by my peers. A lack of clear identification, assessment and regular review of nutritional and hydration needs is considered a moderate **deviation** from accepted practice. **Departure from accepted practice: Moderate**

Care planning

[Mr B's] care plan included preferences for personal hygiene such as a daily shower and oral care. The documented evidence indicates that Mr B was not showered daily, and this may have been due to aggressive behaviour at times; however, he was assisted with a regular body wash. It is unclear whether this was communicated to [Ms D]. There is minimal documentation about assistance with oral hygiene; this may be because oral care is part of personal cares. Documentation shows that [Mr B] did not receive treatment from the Podiatrist on 13 March 2023.

[Mr B's] care plan identified that he preferred to have a daily shave. There is no documented evidence indicating why [Mr B's] beard was shaved off. To provide culturally safe care, this intervention requires consent, and it is not clear if [Mr B] provided the consent to shave his beard or if [Ms D] (EPOA) was involved in the formulation of [Mr B's] care. Seeking guidance from [Ms D] regarding this would have enabled staff to provide [Mr B] with dignity and culturally safe care. While documented evidence states that [Ms D] was part of a three-weekly review meeting of [Mr B's] care on 13 February, it is not clear if [Ms D] was provided with a copy of the care plan following the meeting.

There is inconsistent documented evidence in [Mr B's] continence assessment documentation — he was identified as continent and requiring assistance with toileting on admission. The care summary and long-term care plan reflected that [Mr B] was assessed as doubly incontinent at times and was provided with a continence product and was also assisted regularly with toileting.

Documentation reflects that [Ms D] requested the use of bed rails for safety, and this was commenced on 14 April and discontinued […] due to end of life. Restraint forms and monitoring records are in line with the policy and standards; however, no evidence was found about a restraint consent form.

While restraint was initiated by [Ms D], this does not negate the need for written and signed consent. There is no documented evidence suggesting that [Mr B] was restrained on a La-Z-Boy chair.

From the evidence reviewed, it appears the clinical documentation did not accurately guide the safe delivery of nursing care and would be viewed similarly by my peers. A lack of consistent assessments and gaps in the care plan is considered a moderate deviation from accepted practice. **Departure from accepted practice: Moderate**

Dr Isabella Wright, NP, BHSc (Nursing), PGDipHSc (Advanced Nursing), MPH, Doctor of Health Science
Nursing Advisor
Health and Disability Commissioner'