Decision 23HDC03118
27 August 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to maintain elderly resident's safety in care home

Introduction

1. I understand that Mr A passed away recently. At the outset, I express my sympathy and heartfelt condolences to the family and friends of Mr A for their loss. I hope that this report brings some closure for Mr A's family.

Complaint background

2. On 15 November 2023, this Office received a complaint from Ms B about the care provided to her father, Mr A (aged 93 years at time of events), at McKenzie Healthcare Limited (trading as McKenzie Healthcare), located in Geraldine.

3. In October 2022, Mr A was admitted to McKenzie Healthcare at rest-home level care. He had various co-morbidities, including congestive heart failure,[1] atrial fibrillation,[2] ischaemic heart disease,[3] type 2 diabetes,[4] and a cholecystostomy[5] (five-year history) with an external abdominal drain that required regular care.

4. Between Month4 and Month5 2023, Mr A was assaulted twice by another resident, referred to as 'Mr John Doe' (for privacy reasons). Mr Doe had been diagnosed with dementia[6] and had been transferred from a local facility to McKenzie Healthcare's secure dementia unit in late April 2022 because of increasing 'physical and verbally aggressive behaviours'. Mr Doe's health appeared to have declined in early 2023, and on 7 Month1 2023 he was re-assessed as requiring hospital-level care and was moved into the hospital wing.

5. The most recent assault in Month5 2023 had resulted in Mr A's abdominal drain being dislodged, and he had required urgent assessment at Timaru Hospital.

6. Approximately a week after the Month5 assault, Mr Doe was moved into psychogeriatric care at another facility.

Outcome sought

7. Ms B told HDC:

> '[M]y concern is not so much with the staff but the system … [S]taff were reluctant to contact the facility manager … as it was Labour Day. I insisted they did … My intent was to ensure the safety of my father and also the other residents, some of whom were

[1] A chronic condition in which the heart does not pump blood as well as it should.
[2] An irregular, rapid heart rate that commonly causes poor blood flow.
[3] Heart damage caused by narrowed heart arteries.
[4] A chronic condition in which the body cannot use the insulin it produces properly, leading to high blood-glucose levels.
[5] A procedure to place a drain into the gallbladder.
[6] A group of symptoms affecting memory, thinking, reasoning skills, and social abilities.

Names have been removed (except McKenzie Healthcare Limited (trading as McKenzie Healthcare) and the aged care advisor on the case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

frightened of the very confused elderly man. It took a full week after that for the confused man to be moved [to another facility]. How can this be allowed to happen in this day and age? My family trusted our parents would be safe and sound. I am horrified … Our elders are so precious and so vulnerable.'

Scope of investigation

8. The following issue arising from the complaint was investigated by HDC:

- *Whether McKenzie Healthcare Limited (trading as McKenzie Healthcare) provided Mr A with an appropriate standard of care between Month4 2023 and Month5 2023 (inclusive).*

HDC investigation findings

9. HDC gathered information from McKenzie Healthcare, including clinical records, guidelines, and organisational policies. On review of this information, the following conclusions were reached.

Post-incident management by nursing staff and senior leadership; and the adequacy of the documentation in relation to managing Mr A's safety and wellbeing following these incidents

- There is no evidence that primary assessments (such as recording of vital signs, or pain assessment) were conducted or an update made to Mr A's care plan following the first altercation on 24 Month4 2023.
- There is no evidence to show that the Clinical Manager or Care Manager checked on Mr A following the first incident (in line with policy guidelines).
- No incident report was completed (in line with policy guidelines) after the second altercation, which occurred on 23 Month5 2023.
- There is no evidence that a review of Mr A's care and safety needs (such as updating his safety plan) was completed by senior leaders following the second incident.
- There is limited evidence that senior leadership completed an event review following both incidents.

Use of behavioural monitoring records in relation to Mr Doe

- It is unclear how regularly Mr Doe's clinical information (including behaviour, medication care, etc) was reviewed.
- Information about Mr Doe's wellbeing was recorded on incorrect nursing forms or at different locations in his file.
- Communication was informal using different communication platforms, leading to essential information not being reflected in Mr Doe's file consistently.

In-house advice

10. In-house advice was sought from registered nurse (RN) Jane Ferreira (Appendix A), who identified the following departures from the accepted standard of care provided by McKenzie Healthcare to Mr A:

- Post-incident management by nursing staff and senior leadership — **Moderate to serious departure**
- The adequacy of the documentation in relation to managing Mr A's safety and wellbeing post these incidents — **Moderate departure**
- The use of behavioural monitoring records in relation to Mr Doe — **Mild departure**

Comments from in-house advisor

11. For context, RN Ferreira provided the following comments regarding the other resident, Mr Doe:

- Medications vs non-pharmaceutical interventions used to manage Mr Doe's episodes of distress
  - While non-pharmacological interventions were used (such as activities provided), Mr Doe received multiple doses of PRN (as required) medication while awaiting review by the older person's mental health team.
- Escalation to the GP in response to Mr Doe's episodes of distress
  - Escalation to the GP was timely and appropriate.
- Was Mr Doe's level of care appropriate?
  - The care team appeared to be doing their best to support Mr Doe (who was in the dementia community of McKenzie Healthcare), and the provider noted that there were difficulties accessing mental health services. 'While it appears that Mr Doe met [the] criteria for a higher level of care, it is difficult to provide further comment at this time based on the evidence available.'

12. In relation to Older Person's Mental Health Services (OPMHS), RN Ferreira noted:

> 'As highlighted by the Aged Care Commissioner, there are identified service challenges in this region of Aotearoa New Zealand [Canterbury] with limited beds available at specialist dementia level care, impacting access to and delivery of appropriate care to vulnerable older people.'

Response to provisional opinion

McKenzie Healthcare

13. McKenzie Healthcare was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations, and its response has been considered in separate correspondence.

14. McKenzie Healthcare was provided with a copy of RN Ferreira's advice. McKenzie Healthcare told HDC:

> 'We wish to acknowledge the grief and distress Mr A and his family experienced as a result of these events and thank Ms B for providing us with an opportunity to review our standards and in doing so identify ways of improving care delivery for others.'

15. McKenzie Healthcare noted the following:

- In terms of Mr A's and Mr Doe's presentations of stress and distress following the altercation, McKenzie Healthcare stated: 'While stress and distress are not uncommon in residential care settings … [w]e agree that a more person-centred approach, in line with the guidelines outlined in the Health Quality & Safety Commission's Frailty Care Guides, should have been more employed in responding to these distressing behaviours. The failure to adequately document and assess these behaviours was a missed opportunity to prevent further escalation and to identify any underlying causes. We acknowledge these shortcomings and take responsibility for the gaps in documentation, assessments, and follow-up procedures …'
- In terms of concerns around senior clinical oversight of the interactions, McKenzie Healthcare stated: 'I would like to clarify that clinical leaders were actively involved in event review process and over[seeing] both incidents and their aftermath … The Registered Nurse promptly escalated the situation by contacting both the Clinical Manager and General Manager for senior oversight … Senior clinical staff were immediately involved, ensuring timely intervention and comprehensive care planning … We acknowledge that while staff received support during this period, gaps in the documentation of these interactions contributed to the lack of formally recorded senior clinical oversight … Moving forward all relevant meetings, interactions, and decisions will be properly documented to ensure clear communication and accountability.'
- In terms of the use of behavioural monitoring charts, McKenzie Healthcare stated: 'We acknowledge this shortcoming and have taken immediate steps to improve the accuracy and frequency of behavioural monitoring documentation.'
- In terms of steps taken to ensure Mr A's safety and wellbeing, McKenzie Healthcare stated: 'While Mr A's immediate safety was ensured, there was a failure to consistently monitor his well-being and distress levels over time … In response, we have reviewed our care protocols and implemented more rigorous monitoring of residents involved in such incidents, ensuring both their physical and emotional well-being are consistently tracked.'
- In terms of providing support to residents who require psychogeriatric care, McKenzie Healthcare stated: 'The lack of timely medical support, compounded by our rural location, contributed to the challenges faced. Moving forward, we have implemented a policy to send potential psychogeriatric D6[7] residents directly to the hospital when all other resources have been exhausted, ensuring immediate access to the appropriate level of care.'

Ms B

16. Ms B was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

[7] An older term that may be still used in some parts of the South Island referring to psychogeriatric specialist hospital level of care. The four 'levels of care' in NZ are rest home, hospital level, rest home dementia, and psychogeriatric specialist hospital care (or D6).

17. Ms B told HDC:

> '[T]here is a glaring error/misreporting from McKenzie re the senior nursing/ management being informed promptly of my father's second assault on Labour Day, 2023. The RN had no intention of reporting the matter to her seniors until the next day as she didn't want to disturb them on their day off. I had to insist she did so, basically telling her that if she didn't, I would find a way to do it myself. It was a serious event … [and] I had a lot of trouble communicating with senior staff at McKenzie on a number of occasions re the standard of care my [father was] receiving.'

18. Ms B said she hoped that from these incidents, McKenzie Healthcare has 'significantly improved … for other vulnerable people in care'.

Decision — breach

19. The issue in this matter is whether McKenzie Healthcare Limited (trading as McKenzie Healthcare) provided Mr A with an appropriate standard of care between Month4 and Month5 2023 (inclusive). RN Ferreira identified issues in the post-incident management and the documentation relating to safety and wellbeing in relation to Mr A's care and advised that in both these areas, the care provided by McKenzie Healthcare fell below the accepted standard of care. I accept RN Ferreira's advice.

20. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[8] requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that McKenzie Healthcare Limited (trading as McKenzie Healthcare) did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

Changes made since events

21. McKenzie Healthcare told HDC: 'We appreciate the opportunity to address these concerns and remain dedicated to enhancing care and clinical oversight across all aspects of our service delivery.' McKenzie Healthcare said that it made the following changes:

- It provided 'enhanced' staff training on documentation, communication, de-escalation, and clinical assessments.
- Monthly audits will be conducted with quarterly reviews to evaluate progress, the Clinical Governance and Quality Manager will oversee and coordinate audits, and the General Manager will ensure that follow-up actions are taken based on audit findings.
- A new system for documenting care interactions was introduced, with an emphasis on more detailed and timely record-keeping to ensure better follow-up.
- It has restricted the oversight processes to ensure that senior staff are directly involved in situations involving distressing behaviours, to enhance decision-making and ensure that prompt action is taken to address any underlying issues.

[8] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

- A Clinical Governance and Quality Manager started in January 2025 to monitor clinical interactions, ensure compliance with care protocols, and drive continuous quality improvement.
- A full review of its care policies is underway to ensure that they align with best practices and meet the needs of residents effectively.

22. RN Ferreira stated:

> 'I note [McKenzie Healthcare] has implemented significant improvements to both clinical and operational processes in response to learnings from this complaint. Their report is very comprehensive, and the supporting evidence shows that considerable time has been invested in strengthening skills, roles and resident care systems.'

23. I accept RN Ferreira's statement and acknowledge the changes McKenzie Healthcare has made since the incidents.

Recommendations

24. In my provisional opinion, I recommended that McKenzie Healthcare Limited provide a written apology to Mr A's family for the issues identified in the report. McKenzie Healthcare Limited has provided this apology, which will be forwarded to Mr A's family.

Follow-up actions

25. A copy of this report with details identifying the parties removed, except the aged care advisor on this case and McKenzie Healthcare Limited (trading as McKenzie Healthcare), will be sent to HealthCERT and Health New Zealand | Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice to Aged Care Commissioner

The following in-house advice was obtained from RN Ferreira:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by McKenzie Healthcare. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Documents reviewed

- Expression of concern received 15 November 2023
- Provider response received 10 January 2024, 24 August 2024
- Clinical records including nursing assessments, care plans, progress notes, monitoring forms, incident reports, health records, meeting minutes and communication records.
- Organisational policies including Complaints, Restraint and Seclusion, Accident and Incidents, Managing Behaviours of Stress and Distress, Communication, Open Disclosure, and an annual education plan.

3. Complaint

[Mr A]'s family have expressed concern regarding his safety while resident at the care home between [Month3] and [Month5] 2023.

<u>Background</u>
[Mr A] was admitted to the care home in October 2022 and resided at rest home level care during the timeframe in question. His medical history included atrial fibrillation, type 2 diabetes, ischaemic heart disease, congestive heart failure, gout, obesity, hypothyroidism, with a cholecystostomy (five-year history) and external abdominal drain, which required regular care. File information showed that [Mr A] required moderate carer assistance to meet activities of daily living and was closely supported by his family. In [Month4] and [Month5] 2023, [Mr A] received injuries following an altercation with another resident (Mr Doe). [Mr A]'s family have expressed their concern about the systems and processes in place at the time, including clinical oversight and leadership, to ensure their father's safety needs were maintained in the circumstances.

4. Review of clinical records

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

In particular, comment on:

Presentations of Stress and Distress

a) Based on the impact of distressing events experienced by [Mr A], please comment on the senior clinical oversight of interactions between [Mr A] and Mr Doe between [Month3] and [Month5] 2023.

The organisation's Accident/Incident policy provides guidance about how to respond to care home events and expectations for reporting requirements. The policy states that incident reports, located within the electronic care record, are required to be completed for all events that occur on a shift. Escalation and the event review process are discussed, noting manager involvement in event analysis, actions and outcomes. The policy discusses the role of debriefing following an adverse event, acknowledging the impact on those involved, and refers to responsibilities to open disclosure, communication, education and support.

The provider has discussed two events which impacted [Mr A]'s safety and wellbeing; however, there is limited supporting information reflected in the care record regarding the event actions and follow-up. Progress notes 24 [Month4] 2023 state that a carer found [Mr A] in his room, visibly distressed. The entry described an altercation between [Mr A] and another resident which resulted in physical contact and an injury sustained to [Mr A]'s right index finger. A registered nurse (RN) was informed, and an incident report completed per policy; however, nursing documentation provides no evidence of a primary assessment, such as recording of vital signs or a pain assessment, or nursing care provided at the time. While the incident report refers to revised safety interventions (to use a call bell to seek staff assistance), there is no apparent update to [Mr A]'s nursing care plan. It is unclear how this information was communicated to the incoming shifts to ensure continuity of care and that safety needs for both parties were maintained. There is no documented evidence to show that the clinical or care manager met with [Mr A] or checked on his wellbeing as part of the event review process.

The provider has discussed a second event which occurred 23 [Month5] 2023 that resulted in physical contact with [Mr A] and possible abdominal injury. While there is no RN discussion of nursing assessment at the time of the event, submitted file information indicates the RN sought prompt guidance from acute hospital services given possible clinical risk to [Mr A]'s abdominal drain. Reviewed hospital information referred to a recent "assault", noting that the care home was managing the incident process. It appears that an incident report was not completed in line with policy guidelines for either resident, with no evidence to show that a review of [Mr A]'s care and safety needs, and those of his peer, were completed by senior leaders following this event. While file information reflects interactions with health services on behalf of Mr Doe, there is limited evidence of proactive leadership or event review provided by the care home leaders in the circumstances. File information refers to communication occurring with [Mr A]'s family, but it is unclear whether a meeting was held to discuss the incident, raised concerns and related corrective actions.

From the evidence reviewed to respond to this question, it appears that care home leaders were not actively involved in event management at this time. Reviewed nursing records describe care occurring; however, there is minimal evidence of senior nurse

leadership or clinical oversight in the circumstances. This would be considered a moderate to serious deviation from accepted practice and viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

b) Please comment on the steps McKenzie Healthcare have taken to ensure safety wellbeing for [Mr A].

The Health and Disability Services (Safety) Act discusses the management and reporting of identified risk, defined as, "*any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided*". The Accident/Incident policy states that an incident form will be completed for all events that occur on a shift, with the manager, or delegated RN, responsible for review and monthly trend analysis, in line with clinical governance processes. The policy states that any preventative action taken will be evaluated to "*ensure that the outcome is satisfactory*".

Records show that an incident report was completed for the event described as "*physical aggression between residents"* on 25 [Month4] 2023. Actions taken to maintain safety and reduce the risk of further events are recorded on the event report, noting that [Mr A]'s family had been informed of the incident. Progress notes 23 [Month5] 2023 state that an altercation had occurred between [Mr A] and another resident, but no further information is provided. It appears that an incident report was not completed, as requested by the author of the progress note entry, with no discussion of nursing assessment or care provided to [Mr A]. As outlined earlier, it appears that RNs were proactive and sought support from Radiology Services following the altercation, but there is no evidence provided of a revised safety plan for [Mr A].

It appears that clinical leaders were aware of the changes in Mr Doe's wellbeing and associated risks to other residents, with interventions in place. While file information reflects interactions with health services on behalf of Mr Doe, there is, however, limited evidence of event review provided by the leaders following the alleged 'assault' or implementation of a revised safety plan for either resident.

From the evidence reviewed to respond to this question, it appears that the care team were actively engaged in supporting [Mr A], with entries describing interactions and delivery of person-centred care. The provider has submitted a detailed response outlining actions taken, with nursing notes describing safety interventions, asking [Mr A] to use a call bell to seek staff assistance rather than interact with Mr Doe to maintain his personal safety. While steps were apparently in place to support resident safety, I consider there to be moderate deviations in documentation standards and reporting processes per organisational guidance, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

c) Is there clinical evidence of nursing assessment into underlying causes of Mr Doe's episodes of distress?

The Health Quality & Safety Commission (HQSC) Frailty Care Guides describe responsive and reactive behaviours as "*actions, words or gestures of a person living with dementia,*

in response to something negative, frustrating or confusing in their social and physical environment" and are viewed as communication of an unmet need (HQSC, 2023). The Management of Behaviours that Challenge (Stress and Distress) policy provides guidance about de-escalation techniques to be used in response to heightened situations and information about maintaining safety needs for the older person, other residents or visitors, and the care team.

It appears that the manager and RN team knew Mr Doe well and applied a holistic lens to his care. The provider has discussed the use of behavioural monitoring tools to assist in the identification of event triggers and signs of unmet needs. Reviewed information also refers to the use of additional monitoring tools (sleep and pain assessments, review of nutritional needs) to inform care decisions. File information has discussed Mr Doe's communication difficulties, offering hearing aids and glasses as tolerated, with a focus on involving him in meaningful exercise and activities as part of non-pharmacological interventions to support his mood and behaviour. Mr Doe had a history of multiple falls, and the provider has discussed proactive interventions to reduce falls risk, such as a review of lighting and mobility plans. Consideration of loneliness as an event trigger was noted and room location altered in [Month3] 2023 to promote companionship and meaningful interactions.

It appears that the team attempted to record clinical observations; however, Mr Doe expressed reluctance with care interventions, triggering altercations with further displays of distress. It appears that medication use increased during the timeframe in question, with reducing efficacy reported (refer question e). There is evidence that the nursing team recognised and sought guidance from medical and specialist health professionals as Mr Doe's needs appeared to change. The provider has discussed meeting with mental health experts and family/whānau on several occasions to ensure that a safe and appropriate plan of care was in place for Mr Doe. Personalised information, such as an agreed nursing care plan was not provided in the submitted evidence to inform further comment about care interventions and evaluation processes. There is no evidence provided of incident reports completed for Mr Doe regarding the two events in question, with no discussion of specific nursing assessment provided at the time in the reviewed information. However, wider information addresses safety concerns with the implementation of intentional rounding as an opportunity to pre-empt Mr Doe's needs or provide redirection.

From the information available to respond to this question, it appears that RNs and the care team were responsive to Mr Doe's care and safety requirements in the circumstances.

d) Please comment on the use of behavioural monitoring records and whether this is consistent with accepted standards of nursing care.

As outlined in the HQSC Frailty Care Guides, behaviour monitoring records are used to provide evidence about displays of distress, to identify triggers and frequency of events to determine trends or patterns and inform approaches to resident care. It is recommended that regular analysis is completed in partnership with other nursing records, such as pain or vital sign monitoring, nutrition and elimination records,

medication administration records, incident forms and qualitative information provided in progress notes. Evaluation of planned care interventions is essential to ensure that the older person is being appropriately supported in a time-bound manner. Where ongoing concerns with resident wellbeing are identified it is recommended that a range of health professionals are involved in further care (HQSC, 2019; HQSC, 2023).

The provider has discussed the use of behavioural monitoring tools to assist in the identification of event triggers and signs of unmet needs. Submitted information has described accounts of distressed behaviour, primarily related to personal care delivery, with interventions which mainly included administration of medications.

Records describe episodes of physical contact experienced by team members during delivery of essential care, but it does not appear that incident reports were completed to identify the frequency of harm events occurring. It is unclear how regularly Mr Doe's clinical information, including medication, care, behaviour, nutrition and elimination records were reviewed by the RN team. It would be considered accepted practice to ensure that the monitoring and care requirements of vulnerable residents were regularly reviewed at RN meetings and actions recorded in meeting minutes. File information indicates that this process was occurring, although it appears more informal communications were shared using different communication platforms. This may raise a risk that essential information is not consistently reflected in a resident's care record.

The provider has advised that the file review completed in response to this complaint identified concerns with accurate documentation processes, noting that information about Mr Doe's wellbeing was recorded on incorrect nursing forms or locations in the care record. This presents an opportunity for improvement in clinical leadership and event analysis to ensure that care information is appropriately triangulated and communicated in a holistic way to ensure consistent delivery of personalised resident care, while also maintaining the safety of others.

- Departure from accepted practice: Mild.

e) Based on the information provided, please comment on the use of pharmaceutical and non-pharmaceutical interventions used to manage Mr Doe's episodes of distress.

Respected health resources recommend that medications are used as a last resort when caring for older people who are displaying behavioural changes with signs of distress. Non-pharmacological approaches are considered to be more effective in supporting the delivery of person-centred care, although it is recognised that certain medications are required to be prescribed to support quality of life (HQSC, 2019; HQSC, 2023).

File information indicates that Mr Doe was well known to the care home team. The provider response referred to support given with interests and activities and stated that a plan was in place to anticipate Mr Doe's care and safety needs while ensuring other residents remained safe in their home. The provider has stated that the care team were aware of their responsibilities to address signs of unmet needs, referring to reviews of sleep patterns and daily activities. It is unclear whether elimination patterns were

regularly reviewed as a possible trigger to mood and behaviour changes, with assessment and management of constipation recognised as a primary nursing responsibility. Other factors for consideration would include the possibility of medication side-effects, such as nausea, headaches, fatigue, dizziness with postural hypotension influencing falls risk and wellbeing, or possible paradoxical reactions (restlessness, agitation, anger or other behavioural effects) that may indicate a need for medical review (Medsafe, 2023).

The provider has advised that Mr Doe's medications were prescribed and titrated by the health district's Mental Health team and reviewed by his General Practitioner (GP). It is unclear what process was in place to review the frequency of use of prescribed, as-required (PRN) doses of antipsychotic and benzodiazepine medications and impact to Mr Doe's health and wellbeing. It would be considered accepted practice to have a short-term care plan in place which outlined care and monitoring interventions, with evidence of regular evaluation by the clinical team. Medication administration records and nursing progress notes are required to reflect evidence of nursing assessment prior to administering PRN doses, and report medication efficacy. This evidence is considered useful to inform the health team about a resident's presentation, related prescribing and/or care interventions.

From the evidence reviewed to respond to this question it appears that while non-pharmacological interventions were offered by the care team, Mr Doe received multiple doses of PRN medications while awaiting review by the older person's mental health team. Nursing records describe reducing efficacy of prescribed medications however there is limited evidence of consultation with the GP or a delegated representative from the allied health team which may have been indicated in the circumstances. As identified, short-term care plan with goals for care, including intervention timeframes with evidence of evaluation was not provided to inform further comment at this time.

f) Please comment on whether there is evidence of timely escalation to the GP or Nurse Practitioner (NP) in relation to Mr Doe's recurring episodes of distress.

The provider has discussed points of contact with health colleagues in their response, and associated service challenges. It appears that the care home was committed to supporting Mr Doe to remain at the care home for as long as possible, in partnership with his family/whānau. While goals for care were not explicitly discussed, it appears that meetings were held with family/whānau in response to increasing safety concerns while the care team awaited consultation with mental health experts who were away at the time.

It appears there were opportunities for closer collaboration with the medical practice in response to Mr Doe's increasing needs, with locum services reportedly available for clinical concerns. The provider has outlined additional care and safety measures introduced for Mr Doe, including intentional rounding and 1–1 carer support. However, given the increasing signs of distress, ongoing reluctance to accept care and additional medication use, it may have been helpful to obtain a clinical opinion while awaiting input from specialist services to rule out possible signs of underlying pain, unwellness or infection.

From the information reviewed to respond to this question, it appears that the approaches to care were adequate in the circumstances. While it seems the care team knew Mr Doe well, there remain opportunities for improvement in nursing assessment, recognition of change/decline and timely care coordination.

Level of Care

g) From the information provided, do you consider Mr Doe's level of care in MHC hospital level care unit to be appropriate between [Month1] and [Month5] 2023; and do you consider reassessment to (D6) psychogeriatric care to be both timely and an appropriate level of care in [Month5] 2023.

The provider has shared context regarding Mr Doe's health background, which required reassessment from dementia- to hospital-level care. The response outlined subsequent changes to his level of functioning during 2023 and related GP involvement in his plan of care, with a suggestion that he may be suitable for transfer back to dementia-level care. File information indicated that Mr Doe's care requirements were initially able to be met at this level of care; however, from [Month2] 2023 onwards, it appears that concerns with mood and behaviour were identified.

It appears that a family meeting was held in [Month3] 2023 regarding care approaches with a decision made to allow Mr Doe to remain at the care home, supported by his family/whānau, for wider social and cultural reasons. The provider has advised that a bed was not available for Mr Doe in the dementia community at the time, and outlined supportive strategies put in place to manage "wandering and resistive behaviours" in the hospital-level community.

Records show that a medication review was provided by mental health services on 24 [Month3] 2023 in response to raised concerns with Mr Doe's health and wellbeing; however, there is no evidence of a specific action plan to inform further comment.

Reviewed information reflects communication between the care home and needs assessors 28 [Month3] 2023 advising that reassessment of care level was not indicated at this stage as Mr Doe's care requirements were manageable. Despite apparent signs of decline in Mr Doe's health and wellbeing, it appears the referral process for reassessment of care was only actioned on 24 [Month5] 2023.

As outlined in the Frailty Care Guides referral to mental health services for older people is indicated for assessment of care level (dementia or specialist dementia (psychogeriatric) level of care), health review and where demonstrated behaviours present risk to the person and others (HQSC, 2023). It appears the team were doing their best to support Mr Doe to remain at the care home, respecting his family's circumstances at the time; however, there was risk involved which was impacting the safety needs of others. The provider has discussed difficulties accessing GP and mental health services and tensions between provider responsibilities and maintaining resident, family/whānau relationships, which influenced their actions. While it appears that Mr Doe met criteria for a higher level of care, it is difficult to provide further comment at this time based on the evidence available.

h) Do you consider the Older Person's Mental Health Service (OPMHS) have provided adequate support to MHC based on the information and referrals received from MHC.

As highlighted by the Aged Care Commissioner, there are identified service challenges in this region of Aotearoa New Zealand, with limited beds available at specialist dementia-level care, impacting access to and delivery of appropriate care to vulnerable older people.

File information indicates that Mr Doe was known to OPMHS and had been under their care while residing in the care home's dementia community. There is evidence of their involvement in [Month3] 2023; however, it does not appear that further support was formally sought by the care home until [Month5] 2023, despite Mr Doe exhibiting signs of concern for several weeks. The provider has described barriers to accessing clinical support, noting those familiar with Mr Doe's history were on leave during the timeframe in question. It is unclear what delegated cover was available, with no care management plan sighted to outline nursing actions in the event of identified crisis. It appears the referral was promptly acted on by the duty team with Mr Doe's request for reassessment accepted, resulting in his transfer to another provider days later.

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

References

Health Quality & Safety Commission. (2019; 2023). Frailty Care Guides. http://www.hqsc.govt.nz/

Medsafe. (2022). Benzodiazepines / Rivotril Oral Solution. RivotrilOralSolution.pdf (medsafe.govt.nz)

Request for additional advice: 25 March 2025

Thank you for the opportunity to review my advice, 11 October 2024, with a request to reconsider my opinions in response to feedback received from the provider.

I have reviewed the information supplied and would like to acknowledge the provider's commitment to quality improvement and the progress made. I note the provider has implemented significant improvements to both clinical and operational processes in response to learnings from this complaint. Their report is very comprehensive, and the supporting evidence shows that considerable time has been invested in strengthening skills, roles and resident care systems.

The provider has discussed the service challenges associated with providing care to Mr Doe at the time and as outlined in my advice, I acknowledge the support provided to him and his family/whānau that was evidenced within nursing documentation. The

provider has discussed changes made to clinical systems to improve oversight of resident care and documentation standards. I note that incident reports were completed retrospectively (9 January 2024) for the resident events 23 [Month5] 2023 with evaluation, which supports record-keeping standards. Education and training has been provided and systems strengthened, which is pleasing to read.

In summary, while the information received provides context to improvement steps, based on my review of care at the time I consider that my original advice remains appropriate in the circumstances.

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