Opinion 21HDC01416
7 November 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate rest-home admission processes and family engagement resulting in urgent reassessment

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Introduction

1. At the outset, I express my sympathy and heartfelt condolences to the family of Mr D for their loss, which occurred after lodgement of this complaint.

Complaint background

2. On 26 June 2021 this Office received a complaint from Ms C on behalf of her family regarding the care provided to her father, Mr D, by Woodlands of Feilding Care Home (Woodlands).[1] Prior to admission at Woodlands, Mr D had lived independently at home, with support from whānau/family and friends, although he was reportedly experiencing cognitive decline and coping difficulties.

3. On 4 March 2021 Mr D was assessed by Supportlinks[2] as requiring rest-home level care and was admitted to Woodlands on 8 April 2021. At the time of admission, an Enduring Power of Attorney (EPOA) was in place but not activated, with Mr D's daughter, Ms C, nominated as his representative for care and welfare. During Mr D's admission, concerns were raised by the care team about his safety and wellbeing, including reported incidents of leaving the home and becoming lost, and whether the level of support Woodlands could provide was appropriate. On 14 April 2021 Woodlands referred Mr D to his general practitioner (GP), Dr A, for activation of the EPOA to enable reassessment for dementia-level care and transfer to another facility.

4. Woodlands consulted the Older Adults Mental Health (OAMH)[3] Service, and on 23 April 2021 Mr D was reassessed as requiring a higher level of care (dementia-level care). On 27 April 2021 Mr D was discharged from Woodlands into the care of his son, Mr E, pending service transfer to another provider on 29 April 2021.

5. Mr D's family have raised concerns about Woodlands' admission process, clinical oversight, EPOA activation, and level-of-care decisions, including the decision to discharge Mr D without adequate notice.

Investigation findings

6. HDC gathered information from Woodlands, including clinical records, guidelines, and policies, obtained in-house aged-care advice from registered nurse (RN) Jane Ferreira (Appendix A) and in-house medical advice from Dr David Maplesden (Appendix B), and

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[1] Karaka Court Limited (trading as Woodlands of Palmerston North Feilding).
[2] Needs Assessment and Service Coordination (NASC) for Palmerston North.
[3] Under Health New Zealand|Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral (Health NZ), OAMH provides services to older adults in the community who are experiencing moderate to severe mental illness. Previously OAMH was called 'Elderhealth'.

Names have been removed (except Karaka Court Limited (trading as Woodlands of Feilding) and the advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

sought direct comment from Clinical Nurse Manager (CNM) B, who was responsible for Mr D's care at the time. Having reviewed this information, the following conclusions were reached.

Pre-admission process

7. Mr D's family raised concern that Woodlands did not receive or review Mr D's notes before accepting him. Having reviewed the information, it appears that the pre-admission processes at the time were lacking.

8. CNM B told HDC that prior to admission, Mr D's family attended Woodlands 'to have a look around', and usual practice at the time was to ask the family members to provide a brief history of the resident and why they needed care. There is no written record of Mr D's family's visit, what was discussed, or what information was provided, requested, or received. Therefore, it is not clear what information was used to inform Woodlands' decision to accept Mr D's admission or how this information was used to inform his care planning.

9. Woodlands told HDC that at the time of events, there were no policies or guidance on the pre-admission meetings or information-sharing requests to assist in admission decision-making, and that it relied mostly on information provided by the prospective resident and their family.

10. Woodlands and CNM B stated that due to privacy considerations, it was not possible to access or request information at the pre-admission stage, such as needs assessment documentation, GP records, or other information, and therefore relied on the family to provide this. Woodlands and CNM B told HDC that had it been made aware at the time of pre-admission that Mr D had experienced incidents when he was living at his residence, and that he had been involved with OAMH, it is likely Mr D's admission would have been declined on the basis that a secure environment would have been more suitable. Woodlands' 'Resident Admission Agreement' outlines the details and conditions of admission, including that Woodlands may provide information to other agencies. However, the admission agreement does not include consent to *request* health information from other agencies for the purpose of admission assessment. Woodlands told HDC that a copy of the admission agreement was provided to the family at the first visit, for them to read and sign. However, there is no signed admission agreement on record. The responsibility of follow-up for this agreement sat with CNM B.

11. In-house aged-care advisor RN Ferreira outlined that at the time of events, accepted practice prior to admission was for a meeting to occur between the facility, resident, and their family/representative to view the care home, discuss care requirements, and plan goals for care. This meeting also provides an opportunity for sharing and review of relevant information to assist decision-making regarding suitability of placement. This would include any recent needs assessments, cognitive scoring,[4] engagements with service providers or supports, and any other relevant medical information. In this case, RN Ferreira identified a moderate departure from practice regarding pre-admission and considered that 'the admitting team had insufficient clinical information to safely inform their decision to admit

[4] Mr D had been assessed as 8/30 on the mini-ACE assessment, indicating severe cognitive impairment.

Mr D and guide his care requirements'. Having reviewed the information, I accept RN Ferreira's view.

12. I consider that without clear policies or guidelines in place to ensure the exchange of relevant information prior to admission, Woodlands was unable to adequately assess its suitability to provide Mr D with the appropriate level of care. Acknowledging that he had been assessed by Supportlinks as requiring rest-home level care, further clinical information and context would have provided a more informed assessment at the pre-admission stage.

13. I consider that without a policy in place for information requests to inform pre-admission clinical assessment, there was an unbalanced reliance on information to be provided by the family/representative, which in turn creates risk that decisions are made on incomplete information. Adding to this is the absence of clear guidance or policies on what should be covered during the initial family meeting (ie, specific request for permission to access records), and any requirement to record this.

14. Woodlands has acknowledged the issues with its pre-admission procedures and provided information on its strengthened systems. I have made recommendations for further strengthening at the end of my report.

Admission process and initial care planning

15. Mr D's family raised concern that Mr D's initial care planning did not match his needs adequately.

Admission forms

16. Woodlands' policy required relevant documentation to be completed during admission, namely, the Admission Form and the Admission Agreement. Mr D's Admission Form was incomplete. Under next of kin, it includes Ms C's information, and, in brackets, that she had EPOA care. However, the designated section for EPOA is blank. There is no record of documents received or requested, no record of any supporting documentation, and no record of a signed admission agreement.

17. Section D13.1 of the Age-Related Residential Care (ARRC)[5] agreement clearly states that an admission agreement must be signed either on the day the resident commences receiving services, or as soon as practical, but not later than 10 working days after admission. There is no record of a signed admission agreement.

Care planning

18. The Woodlands care plan policy requires that admission assessments use information provided by the resident, their representative or referrer, and health providers to develop an appropriate care plan. In-house advisor RN Ferreira stated that the basis for the development of the initial care plan should be the most recent needs assessment. In Mr D's case, this did not occur.

[5] Rest homes operate under the ARRC Services Agreement, a national contract between Health NZ and providers.

19. The initial care plan states that it was developed with Mr D and a relative, but there is no information to indicate the identity of the relative, and there is no evidence of consultation with the family for this purpose. There is no information to indicate whether consideration was given to cognitive scoring or identified or expressed safety or care concerns, or that the most recent needs assessment was reviewed or requested.

20. Mr D was admitted on 8 April 2021, and on this date, he signed an informed consent form that granted Woodland's permission to request relevant information from providers. There is no indication that this occurred.

21. The admission process and initial planning was completed in a timely manner; however, it appears that there was no access to reliable information and whānau involvement to inform an appropriate plan of care. In-house advisor RN Ferreira identified this as a moderate departure from standard practice, and I accept this view.

22. Woodlands noted concern that after a few days Mr D had some issues with equipment use and interactions with others, and instances of disorientation/being lost and seeking to meet friends outside the home, which may have indicated that he was feeling unsettled or lonely. Mr D's family highlighted to HDC the stress Mr D experienced transitioning from independent living to one of a shared space with monitoring of his movements.

23. It is not clear from review of the records what alternative methods or strategies were attempted with Mr D to assist him to settle in, and it is unclear whether the diversional therapist or activities team were involved in supporting him with meaningful tasks or assisting him in engaging in the activities programme. There does not appear to have been a nursing assessment undertaken in response to Mr D's escalation of behaviours and stress, or analysis of triggers or consideration of contributing factors, such as unmet needs, in line with the organisation's policies and recognised approaches to managing stress and distress.

24. In recognising the likely distress Mr D was experiencing at the drastic changes in living circumstance, I am critical that the approaches above were not attempted before there was an urgent enactment of Mr D's EPOA.

EPOA documentation

25. On admission it was recorded that Mr D had an inactive EPOA with his daughter as his care and welfare EPOA. The Woodlands admission checklist requires that EPOA documentation is obtained and placed on file, and notation provided if it is not available. This did not occur. RN Ferreira identified this as a moderate departure from accepted practice. Woodlands has accepted that this was an oversight.

26. CNM B stated that she requested a copy of the EPOA from the family several times via phone after admission, and eventually it was received from Supportlinks (as part of the EPOA activation process). Review of the records shows no evidence of discussion or interactions with Mr D's children regarding EPOA documentation or requests made for file copies, which was the expected practice at the time.

27. Due to the lack of records made by CNM B, I am unable to state with certainty whether attempts were made to obtain the EPOA documentation. Regardless, I am critical that such

crucial documentation was not on Mr D's records after admission, or any record indicating whether there were difficulties obtaining this, in line with standard practice and Woodlands' checklist.

Involvement of nominated EPOA in activation process

28. Mr D's family raised concern that Mr D's health and welfare EPOA, Ms C, was not directly involved in the EPOA activation process.

29. On 14 April 2021 Mr D's mental capacity was assessed by his GP, Dr A, and his EPOA was activated. This process was initiated after an urgent request from CNM B to Dr A stating: '[W]e would like the EPOA enacted so he can be moved to a dementia unit as soon as possible.' There are no records to indicate whether this was discussed with any family member prior to the request.

30. CNM B told HDC that she had sought guidance from Supportlinks around Mr D's behaviours and was advised to seek EPOA activation and urgent reassessment for dementia-level care. Having reviewed the records, there is no correspondence regarding Supportlinks' guidance, although there is a referral from Supportlinks to OAMH on 14 April 2021 requesting an urgent reassessment. This referral notes Ms C as the care and welfare EPOA. However, there is no evidence that Supportlinks or CNM B contacted Ms C directly about this referral for reassessment. Records show that email communication occurred between CNM B and a Supportlinks Service Coordinator regarding EPOA documentation on 14 and 15 April 2021, with EPOA copies shared and with further interactions regarding a change in care level, but this communication does not appear to involve Ms C as the nominated representative.

31. Dr A told HDC that CNM B informed her that Supportlinks and OAMH psychiatry had discussed Mr D and agreed that he needed to be moved to a dementia-level facility. Dr A said that prior to conducting the mental assessment, she asked CNM B several times to ensure that Mr D's nominated EPOA or family be present to ensure appropriate engagement with welfare decision-making. Dr A stated that she was advised by CNM B that both Mr D's EPOAs had been consulted about the mental capacity assessment, and they agreed with initiating the assessment but could not attend, and another family member would be present. Having reviewed the information, there is no record that either EPOA was directly contacted by Woodlands or CNM B or these matters discussed.

32. The ARRC agreement clearly states that the resident and their family/whānau or nominated representative will be involved in decisions affecting the resident's life (D4.1d), including care planning (D16.3f) or when there are any changes in a resident's condition (D16.4b).

33. In the circumstances of Mr D's case, neither of his nominated EPOAs (Mr E or Ms C) were present for his mental capacity assessment and EPOA activation on 14 April 2021. Ms C stated that her brother Mr F, who was not a nominated EPOA, was visiting Mr D at the time and was incidentally present during this process. I acknowledge that a family member was present, but I consider that the activation of EPOA with the intent to assess for change of care level from rest home to dementia is a significant decision that would affect Mr D's care and welfare, and clear effort should have been made to ensure that his nominated EPOAs

were either in attendance or consulted adequately. On review of the available information, this did not happen.

34. Ultimate responsibility for enacting the EPOA sits with Dr A as a medical professional. I sought in-house medical advice from Dr David Maplesden regarding the adequacy of Dr A's process for EPOA activation. Dr Maplesden considered that Dr A's management of this process was consistent with accepted practice and did not identify any areas of concern.

35. I accept Dr Maplesden's advice, and I am not critical of Dr A for her role in the process. In my view, she made reasonable attempts to ensure (via CNM B) that Mr D's nominated EPOAs had been notified of the assessment and reasonably accepted that another family member was present to provide information and some representation. Dr A has apologised for any distress and inconvenience experienced by the EPOA activation process.

36. RN Ferreira advised that it would be considered accepted practice to involve whānau/family and ensure that all stakeholders were appropriately informed and able to provide timely support where required, including arranging a whānau/family meeting to ensure that consultation occurred regarding the indications for activation of EPOA responsibilities, and about the reassessment process. Having reviewed the available information, it appears that this did not occur.

37. In response to this complaint, Woodlands accepted the deficiencies in the EPOA process, noting that, as the care and welfare EPOA, Ms C should have been contacted first and included in all discussions and emails regarding Mr D. Woodlands accepts that communication regarding the enactment of the EPOA was lacking and advised it regrets any undue stress this caused the family.

38. CNM B told HDC that in hindsight, although Mr F was present at the time, she should have involved the family more in the EPOA process.

39. Woodlands told HDC that at the time of these events, it did not have an EPOA policy, and in response to this complaint it is considering whether an EPOA activation policy is required.

Reassessment process

40. After the EPOA activation, Mr D was referred to OAMH for psychiatric and care-level reassessment, scheduled for 28 April 2021. Mr D's family raised concern that Mr D underwent the reassessment process without any family member present.

41. As outlined in the ARRC agreement, service providers have a responsibility to maintain resident safety. Where risk is identified and the provider has recognised that they are unable to meet the resident's requirements, a reassessment is required, ensuring that whānau/ family are involved (D21.1c).

42. On Friday 23 April, after CNM B had reported several incidents of Mr D's confusion and restlessness, an OAMH doctor conducted the reassessment. This occurred without any family members present in person or any prior family consultation. OAMH told HDC that Mr D's family were able to participate via phone during the assessment.

43. Records indicate that OAMH attempted to contact Ms C twice to inform her but could not establish contact. OAMH noted that Ms C had provided permission for Mr E or Mr F to be contacted if she was unavailable. It is not clear whether any attempt was made to contact Mr E, Mr D's other EPOA. It appears that Mr D's son Mr F was then contacted to discuss the assessment.

44. As outlined in paragraph 36, RN Ferreira advised that it would be considered accepted practice to arrange a whānau/family meeting with the health team to ensure that appropriate consultation occurred regarding the reassessment.

45. OAMH has accepted that it did not follow its usual process of early family engagement, however notes this was due to the urgency of the assessment and concerns regarding Mr D's risk and safety. OAMH acknowledged that it would have been best to inform the family prior to the assessment (even if shortly before) to provide the opportunity to attend in person.

46. On review of the records, it is clear that Woodlands held concerns about its ability to meet Mr D's needs. However, on completion of the reassessment, with the exception of 15-minute checks being implemented, neither Mr D's care plan nor his safety needs were amended by Woodlands.

47. File information shows that OAMH assessed Mr D and advised that he met criteria for dementia-level care on Friday 23 April, and that CNM B was aware of this. However, this information was not communicated directly to Ms C as EPOA, by either Woodlands or OAMH, until Tuesday 27 April, which is concerning.

Discharge from Woodlands

48. At 4pm on 27 April Mr D was discharged from Woodlands. Mr D's family raised concern that this was against Woodlands' policy, which requires a 21-day notice period. The family expressed distress that they had to find urgent alternative arrangements for Mr D until he could access a dementia-care facility, which occurred on 29 April 2021.

49. Woodlands told HDC that after further incidents of Mr D being unsettled, leaving the facility, and becoming lost (including an incident involving Police) and clear communication from Mr D that he did not wish to stay at Woodlands, it became apparent that Woodlands could not provide a safe environment for Mr D. The records indicate that after Mr D had been returned to the facility on 27 April 2021 when he had gone missing, he packed his suitcases and left the facility to wait by his son's car so that he could go home with him. Woodlands told HDC that it could not force Mr D to return, and it was clear that Mr D refused to stay.

50. It appears from the records that discussion occurred with Mr D's son Mr E about this matter, and an agreement was reached for Mr D to be placed in Mr E's care until a placement could be found in a dementia-level care home.

51. Section 12.1(a) of the Woodlands 'Resident Admission Agreement' outlines that a resident may be asked to leave the facility immediately following the expiry of 21 days' notice being given to the resident advising of the termination of the agreement.

52. Having reviewed the Resident Admission Agreement, section 13 appears more applicable to this circumstance, which outlines that there may be situations where a resident's needs change and those needs can no longer be met by Woodlands. In these circumstances, the agreement requires that a reassessment is done, attempts made to find solutions to assist the resident to stay, an alternative service provider found if requested, and efforts made to 'ensure that transfer from the facility to an alternative service provider takes place in an appropriate and timely way'.[6]

53. Records show that after the reassessment of care level on 23 April 2021, Woodlands was supportive of Mr D remaining in its care until he was able to transfer to another provider who offered dementia-level care. Regular checks were supposed to be in place to ensure that Mr D remained safe, but there is no evidence that a short-term care plan with clear interventions commenced to guide his interim care and safety needs, and no supporting records of monitoring to show the visual checks and care delivery that occurred. Subsequently Mr D remained distressed and unsettled and went missing on 27 April 2021.

54. CNM B told HDC that she had assumed that the staff had updated Mr D's care plan and filled in monitoring forms. She acknowledged that she did not check on this and has accepted responsibility that these were not completed.

55. Having reviewed the available information, it is clear that Mr D's needs changed, and it appears that policy was partially met regarding instigating the reassessment process. However, I consider that there were inadequacies in ensuring that Mr D's transfer occurred in an appropriate and timely way, on the basis that his interim care and safety needs were not amended, and he was discharged before the transfer could take place.

56. I accept that it was not possible for Woodlands to force Mr D to stay, and that in line with Mr D's wishes an agreement was made with his son, Mr E, for Mr D to be discharged to Mr E's care pending placement at a more suitable facility.

57. RN Ferreira considers that the care provided to Mr D met the minimum standards in the circumstances, with opportunities for improvement in risk assessments and documentation standards. I accept this view.

58. Woodlands has acknowledged that it was inappropriate for the family to be told that Mr D was to leave the facility by a certain time.

In-house aged-care advice

59. RN Ferreira identified the following departures from the accepted standard of care provided by Woodlands:

- Pre-admission processes — moderate departure
- Admission care plan and engagement with family — moderate departure
- Post-incident and behavioural management and support — moderate departure

[6] Section 13 'Changes to level of care'.

- EPOA records and processes:
  - Obtaining records — moderate departure
  - Engagement and consultation with Ms C and family — moderate to serious departure
  - Communication with GP and Supportlinks — moderate departure

In-house medical advice

60. Dr Maplesden provided advice regarding GP processes for EPOA activation. Dr Maplesden was not critical of the process used by Dr A and, noting that it occurred in a pressurised context, he considered it to be appropriate.

Opinion

Woodlands of Feilding — breach

61. RN Ferreira identified issues in pre-admission and admission processes,[7] EPOA records and activation, and engagement with family. She advised that in all these areas the standard of care provided by Woodlands fell below the accepted standard of care. Having independently reviewed the records and responses, I accept RN Ferreira's advice.

62. Woodlands was provided with the opportunity to comment on RN Ferreira's report. Woodlands accepted it in full and apologised for the departures noted. Woodlands was also provided with the opportunity to comment on the provisional decision. Woodlands told HDC it was never its intention to cause distress to the family, and its primary concern was always Mr D's safety and wellbeing. I acknowledge and accept this statement, and it is clear from the records that all staff genuinely had Mr D's wellbeing at the centre of their decision-making. However, I do consider that there were shortfalls in the care provided to Mr D that were systemic in nature.

63. Acknowledging that initially Mr D was assessed by Supportlinks as requiring rest-home level care, I consider that without clear policies or guidelines in place to ensure the adequate exchange of information at pre-admission and admission, Woodlands was unable to adequately assess its suitability to provide Mr D with the appropriate level of care. Subsequently, his initial planning and support was inadequate and unlikely to address his needs and likely resulted in additional stress and distress. There are no records that alternative methods or strategies were attempted with Mr D to assist him in settling in (other than monitoring), and it is unclear whether the diversional therapist or activities team were involved in supporting him with meaningful tasks or assisting him in engaging in the activities programme.

64. I consider that once identified that Woodlands could not provide the right level of support for Mr D, the matter was escalated appropriately with EPOA activation and subsequent reassessment. I note, however, that the process by which this was done was flawed, with the EPOA activation requested without prior consultation with the family, no direct contact

[7] Including initial care planning.

made with the designated EPOAs, inadequate family consultation during the reassessment process, and a stressful discharge process that left the family feeling unsupported.

65. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, and with reference to the departures in practice noted by RN Ferreira, I consider that Woodlands did not provide services to Mr D with reasonable care and skill and breached Right 4(1) of the Code.

CNM B — adverse comment

66. As the Clinical Nurse Manager, CNM B was responsible for the oversight and management of Mr D's care from the point of pre-admission to discharge. Having reviewed the information available, there are noted deficiencies in record-keeping, including no record of the initial family meeting or information gathered/requested to inform decision-making and planning, incomplete admission documentation, including no record of a signed resident admission agreement, EPOA documentation, and admission form, and no clear record of consultation with the family for the initial care plan or changes made to his care plan in response to EPOA activation and reassessment.

67. Acknowledging that there was no internal policy or guidance around the EPOA activation process, and that a family member happened to be present, I remain critical of CNM B for failing to contact Mr D's nominated care and welfare EPOA, Ms C, directly during the activation process, and for appearing to initiate the process without first consulting with the family. I am also critical that there was a delay in formally advising Ms C that Mr D had been re-assessed as requiring dementia-level care.[8] I consider that at the time, CNM B was aware that Ms C was the nominated care and welfare EPOA, and CNM B should have ensured that Ms C was directly informed of the request for EPOA activation and potential reassessment of care level. RN Ferreira was also critical that the steps followed by CNM B in the EPOA activation process at the time were not in line with accepted approaches to practice. Having reviewed the available information, I accept this view.

68. CNM B did demonstrate clear communication with the family around incidents and reported concerns and correctly escalated those concerns to ensure that Mr D was able to be reassessed to ensure that he was placed at a facility that could better meet his needs. I note, however, that the necessity of this process was driven by inadequate information collection during admission processes, and that the EPOA activation and reassessment process was flawed and lacking in adequate consultation with the family.

69. I consider that the above deficiencies contributed to the experience of Mr D and his family, and I am critical of CNM B for this.

70. CNM B was provided the opportunity to comment on the provisional decision. Where relevant her comments have been included in the body of the opinion. I note that CNM B did not provide any new information that has not already been considered in forming this opinion.

[8] Reassessed on 23 April; however, not advised until 27 April.

Health NZ MidCentral OAMH — educational comment

71. RN Ferreira outlined that it was accepted practice to arrange a whānau/family meeting with the health team to ensure that appropriate consultation occurred regarding the reassessment. In the circumstances of this case Mr D's reassessment was brought forward from 28 to 23 April 2021 and was completed without a family meeting in advance and without Mr D's nominated EPOA being notified directly. OAMH told HDC that Mr D's family were able to participate in the reassessment process by phone. I accept that the reassessment was brought forward due to safety concerns, which resulted in a deviation from standard practice.

72. OAMH has acknowledged this and acknowledged that the family should have been contacted prior to the assessment. OAMH told HDC it remains committed to continuous improvement in its services including ensuring robust communication and family engagement especially when urgent assessments are required. I encourage OAMH to continue improving its processes in this regard.

Changes made since events

Woodlands

73. Woodlands told HDC that the following changes have been made:

a) All appointed family members/advocates are copied into all documentation regarding assessments.

b) The admission policy and prospective residents' handbook has been updated to include specific information about settling in, including that at times a reassessment process may need to be undertaken.

c) Management notifies the company directors if there are concerns regarding the safety of residents at Woodlands.

d) The Management Team with the Directors of Woodlands acknowledged that changes needed to be made to ensure that open disclosure occurs, with support and guidance to families should reassessment be required.

Dr A

74. Dr A stated that she has made the following changes to her practice regarding the EPOA process:

a) She has undertaken self-directed education to further her understanding of EPOA and its processes.

b) She completed the education module 'Performing Capacity Assessments Information for GPs'.

c) She changed her practice to ensure direct communication with EPOA holders wherever feasible and to provide more detailed documentation of the assessment process and the rationale behind decisions made.

75. I acknowledge these changes and encourage Dr A to continue to improve her practice.

CNM B

76. CNM B advises that she has made the following changes:

a) has changed her practice to ensure that safety checks are more thorough.

b) now documents everything in Woodland's notes, even if it is the briefest of exchanges between family members, whether by word of mouth, emails or telephone conversations

c) ensures comprehensive notes are recorded on admission

d) involves the EPOA in care planning and any changes, and ensures full communication is placed on record

e) ensures that staff are following her instructions, especially when it involves monitoring a person's whereabouts in the facility.

Recommendations

Woodlands

77. I acknowledge the changes made to the admission policy and prospective residents' handbook, along with the other changes made by Woodlands, and I consider these to be appropriate in the circumstances.

78. To address other matters and to ensure accountability, I recommend that Woodlands:

a) Provide a written apology to Mr D's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to Mr D's family, within three weeks of the date of this report.

b) Consider developing a policy or guidance for the initial family/representative meeting and pre-admission process, to ensure that relevant information[9] is formally requested from family/representatives and other relevant parties and received as part of admission decision-making. Woodlands is to provide HDC with an update on this within eight weeks of the date of this report.

c) Consider amending the admission agreement to include consent to request information from relevant sources. Woodlands is to provide HDC with an update on this within eight weeks of the date of this report.

d) Conduct an audit of 25 of the most recent admissions to ensure compliance with:

   i. Provision of information about settling in and potential reassessment processes.

   ii. Completion of documentation, including relevant clinical/needs assessment information, a signed admission agreement, EPOA details, and documentation.

   A summary of audit findings with any corrective actions to be implemented should non-compliance be identified is to be provided to HDC within eight weeks of the date of this report.

[9] Such as recent needs assessments, cognitive scoring, engagements with service providers or supports, and any other relevant medical information.

e) Consider implementing a requirement that a family/representative meeting occur before any decision to activate an EPOA and/or request for reassessment, to ensure that family/representative views are obtained and recorded adequately. Woodlands is to provide HDC with an update on this within eight weeks of the date of this report.

CNM B

79. I recommend that CNM B:

a) Provide a written apology to Mr D's family for the issues identified in this report, within three weeks of the date of this report.

Previously I recommended that CNM B reflect on the deficiencies in care identified in this case, particularly around record-keeping and adequacy of documentation, and provide a written report on her reflections and the changes to practice she has instigated as a result of this case. I confirm that CNM B has completed that recommendation.

Follow-up actions

80. A copy of this report with details identifying the parties removed, except Karaka Court Limited (trading as Woodlands of Feilding) and the advisors on this case, will be sent to HealthCERT and Health NZ and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house advice was obtained from Jane Ferreira, RN, PGDipHC, MHlth, Nurse Advisor (Aged Care):

'CLINICAL ADVICE — AGED CARE

CONSUMER	:	Mr [D]
PROVIDER	:	Woodlands of Feilding Care Home
FILE NUMBER	:	C21HDC01416
DATE	:	9 May 2024

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1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Woodlands of Feilding Care Home. 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.

- Letter of complaint received 25 June 2021
- Provider response received 23 September 2021 and 7 February 2024
- Clinical documentation including admission assessments, care plan, progress notes, monitoring forms, communication records, medical records, EPOA and consent documentation.
- Organisational policies including Admission, Advance Directives, Open Disclosure/Adverse Event/Communication, Care Plans, Management of Challenging/ Disturbing Behaviour, Missing Resident
- Policy documents including Resident Admission Agreement, Admission Checklist, Admission Form, Admission Procedure Audit.

3. Complaint

[Mr D]'s family have expressed concern about the care and communication provided to him while residing at the care home in April 2021. Their concerns relate to the resident admission process, clinical oversight, EPOA activation and level of care decisions.

Background

Prior to admission [Mr D] had lived independently at home, with support from whānau/family and friends. His medical history included vascular cognitive impairment, TIA [transient ischaemic attack]/syncopal events, hypertension, hyperlipidaemia, GORD [gastroesophageal reflux disease], type 2 diabetes, OA [osteoarthritis], and prostatism. Records show that an Enduring Power of Attorney (EPOA) for personal care and welfare was in place but not activated, with [Mr D]'s daughter [Ms C] nominated as his representative. File information indicates that [Mr D] was experiencing cognitive decline and coping difficulties while living at home. Following referral, he was assessed by Supportlinks as

requiring rest home level care and admitted to the care home on 8 April 2021. During [Mr D]'s admission the care home team observed risk-taking behaviours, raising wellbeing and safety concerns. The care home sought support from Older Adults Mental Health (OAMH) Service, informed Supportlinks about safety and care level concerns, and referred [Mr D] to the GP for EPOA activation. Following consultation with OAMH, [Mr D] was reassessed to a higher level of care. Due to increased risk, he was discharged from the care home on 27 April 2021 to the care of his son, pending transfer to another service provider on 29 April 2021. Family have expressed concern with care, communication and decision-making by health professionals during this time.

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:

a) Do you consider Woodlands have undertaken the appropriate pre-admission steps to ensure all information was obtained to ensure a fully informed decision prior to accepting [Mr D] into RHL care.

Prior to accepting a new admission, it is considered accepted practice for the care home leaders to meet with the resident and their nominated representative to view the care home, discuss care requirements and plan goals for care. This provides an opportunity for the care team to review the preadmission information, including health records, in partnership with the resident to ensure that all parties are well informed prior to admission. The preadmission meeting is also an opportunity for the care home to review the supporting information and make an informed decision regarding admission suitability or seek clarification and guidance from other health professionals in the circumstances.

Records show that [Mr D] was assessed by a needs assessor on 1 March 2021 as requiring rest home level care and placement was authorised on 24 March 2021. It is unclear from the submitted evidence whether the care home's clinical leader had requested, or received, a copy of [Mr D]'s recent needs assessment which would have identified his current abilities and support requirements. This is considered a key document when preparing for a new admission to inform decisions regarding ongoing care provision and appropriate service delivery. It is also unclear whether the Clinical Nurse Manager (CNM) had access to medical and allied health records to inform the assessment process.

The Woodlands Admission Checklist provides a comprehensive list of actions and responsibilities for completion prior to and including day-of-admission activities.

There is no evidence that a family meeting was held or that a nursing handover occurred between the assessing registered nurse (RN) to the care home clinical team prior to admission. Usual practice would be to receive a verbal handover of nursing and medical information, supported by a written care document and needs assessment. Partnered with this is a responsibility to establish who the resident's nominated representative is, ensure that copies of appropriate legal documents are on file and that whānau/family or nominated representatives are included in the admission process.

From the information reviewed to respond to this question, it appears that the admitting team had insufficient clinical information to safely inform their decision to admit [Mr D] and guide his care requirements in the circumstances. The provider has acknowledged this and submitted evidence of strengthened systems and processes which appears appropriate and aligned with accepted practice.

- Departure from accepted practice: Moderate.

b) Please comment on the clinical oversight and collaboration with family relating to admission risk assessments, initial care plan provision to guide the safe delivery of care for [Mr D]. Is this in line with accepted standards of nursing care?

The Care Plan policy states that '*the admission assessment will utilise information gained from the resident, the nominated representative and that provided by the referring agency and/or previous provider of health and personal care services along with observations and examinations carried out*'.

File information shows that admission forms and initial nursing assessments were completed by an RN on the day of admission with an interim care plan commenced. The care plan states that the document was developed in consultation with the resident ([Mr D]) and a relative but does not identify who this was. Progress notes provide a comprehensive introduction regarding [Mr D]'s health background, care requirements and daily routines but there is no discussion of a family member or support person present on the day of admission.

Pre-admission health records state that EPOA was in place but not activated. Progress notes state that [Mr D] had "mild cognitive impairment". The informed consent document was signed by [Mr D], in keeping with his assessed ability at the time. As outlined in question (a), there is no evidence that the needs assessment completed in March 2021 was used to inform [Mr D]'s nursing assessments and plan of care, with no evidence of whānau/family participation in the admission process at this time. There is no reference to preadmission information regarding cognitive scoring, safety issues or care concerns raised by family as the primary referrers when completing risk assessments or related care planning.

From the information reviewed to respond to this question, while it appears that admission documentation was completed in a timely manner, there appear to be

concerns with access to reliable information and whānau involvement to inform an appropriate plan of care which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

c) Please comment about the facility's follow up of EPOA documentation on admission and whether this is in line with accepted practice.

The Admission checklist states that it is the manager's responsibility to obtain a copy of the EPOA and advance directives at the time of admission. The checklist outlines management responsibilities to provide the resident or relatives (whānau/family) with an admission pack, to discuss the admission agreement with them, obtain copies of EPOA records and sign supporting documentation. The Admission Form (1) is incomplete with essential information missing regarding EPOA contacts, with no file evidence provided of completed supporting documentation; a signed admission agreement or copies of EPOA documents.

Email communications reflect interaction between the CNM and the Supportlinks Coordinator regarding [Mr D]'s EPOA documentation with copies reportedly sent by the coordinator to the CNM on 15 April 2021. Given [Mr D] had been admitted to the care home on 8 April it would usually be considered accepted practice for the current service provider to communicate directly with the resident's nominated representative to request copies of EPOA documents, in keeping with admission responsibilities. Whānau/family communication records provide no evidence of discussion or interactions with [Mr D]'s children regarding EPOA documentation or request made for file copies.

I note the Admission Policy appears to have been revised with the Information Booklet updated in response to this complaint and appears appropriate in the circumstances.

From the information reviewed to respond to this question it appears that the processes to access EPOA documentation did not align with the organisation's recommended approach and accepted practice standards in the circumstances.

- Departure from accepted practice: Mild to moderate

d) Please comment on clinical oversight relating to post incident follow up and analysis of risk; is there evidence of post incident interventions and timely escalation of concerns.

Medical records prior to admission reflect that [Mr D] was known to OAMH services and discuss signs of cognitive and functional change. The initial nursing assessments identified that [Mr D]'s medical history included Type 2 Diabetes, noting that he did not routinely check his blood glucose levels (BGL). Records show that vital signs were recorded on admission to inform baseline observations but a BGL was not recorded. Health information also indicated that [Mr D] experienced intermittent hip pain and occasional episodes of constipation. While an interim care plan was in place, there was no specific plan of care commenced

to guide his care and safety needs during the settling-in phase, with no evidence of monitoring forms in place to inform evidence-based clinical decisions.

As indicated in file notes, [Mr D] had been living alone in the community therefore adjusting to being part of a shared environment would take some time to orientate to. It is unclear whether regular observations (intentional rounding) were commenced by the RN team as a precautionary safety intervention.

Records show that [Mr D] had previously cared for his wife when unwell so he was familiar with supporting vulnerable people. He was a retired tradesman and familiar with engaging in building or repairs of household items. Progress notes and whānau/family records reflect concern with peer interactions and equipment use, but it is unclear what alternative strategies or solutions were offered to him.

Behaviour monitoring records report that [Mr D] was lost at times in the care home or seeking to leave and meet friends or go home, indicating that he was unsettled or lonely. It is unclear whether the diversional therapist or activities team were involved in supporting him with meaningful tasks or assisted him to engage in the activities programme. It appears that the care team were attentive to monitoring his whereabouts; however, records show an increase in frustration with verbal altercations regarding his actions. There is no evidence of any nursing assessment undertaken in response to these events, analysis of triggers or consideration of contributing factors, such as unmet needs, in line with the organisation's policies and recognised approaches to managing stress and distress (HQSC, 2019; HQSC, 2023).

Email records reflect that the CNM was concerned about [Mr D]'s safety with records stating that the GP and Supportlinks were informed of the incidents. On 19 April the CNM raised concerns about [Mr D]'s unsettled behaviour with OAMH, noting that he was leaving the building with purpose but was unable to articulate where he was going or return safely, requiring support from members of the public. OAMH communication acknowledged the CNM's view regarding his admission period (11 days), noting that it was still "early days" in his move to residential care. A further report on 23 April 2021 discussed [Mr D]'s recent assessment outlining concerns with memory, insight and safe decision making, noting recent incidents including leaving the care home, concern with judgement and risk-taking, and the care home's reported difficulties in maintaining his safety needs.

I note there are no event reports provided in the submitted evidence to inform further comment regarding incident management processes. There is no evidence of changes made to his plan of care in response to these events. [Mr D] was reported missing on 27 April 2021 requiring police involvement which would meet criteria for a serious event, however there is no evidence of event documentation, investigation or reporting processes. The provider has acknowledged the lack of record keeping and apologised.

From the information reviewed to respond to this question it appears that the care team were responsive to [Mr D]'s needs with timely escalation to, and collaboration with, allied health services. However, there is limited evidence of nursing assessment and care evaluation to inform the reassessment process, with improvement required in incident management, communication and documentation standards. There also appears to be an opportunity for improving knowledge and understanding about caring for people living with a diagnosis of dementia or cognitive change, and related clinical responsibilities which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

e) Do you consider the communication between Woodlands and [Ms C] related to activation of the EPOA and reassessment of her father to be fair and reasonable based on the information provided.

The Age-Related Residential Care (ARRC) agreement clearly states that the resident and their family/whānau or nominated representative will be involved in decisions affecting the resident's life (D4.1d), including care planning (D16.3f) or when there are any changes in a resident's condition (D16.4b) and providers will acknowledge the significance of these support networks (D4.1e).

The Residential Care Placement Authority stated that [Mr D] had been assessed by Supportlinks on 1 March 2021 as requiring rest home level care. File information showed that EPOA was in place, but not activated, at the time of [Mr D]'s admission to the care home. As previously discussed, copies of EPOA documents were not on file, in line with recognised admission processes.

Submitted email records between the provider and Supportlinks report several incidents with ongoing concern for [Mr D]'s safety. Entries in the Whānau/Family record 12–13 April 2021 and progress notes state that [Mr D]'s daughter had been informed of the behavioural incidents, noting that the GP and Supportlinks had also been informed but rationale for involvement was not provided. Entries describe the events but do not report concern with safe decision-making. There is no evidence of communication held with [Ms C] as [Mr D]'s nominated representative regarding the urgent GP assessment to activate EPOA responsibilities, and proposed reassessment of [Mr D]'s care level. While activation of EPOA is a medical decision, it would be considered accepted practice to involve whānau/family, as outlined in the GP response, and ensure that all stakeholders were appropriately informed and able to provide timely support where required.

From the information reviewed to respond to this question I consider the activation process was not fair and reasonable in the circumstances. It is clear that the steps followed by the CNM at the time were not in line with accepted approaches to practice and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious

f) **Do you consider the communications between Woodlands' Care Manager to the GP and Support Links relating to the request for EPOA activation and reassessment to be fair and reasonable and in line with expected nursing practice.**

As outlined above, the ARRC agreement provides clear guidance regarding expectations for service delivery.

On review of the submitted information it appears that the RN team escalated their concerns regarding [Mr D]'s safety and wellbeing in a timely manner; however, there appears to be a lack of coordination between the stakeholders.

GP records state that an emergency visit to see [Mr D] occurred on 14 April 2021, in response to a request by the CNM to consider EPOA activation. Email communication between the CNM and GP service 14 April 2021 described concerns with [Mr D]'s safety and decision-making, stating that … *we would like the EPOA enacted so he can be moved to a dementia unit as soon as possible …*

It is unclear from file documentation whether [Mr D]'s nominated representatives were aware of this intent. Records show that email communication occurred between the CNM and Supportlinks Service Coordinator regarding EPOA documentation on 14 and 15 April with EPOA copies shared, with further interactions regarding a change in care level, but do not appear to involve [Ms C] as the nominated representative.

As outlined in OAMH communication, it would be considered accepted practice to arrange a whānau/family meeting with the health team to ensure that appropriate consultation occurred, regarding the indications for activation of EPOA responsibilities and about the reassessment process.

From the information reviewed to respond to this question, it is clear that the steps followed by the care home manager at the time were not in line with accepted approaches to practice.

- Departure from accepted practice: Moderate to serious

g) **Please comment on whether Woodlands took appropriate steps and showed compassion to ensure the safe and supportive provision of care for [Mr D] and his family during admission; while awaiting reassessment; and when an alternative facility was required following dementia sign off?**

File information reflects that [Mr D] was closely supported by his family who cared about his wellbeing. As discussed, a transition to a new environment is an adjustment for both the resident and their whānau/family and as outlined in the provider's policies, open disclosure and clear communication is an essential part of care partnership. Progress notes across the admission describe care occurring and records show that [Mr D]'s EPOA was kept informed of safety concerns. As outlined in the ARRC agreement, service providers have a responsibility to maintain resident safety. Where risk is identified and the provider has recognised

they are unable to meet the resident's requirements, a reassessment is required, ensuring that whānau/family are involved (D21.1c). File information shows that OAMH assessed [Mr D] and advised that he met criteria for dementia level care on 23 April, however this information was not communicated to [Ms C] as EPOA, and whānau/family for several days which is concerning.

Records show that the care home were supportive of [Mr D] remaining in their care until he was able to transfer to another provider who offered dementia level care. While OAMH advised that regular checks were in place to ensure [Mr D] remained safe, there is no evidence provided that a short-term care plan with clear interventions was commenced to guide his interim care and safety needs, with no evidence of supporting monitoring records to evidence visual checks and delivery of care.

Progress notes indicate that [Mr D] remained distressed and on 27 April was reported missing from the care home. He was safely located and returned to the care home. However due to ongoing risk with demonstrated intent to leave the premises a decision was made to discharge [Mr D] into the care of his son while awaiting placement with another provider.

From the information reviewed to respond to this question, it appears that the care provided to [Mr D] was of the minimum standard in the circumstances, with opportunities for improvement in risk assessments and documentation standards.

- Departure from accepted practice: Mild to moderate

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

References

Health Quality and Safety Commission. (2019; 2023). Frailty Care Guides.
https://www.hqsc.govt.nz/resources/resource-library/frailty-care-guides-nga-aratohu-maimoa-hauwarea-2023-edition/

Appendix B: In-house medical advice to Commissioner

The following in-house medical advice was obtained from Dr David Maplesden:

'**CLINICAL ADVICE —MEDICAL**

1. My name is David Maplesden. I am a graduate of Auckland University Medical School and I am a vocationally registered general practitioner holding a current APC. My qualifications are: MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP (Dist) 2003. Thank you for the request that I provide clinical advice in relation to the complaint from Ms [C] about the care provided to her father, Mr [D], by Dr [A] of […] Medical Centre. 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. I have reviewed the following information:

- Complaint from Ms [C]
- Response from Dr [A]
- Response and care documentation [from] Woodlands […]
- Clinical notes Te Whatu Ora Mid Central
- Clinical notes […] Medical Centre […]

3. I have been asked to comment on the capacity assessment undertaken on [Mr D] by Dr [A] on 14 April 2021 in relation to activation of EPOAs for property and personal care and welfare. It is important to note I am assessing the EPOA activation assessment process undertaken by [Dr A], not her decision that [Mr D] lacked capacity to make decisions regarding his long-term placement.

4. [Dr A] notes her first contact with [Mr D] was a request by [Woodlands] nursing staff on 13 April 2021 to clerk him as a new admission to the facility at rest home level care. She established from the nursing team his history of vascular dementia with worsening memory, that he had had his driver licence revoked the previous year but continued to drive, family were managing his finances on his behalf, and despite a community care package in place since a recent hospital admission he was not managing at home. On the day of the planned assessment [Mr D] had left the facility without notifying staff and, in discussion with the facility manager, [Dr A] noted staff had increasing concerns regarding aspects of [Mr D]'s behaviour that potentially put him and other residents at risk and that the facility did not have the resources to manage this.

5. [Dr A] scheduled a new date for her review of [Mr D], and she states she made it clear to the facility manager that [Mr D]'s nominated attorneys should attend (face to face or virtually) so his future placement could be discussed. In the interim [Dr A] gained collateral information from [Mr D]'s clinical records (including previous elder health assessments with diagnosis of vascular dementia and mini-ACE score of 8/30 on 4 March 2021), long-term conditions nurse […] who had been visiting [Mr D] regularly for several years, and the practice GP [Dr G]

who had recently had most contact with [Mr D] (including discussions with [Mr D] and his family regarding long-term placement due to his deteriorating cognition). On 14 April 2021 [Dr A] was asked by the [Woodlands] manager to attend urgently to activate [Mr D]'s EPOA for personal care and welfare so he could access an appropriate level of care (safety concerns as noted above). [Dr A] states she reiterated the need for the nominated attorney and/or family members be in attendance and she was informed that the facility manager had discussed the situation with [Mr D]'s nominated attorneys and *they were both in agreement that this was an appropriate step and … the daughter, [Ms C]* [nominated attorney for personal care and welfare] *was unavailable to attend remotely or in person due to work commitments.*

6. Prior to attending the assessment, [Dr A] called [Dr G] who was currently on leave and states *we spoke at length about [Mr D]'s case and his interactions and discussions with the family. [Dr G] reported to me that [Mr D] had been cognitively impaired for some years and this had deteriorated over the past few years ... No cause had been found for his worsening cognition during [his recent] admission. I read the discharge summary where it was felt to be a progression of his known dementia. [Dr G] told me that he had had several meetings with both [Mr D]'s son […] and daughter [Ms C] separately about his difficulties caring for himself. He told them the next step given his continued driving and inability to cope at home would be to have his mental capacity assessed by a doctor which could lead to activation of his EPOA. This was confirmed by the notes … [Dr G] felt that [Mr D] did not have any insight into his memory problems and was not making safe decisions … He had sent Nurse […] to see [Mr D] at home to do a formal mini-ACE assessment on 4 March 2021. This was done with the intention of taking the necessary steps before activating the EPOA. His score was 8/30, indicating severe cognitive impairment. He told the family of this result and that the EPOA would need to be activated if [Mr D] refused to move into an appropriate care level rest home to meet his needs. He said [Mr D] had then been willing to move to a rest home, so there hadn't been an imminent need for an assessment leading to activation of the EPOA for personal care and welfare at that time.*

7. On arriving at [Woodlands] to perform the capacity assessment on 14 April 2021, [Dr A] states she again confirmed with the facility manager that both of [Mr D]'s nominated attorneys were aware the capacity assessment was being undertaken. *She said to me that another son was present on behalf of the family. I confirmed she had spoken to the EPOAs and they had been unable to attend but knew I was coming to see him and to conduct a mental capacity assessment.* [Dr A] introduced herself to [Mr D] and his son and discussed the purpose of the assessment including possible activation of EPOA. She states she discussed with [Mr D] his perception of his current and previous living arrangements and why his family and others might have concerns about his ability to look after himself. It appeared [Mr D] had very limited insight into his limitations or the possible consequences of the limitations and appeared to lack the ability to discuss what could be done for him to live safely at home alone (his desire). [Mr D] was questioned specifically on his continued driving despite revocation of his licence

and was unable to verbalise possible consequences of his actions in this regard. [Mr D] became more distressed and confused as the interview preceded, and [Dr A] believed she had sufficient information on which to base her decision that [Mr D] lacked capacity to make decisions regarding his finances and personal care and welfare. [Dr A] states: *Given the urgency of the situation in terms of what might happen if I didn't assess [Mr D] that day, I believe that it was appropriate for [Mr D]'s EPOA for care welfare and finances to be activated due to my assessment of his lack of mental capacity.* The decision was discussed with [Mr D]'s son who was present, and he was asked to convey the decision to relevant family members. The facility manager advised she would also convey the decision to the nominated EPOA for personal care and welfare, Ms [C]. [Dr A] returned to her practice and completed the relevant legal documents.

8. The provider response appears consistent with the clinical notes reviewed. The GP notes relating to the capacity assessment (dated 15 April 2021 and identified as retrospective) might have been more extensive with respect to interview examples specific to the issues at stake (placement and financial management) illustrating [Mr D]'s lack of capacity in those areas but, in combination with the more specific information present on the legal activation forms, is adequate. When I compare [Dr A's] overall assessment and management of the capacity assessment process with numerous other complaints I have reviewed in this area, I regard her management as the most consistent with accepted practice I have seen. She gained appropriate collateral information from various relevant sources. She made reasonable attempts to ensure the nominated attorneys were aware of the assessment process and I note a family member was present at the assessment both as a source of further collateral information and to provide a point of contact for other family members. The assessment process as described was very reasonable and appropriate legal documentation was completed in a satisfactory manner. This was all done while under significant pressure from [Woodlands] to complete the process. Notwithstanding these comments, I recommend the practice have available as a resource the publication *A Toolkit for Assessing Capacity*[1] and note there are additional useful resources available on the local Community Health Pathways[2].'

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[1] A Douglass, G Young and J McMillan. A Toolkit for Assessing Capacity. 2019. http://www.barristerschambers.co.nz/mcap/assets/Capacity_Toolkit_%20May_2019.pdf Accessed 14 July 2025

[2] Whanganui & MidCentral Community Health Pathways. *Mental Capacity.* https://ccp.communityhealthpathways.org/ Accessed 14 July 2025