HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Management of resident at care home

Introduction

1. On 24 March 2022, this Office received a complaint from Ms A about the care provided to her mother, Mrs B, by Te Whare Hononga Limited Partnership (trading as Monte Vista Residential Care [MVRC]) from her admission on 8 December 2020 until June 2021. Her concerns relate to staff recognition of her mother's decline and the delivery of timely clinical assessment and care.[1]

Background

2. Mrs B was admitted from hospital to MVRC for rest-home-level care on 8 December 2020. Mrs B had significant health conditions, including hypertrophic cardiomyopathy (thickened heart muscle), moderate left ventricular hypertrophy (thickening of the heart's left ventricle walls), atrial fibrillation (irregular and often rapid heart rate), osteoporosis (weakened bones), chronic obstructive pulmonary disease (a lung disease that causes restricted airflow and breathing problems), and memory impairment. Mrs B was experiencing declining health and required regular support to meet activities of daily living.

3. Mrs B had lost approximately 5kg in the month before her admission to MVRC, and she had complex medical needs and nursing requirements while settling into her new environment.

4. At the end of December 2020, she had an episode of raised temperature and lower leg swelling, along with a likely urinary tract infection. It was noted that her weight had increased over the preceding weeks and that she had an intermittent dry cough. In early January 2021, Mrs B's records indicated that her lower leg oedema was improving, but Mrs B expressed concern to a nurse in late January 2021 about further leg swelling.

5. In early February 2021, Mrs B was moved to a new room at MVRC. Around this time, she experienced episodes of shortness of breath on exertion. Later in February 2021, Mrs B experienced a swollen right lower leg with exudate that required wound care management. During a hospital appointment on 22 February 2021, it was noted that Mrs B had significant cardiac dysfunction. Mrs B continued to gain weight. Her family requested an after-hours consultation with a general practitioner (GP) on 27 February 2021, where signs of heart failure with fluid overload were noted.

6. On 8 March 2021, MVRC's GP noted that Mrs B's oedema, cough, and shortness of breath were resolving. However, by 13 March 2021, signs of congestive heart failure had returned.

[1] Ms A had also raised additional concerns about the care provided at MVRC, and they have been addressed separately.

Mrs B had a fall event on 22 March 2021, and she was hospitalised in April 2021 because of her declining health.

7. Sadly, Mrs B passed away in mid-June 2021 at MVRC.

8. The investigation into MVRC's care of Mrs B has focused on four areas: its clinical oversight, falls management, escalation of care, and management of a medical event Mrs B experienced while offsite.

In-house clinical advice

9. In-house clinical advice was sought from Jane Ferreira, Nurse Advisor (Aged Care) and Registered Nurse (RN) (Appendix A), who identified the following departures from the accepted standards of care:

- Clinical oversight – moderate departure
- Escalation of care – mild departure
- Falls management – moderate to severe departure
- Management of a medical event while offsite – mild to moderate departure.

Decision: Te Whare Hononga Limited Partnership – breach

10. I would like to begin by acknowledging how distressing it was for Mrs B's family to observe her health deteriorate over the seven months she was resident at MVRC and for them to feel she was not receiving the care she required over this time. It is understandable they have sought a review and for MVRC to be held to account for any identified deficiencies in the standard of care they provided to Mrs B. I take this opportunity to extend my sincere condolences to Mrs B's family for their loss. After my review of the information gathered over the course of this investigation, I have concerns about certain aspects of the care MVRC provided to Mrs B, as set out below.

Clinical oversight

11. My advisor, RN Ferreira, reviewed Mrs B's clinical records and progress notes and the organisational policies in place at the time from her admission in late 2020 until Mrs B passed away close to seven months later in June 2021. Her report is appended. Overall, I accept RN Ferreira's advice that, from the evidence that MVRC has supplied, the clinical oversight Mrs B received while resident at MVRC was of a minimum standard and not in line with accepted nursing practice given Mrs B's presentation. My advisor has highlighted variable and suboptimal care planning, record keeping, and monitoring practices.

12. RN Ferreira has indicated that relevant nursing and medical assessments were undertaken on Mrs B's admission and that this information was used to develop an initial care plan. However, RN Ferreira has also highlighted that, importantly, a specific plan of care was not commenced at this time to support Mrs B's complex medical needs and nursing requirements while settling into her new environment. She has also identified multiple

examples where MVRC did not implement a short-term care plan in response to a specific event/health issue, despite there being an indication to do so.

13. Further, RN Ferreira found it unclear how care concerns were communicated between the clinical leaders and the care team to ensure consistent, evidence-based, personalised care delivery. She has said in her advice that it was unclear whether the care home clinical team held weekly review meetings to identify and discuss at-risk residents such as Mrs B or what decision-making occurred regarding care prioritisation and ongoing care evaluation.

14. RN Ferreira advised that it was unclear what type of information the nursing team monitored, reviewed, or evaluated to alert them to signs of Mrs B's fluid retention and decline in health. She found limited documented evidence of senior nurse oversight of Mrs B to guide clinical reasoning and related actions during the timeframe in question. For example, on 21 December 2020, the records indicate that Mrs B's feet appeared swollen. She was seen by her GP, and the swelling quickly resolved with elevation. However, RN Ferreira stated that the clinical records contained no evidence of skin assessment or limb measurement or any health education provided to Mrs B. It was unclear whether footwear, falls risk, and call bell access was reviewed or additional monitoring was commenced.

15. A further example my advisor refers to occurred on 28 January 2021, when Mrs B expressed concern about swelling in both of her lower legs. The duty RN reported no apparent signs of swelling and advised her to put her stockings on. Progress notes discussed the use of compression stockings, but there was no guidance in the care plan for carers about the application, positioning, and removal of compression stockings, including indications for use while in bed or management of footwear or falls risk. RN Ferreira commented that it would be recommended to discuss stocking size and compression rating, frequency of skin assessment, and care and safety needs such as wrinkle-free stocking position, with a pathway for escalating care concerns or nurse specialist input.

16. On 14 February 2021, Mrs B reported a swollen right leg with fluid leakage, which continued over the following days. RN Ferreira stated that there was no evidence of nursing assessment or wound management until 17 February 2021. However, no review of vital signs, weight records, the volume of fluid leakage, or signs of infection was undertaken, and continence products/sanitary pads were used to absorb the fluid. RN Ferreira stated that it was unclear whether support was sought from the clinical manager or a wound nurse specialist regarding the leakage and access to more suitable, dedicated wound products, which would be considered more appropriate and respectful in the circumstances.

17. I accept RN Ferreira's view that, overall, there was a moderate departure from accepted practice in relation to the clinical oversight of Mrs B's care while she was resident at the care home. RN Ferreira identified opportunities for improvement in nursing assessment; care planning; documentation standards, including timely recognition of resident change or decline; and related responsibilities, including clinical decision-making, care escalation and follow-up.

Escalation of care

18. Throughout the time in question, there was discussion of vital sign monitoring and escalation of concerns to Mrs B's GP. However, RN Ferreira stated there appeared to have been delays in recognising Mrs B's decline and a lack of timely communication and follow-up with the local medical centre.

19. For example, on 22 February 2021, the local medical centre was informed about Mrs B's breathlessness and weeping right leg. Although MVRC emailed the local medical centre on 23 February 2021,[2] there was no evidence of further follow-up with the GP over the next four days on the management advice being sought.

20. On 27 February 2021, Mrs B was seen by an after-hours GP at another medical centre at the request of Mrs B's family, and she was started on a short course of diuretics. There is no evidence that a short-term care plan was commenced to outline nursing interventions and monitoring responsibilities, which would be accepted practice for an unwell resident at this time.

21. RN Ferreira concluded that MVRC's management of this aspect of care represented a mild departure from accepted standards

Falls management

22. Progress notes indicate that Mrs B experienced a fall event on 22 March 2021. RN Ferreira commented that there was no discussion of the incident in the care record, such as harm sustained, a post-fall nursing assessment, pain assessment, vital signs monitoring, falls risk review, contributing factors, corrective actions, or other related actions that would be considered part of an accepted falls management protocol.

23. I accept RN Ferreira's comment that the lack of documentation after a fall would be considered a moderate to serious departure from accepted practice standards for incident management, falls prevention, and management processes.

Management of a medical event while offsite

24. Ms A raised concerns that her mother became unwell during an eye appointment with an external service provider on 26 February 2021. She was transported back to MVRC, but it does not appear that an RN assessed her on return.

25. MVRC's Transportation policy states that, if a resident becomes unwell during an outing, staff should safely stop the vehicle and seek assistance as necessary. It is unclear why an ambulance was not called to assess Mrs B at the time of the event, MVRC was not contacted, and concerns were not handed over to the duty RN on Mrs B's return to MVRC. There is no indication that MVRC staff were aware that Mrs B had been unwell while away from the care home.

[2] The local medical centre has confirmed that it did not receive the email from MVRC, and it is possible the email may have been rejected because of the size of the attached photograph of Mrs B's leg.

26. RN Ferreira advised that usual reporting practice would be to document the time a resident was returned to the care home, noting any relevant information handed over from the service provider or the resident's support person. Given a possible medical event while offsite, accepted practice would be to take an event history, assess the resident, and seek GP or paramedic support as clinically indicated. I accept RN Ferreira's advice that the care provided on this occasion was a mild to moderate departure from accepted standards.

Conclusion

27. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) states that 'Every consumer has the right to have services provided with reasonable care and skill.' In the circumstances, and having reviewed all the information available, for the reasons set out in the preceding paragraphs, I consider that MVRC did not provide services to Mrs B with reasonable care and skill and breached Right 4(1) of the Code.

28. MVRC has acknowledged this finding.

Changes made since events

MVRC response

29. MVRC told HDC that they extend their condolences to Mrs B's family. MVRC acknowledged the identified shortcomings and are committed to implementing corrective actions to ensure safe, culturally responsive, and clinically robust care for residents.

30. MVRC advised that it has made the following corrective actions as a result of the complaint.

Clinical oversight

- Improved mandatory short-term care plans for pressure injuries, wounds, and infections, which are reviewed regularly until resolution;

- Implemented weekly clinical review meetings (facility manager, clinical nurse lead, RN team) to identify at-risk residents and track interventions;

- Strengthened senior RN oversight so residents with complex needs are reviewed weekly by the clinical nurse lead;

- Frequent oversight of weight and fluid balance monitoring protocols, including automatic triggers for escalation.

Escalation of care

- Implemented dual communication methods with GPs (phone confirmation followed by secure email upload);

- Strengthened ISBAR[3] framework for all communications with GPs, allied health, and after-hours services;
- RN to re-contact GP within four hours if no response has been received;
- Facility Manager/Clinical Nurse Lead to be notified if concerns remain unresolved within 24 hours;
- Training sessions for all RNs on escalation, ISBAR use, and accurate documentation of family concerns in clinical records.

Falls management

- Implemented mandatory RN event form to be completed within 30 minutes of an incident;
- All fall events are reviewed in monthly clinical governance meetings, with trend analysis and preventive strategies;
- Falls data are included in weekly and monthly reports that are shared with staff and senior management.

Management of a medical event while offsite

- The transportation policy has been reviewed to include guidelines on escalation to ambulance/paramedics if a resident becomes unwell during an outing;
- All staff transporting residents must hold a current first aid certificate and complete annual refresher training;
- Requirement for drivers/staff to complete a handover to the RN on duty upon return;
- Documentation of health events occurring during transport in resident notes.

Recommendations

31. Noting the passage of time since these events occurred, the changes that have already been made as a result of this complaint, and with reference to the findings from the most recent certification audit of this facility undertaken on 22 May 2025, I recommend that Te Whare Hononga Limited Partnership:

(a) Provide a written apology to Mrs B's family for the breach of the Code identified in this report. The apology is to be sent to HDC within three weeks of the date of this report, for forwarding;

[3]ISBAR stands for Identify, Situation, Background, Assessment, and Recommendation. It is a structured communication tool used primarily in healthcare settings to enhance the clarity and safety of information transfer during patient handovers.

(b) Provide an update to HDC on the implementation and effectiveness of the corrective actions taken since these events, along with details of any further service improvements made, within three months of the date of this report.

32. In addition to these recommendations, I suggest that MVRC may wish to review the arrangement it has in place with the local medical centre for accessing an alternative GP when a resident's 'regular' clinician is unavailable, and update the arrangement as warranted.

Follow-up actions

33. A copy of this report with details identifying the parties removed, except MVRC, Te Whare Hononga Limited Partnership, and the advisor on this case, will be sent to HealthCERT, Health New Zealand | Te Whatu Ora, and Te Tāhū Hauora Health Quality & Safety Commission and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to the Commissioner

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

CLINICAL ADVICE – AGED CARE

CONSUMER : Mrs [B]

PROVIDER : Monte Vista Care Home

FILE NUMBER : C22HDC00981

DATE : 15 June 2023

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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 Monte Vista 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 dated 21 April 2022
   - Provider responses dated 4 July 2022, 10 March 2023
   - Clinical file records, including nursing assessments, care plans, progress notes, monitoring forms, communication, and allied health and medical records
   - Organisational policies, including Complaints Management, Wound and Skin Care
   - Additional evidence received 14 March 2023, including email communication
   - Additional evidence received 29 May 2023, including organisational policies for resident admissions, nutrition, hydration and weight management, transport, palliative and end-of-life care; medication records; meeting minutes; and allied health information

3. **Complaint**
   [Mrs B]'s daughter, [Ms A], has expressed concern regarding the care provided to her mother while resident at the care home. Her concerns relate to the recognition of decline, delivery of timely clinical assessment and care, and staff interaction and communication.

4. Review of clinical records

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

In particular, comment on:

- the clinical oversight during the period December 2020 to March 2021
- the standard of communication with the GP practice and after-hours surgery
- the process for attending an external health appointment and care on return to the care home
- any additional areas for comment.

Background

[Mrs B] was admitted to the care home at rest home-level care from hospital on 8 December 2020. Her medical history included chronic obstructive pulmonary disease (COPD), decompensated heart failure, atrial fibrillation (not anticoagulated), osteoporosis, polymyalgia rheumatica, hypertrophic cardiomyopathy, moderate left ventricular hypertrophy, and memory impairment. File information indicated [Mrs B] was experiencing declining health, requiring regular support to meet activities of daily living, and passed away [mid] June 2021. I extend my condolences to [Mrs B]'s family at this time.

a) Do you consider the clinical oversight during the period December 2020 through to March 2021 to be in line with acceptable nursing practice given the presentation of [Mrs B]?

The electronic care record reflects that relevant nursing assessments were completed on admission on 8 December 2020, and collated data were used to inform an initial care plan, in line with the organisation's Admission policy and procedures (Sept 2021). The clinical file reflects that an interRAI clinical assessment was completed on 21 December 2020, with the nursing care plan reviewed on 23 December 2020 and updated on 6 January 2021, which appears to meet provider contractual requirements under the age-related residential care (ARRC) service agreement.

The admission policy requires a new resident to be seen by their medical practitioner within two working days of their admission to the care home. [Mrs B]'s hospital discharge summary was sent to her medical centre on the day of admission, 8 December 2020, and a health visit was requested by the duty registered nurse (RN). File information shows that [Mrs B] was seen by her own general practitioner (GP) on 11 December 2020 and admission medical documentation completed.

Clinical notes reflect that changes were made to prescribed medications, as recommended in the hospital discharge summary, which stated that a diuretic medication (Frusemide) had been discontinued. The interim care plan has outlined daily requirements, but there does not appear to be a specific plan of care commenced at this

time to support [Mrs B]'s complex medical needs and nursing requirements while settling into her new environment.

There is no discussion regarding the use of monitoring documents to inform evidence-based nursing assessment and care planning. Given [Mrs B]'s cardiac and respiratory history, weight loss, and recent medication changes, it would be accepted nursing practice to establish a robust plan to monitor for signs of change or decline in heart function, such as fatigue, cough or shortness of breath, increased heart rate, or weight changes, nutritional intake, or signs of ankle, leg, or abdominal oedema. Other factors would include assessment of pain, skin integrity, or pressure injury risk to ensure early detection of cellulitis or other health concerns. It is unclear what supportive measures were considered at the time, such as oxygen management, or specific care wishes identified regarding advance care planning and goals for care.

The organisation's weight management policy states that, if unintentional weight change is detected, ensure a thorough, multi-disciplinary clinical assessment and development of a specific short-term care plan to define strategies to meet the specified care goal. File records show that [Mrs B] had been experiencing weight loss prior to admission to the care home, with medical reports indicating that changes appeared related to existing healthcare issues.

As outlined in the provider response and progress notes, [Mrs B] had lost 5kg in the month prior to admission. The nursing care plan section 'Dietary Needs', 23 December 2020 has discussed risk factors, stating that [Mrs B] had a low BMI [body mass index], with a goal for her weight to remain between 45 and 50kg. Her history indicated concern with eating and drinking, and the care plan states [Mrs B] was on weekly weight recordings and monitored to ensure weight gain was not related to fluid retention. It is unclear what type of information was monitored, reviewed, or evaluated by the nursing team to alert them to signs of fluid retention or health decline. There is limited documented evidence of senior nurse oversight to guide clinical reasoning and related actions during the timeframe in question.

The progress note records reviewed between December 2020 and March 2021 reflect qualified nurse involvement in care, with RN entries routinely completed on each shift; however, the care record only reflects seven entries by caregivers during the timeframe in question. It is unclear if separate personal care records or monitoring forms were completed during [Mrs B]'s admission to evidence delivery of planned care, but these do not appear to be included in the evidence bundle. It is unclear if the care home clinical team held weekly review meetings to identify and discuss at-risk residents or what decision-making occurred regarding care prioritisation and ongoing care evaluation.

On 21 December 2020, RN progress notes state that [Mrs B] presented with a raised temperature and that her feet appeared swollen, noting that Frusemide was stopped prior to admission to the care home. Her temperature was monitored, and she was given PRN [as needed] paracetamol as prescribed. The clinical coordinator reportedly alerted the GP via fax, and a compression dressing was applied to [Mrs B]'s legs. [Mrs B] was seen

by her GP the same day in response to lower leg swelling, with GP notes commenting that swelling quickly resolved with elevation.

There is no further discussion of skin assessment, limb measurement, or health education provided to [Mrs B] regarding rest and elevation. It is unclear if footwear, falls risk, and call bell access was reviewed as part of falls prevention strategies or additional monitoring commenced to support safety needs. Nursing notes refer to fever, puffy feet, and a GP request to collect a urine sample, but there is no evidence that a short-term care plan was commenced for identified nursing concerns, which would be considered accepted practice under the circumstances to monitor care and safety needs. A urine sample was reportedly sent to laboratory services on 22 December, with nursing notes stating that [Mrs B] was eating and drinking well.

Entries on 23 December refer to an elevated temperature, likely urinary infection, and to 'push fluids'. It is unclear from the file documents if [Mrs B] was on free or restricted fluids related to her health history and if nurses sought clarification from the GP regarding this. It is unclear what health education was offered to [Mrs B] regarding oral fluid intake, what guidance was provided to the care team, or if a fluid balance chart was commenced, which would be usual practice at this time.

Nursing progress notes on 24 December raise concern regarding lower leg oedema, an intermittent dry cough, and weight increase of 5kg between 9 and 23 December 2020. The clinical record shows that [Mrs B] was seen again by her GP on 24 December and commenced on antibiotic therapy (Nifuran) for a suspected urinary infection. Progress notes in the electronic care record state that a short-term care plan was commenced for the urine infection at this time; however, this does not appear to be included in the evidence bundle, and there is no discussion of post-treatment evaluation, which would be accepted practice.

On 25 December, RN entries reflect concern regarding bilateral lower leg rashes. There is discussion of peer RN collaboration to determine an agreed care pathway, noting that an email with a photograph was sent to the medical centre. The care record reflects that correspondence was reviewed by a GP, and [Mrs B] commenced on a second antibiotic medication (flucloxacillin) on 26 December 2020 for likely cellulitis. Additional monitoring appears evident, with nursing notes referring to encouragement with oral fluids and commencement of a short-term care plan (not sighted), but no further discussion of nursing assessment regarding pain, mobility, or skin integrity is provided. There appears to be possible treatment delays, with progress notes stating that care home stock medication had been utilised until pharmacy stock was received on 29 December 2020; however, no medication prescriptions or administration records are provided from this timeframe to inform further comment.

Entries in the electronic care record for January 2021 indicate care was occurring per plan, with statements discussing activities of daily living, observations of improved lower leg oedema, oral intake, and medication administration with no overt concerns raised. [Mrs B] was seen by a Respiratory Nurse Specialist on 11 January 2021, who reported

that she appeared to be 'thriving in the new environment' and discharged her from the community health service.

On 28 January, [Mrs B] expressed concern to the RN regarding swelling of both lower limbs and wished to consult her GP. The duty RN reported no apparent signs of swelling but noted that [Mrs B] was still concerned and advised her to put her stockings on. It is unclear what follow-up occurred regarding [Mrs B]'s request to see her GP.

An entry from night staff on 29 January states 'a settled shift, compression stocking in place'. While progress notes discuss the use of compression stockings, there is no guidance for carers regarding the application, positioning, and removal of compression stockings, including indications for use while in bed or management of footwear or falls risk reflected in [Mrs B]'s care plan. It would be recommended to discuss stocking size and compression rating, frequency of skin assessment, and care and safety needs such as wrinkle-free stocking position, with a pathway for escalating care concerns or nurse specialist input.

The care record reflects that [Mrs B] was moved to a new room on 2 February; however, the rationale for the move is unclear. There is no discussion noted regarding orientation to her new environment or a plan of support to meet her care and safety needs given her history of memory impairment. Progress notes on 6 and 10 February discuss shortness of breath on exertion, relieved with prescribed medications and supportive interventions. There is limited discussion of vital sign monitoring or weight recording at this time. Weight records were not included in the submitted evidence, and it is unclear from care plans and progress note entries if daily or weekly weight monitoring was occurring.

Progress notes on 14 February state that [Mrs B] reported a swollen right lower leg with exudate to the RN, who discussed skin integrity and dressing application. There is no evidence of nursing assessment or wound management documentation completed at this time. It is unclear if vital signs and weight records were reviewed to consider signs of health decline or what supportive measures were offered, such as encouraging regular rest periods and elevating the foot of [Mrs B]'s bed. Notes reflect that the site was reviewed on 15 February, with the entry stating 'legs checked, better than yesterday'. There is no evidence of resident review on 16 February.

On 17 February, progress notes state that the dressing was changed to the right leg and a wound assessment completed. The duty RN reported introducing a continence product to support wound management for fluid absorption; however, the volume of exudate is unclear from the wound assessment, with little discussion provided within the RN progress notes. It is unclear what factors contributed to delayed documentation, as accepted practice would be for nursing assessment and related care planning to commence when the site was first identified.

On 18 February, the RN reported the dressing was checked, left intact as no ooze sighted. On 19 February, [Mrs B] was reportedly short of breath at 0220hrs. The same day, an RN reviewed her right leg, and noted the left leg was swollen, red with clear fluid present. The entry states the site was 'wrapped in a sanitary pad with crepe bandage, no other

concerns'. It does not appear that vital signs were checked, weight or leg circumference measured as part of monitoring responsibilities, or signs of wound infection considered given recent history of cellulitis, and health decline. It is unclear if the RNs sought support from the clinical manager or a wound nurse specialist regarding concerns with wound exudate and access to more suitable, dedicated wound products, which would be considered more appropriate and respectful in the circumstances.

Progress notes state that [Mrs B] appeared lethargic on 20 February and needed to drink more fluid; however, it is unclear how this was managed and evidenced. On 22 February, [Mrs B] attended a hospital appointment. The health report notes 'significant cardiac dysfunction with marked progression compared to results in testing 5 months prior' (September 2020). It is unclear from the clinical record if a family meeting was held with the GP/NP, allied health colleagues, and care home leaders to discuss advance care planning or goals for care, which would be accepted practice at this time.

On 23 February, nurses report signs of shortness of breath, relieved by prescribed medication and positioning. The entry states the GP was informed via email of episodes of breathlessness and weeping right leg with a photograph, but there is no evidence of RN follow-up with the GP or medical centre across shifts for the next four days, which is concerning.

Nursing notes on 24 February state that wounds were assessed, but there is no supporting commentary regarding skin integrity, resident wellness, or wound status. Entries on 25 February refer to a family outing with a query raised regarding wound improvement. It is unclear what information was communicated at this time to [Mrs B]'s family/whānau regarding the wound management plan and ongoing care.

On 26 February, the care record reflects that [Mrs B] was taken by a member of staff to attend a 3pm healthcare appointment. As described in the complaint communication, [Mrs B] reportedly became unwell during the health visit, and a decision was made to return to the care home for RN review. There is no documented discussion in progress notes by the RN team of any identified health concerns observed on [Mrs B]'s return to the care home, nor completion of a nursing assessment as requested by [Mrs B]'s daughter, nor evidence that a handover process occurred between the driver and duty RN on [Mrs B]'s return from the outing, which presents an improvement opportunity.

On 27 February, [Mrs B] was seen by an after-hours GP at the request of family in response to their concerns with shortness of breath, leg swelling with wound ooze, and health decline. The GP notes discuss signs of heart failure with fluid overload, recent weight gain of 4kg, and a plan to recommence diuretic therapy. Records show [Mrs B] was started on a short course of Frusemide twice daily for a week, pending GP review. The supporting RN progress note entry is very brief, referring to the GP visit and medication plan; however, there is no evidence that a short-term care plan was commenced outlining nursing interventions and monitoring responsibilities, which would be accepted practice for an unwell resident at this time.

There is no evidence that a fluid balance chart was commenced to monitor intake and output to inform weight records and other health information. A small sample of medication administration records dated 1 January to 1 March 2021 was provided, which appears to show that [Mrs B] received due medications as prescribed. While weight records were not provided in the evidence bundle, there is discussion within progress notes of daily weight monitoring and delivery of wound care occurring; however, there is no evidence of clinical manager input or discussion of wider nursing review of care and safety needs, which would be accepted practice at this time.

Care teams need to be aware of individual hydration needs and understand the importance of accurate record keeping, such as the volume of oral intake or frequency of weight recording as data are used to inform care management. It's important for care teams to be aware of resident output patterns and dehydration risk, especially for residents on prescribed diuretic therapy. Low-intake dehydration can contribute to confusion, increased falls risk, and wider health issues, which do not appear to be recognised in [Mrs B]'s nursing assessments or care plans during the timeframe in question.

[Mrs B] was next seen by a GP on 8 March, with clinical notes indicating that ankle oedema, cough, and shortness of breath was almost resolved. GP notes state that medications were reviewed and Frusemide reduced to a maintenance dose to reduce the risk of dehydration, falls, and kidney injury; however, there is no evidence of updates or evaluation provided in nursing care plans, which would be considered accepted nursing practice.

There appear to be delays in updating the electronic medication record regarding charting of Frusemide, with progress notes reporting changes were actioned on 10 March. Usual nursing practice would be to ensure that medications were prescribed to the provider's paper-based or electronic medication management platform at the time of GP assessment to ensure prescribed medications were safely administered in a timely way to ensure resident care occurred as planned.

The GP has commented on 13 March that [Mrs B] presented with mid-shin oedema, indicating that she had redeveloped signs of congestive heart failure. She was seen again on 19 and 23 March for ongoing assessment and care, prior to hospitalisation in April 2021 related to declining health.

While evidence of a family/whānau contact record was not provided, file information reflects that regular communication occurred between the care home and [Mrs B]'s family regarding her health and care needs during the timeframe in question. Nursing progress notes and communication records appear to indicate that staff were generally responsive to [Mrs B]'s needs and care requirements. There is discussion of vital sign monitoring and escalation of concerns raised to the medical centre via fax or email; however, it appears the responsibility for coordination and follow-up was not well managed by the nursing team. It is unclear how care concerns were communicated between the clinical leaders and the care team to ensure evidence-based, personalised care delivery consistently occurred. Platforms such as clinical review meetings, qualified

staff meetings, or shift handovers are good opportunities to collaboratively review and evaluate resident care needs or provide education.

From the evidence reviewed to respond to this question, it appears the care provided to [Mrs B] was of the minimum standard of accepted practice in the circumstances. There are opportunities for improvement in professional nursing assessment, care planning, and documentation standards, including timely recognition of resident change or decline, and related responsibilities to clinical decision-making, care escalation and follow-up, which would be viewed similarly by my peers.

Departure from accepted practice: Moderate

Additional comment:

According to file information, it appears that [Mrs B] experienced a fall event on 22 March 2021; however, there is no discussion of the incident in the care record, apart from a note reflecting that an adverse event (E000512) was reported on 22 March 2021.

There is no discussion of event history reported by care or qualified staff in the care record. An entry by the PM RN stated that [Mrs B]'s nominated representative was 'informed regarding the morning fall'; however, there is no discussion of harm sustained or evidence of any post-fall nursing assessment or related actions as part of accepted falls management guidelines.

Entries refer to administration of PRN paracetamol for sacral pain at 1207hrs and 1700hrs, noting good effect; however, there is no supporting evidence that a pain assessment, review of skin integrity, or wider nursing assessment occurred, which would be accepted practice.

An entry on 23 March 2021 states that [Mrs B] was given Panadol for post-fall pain management; however, there is no evidence that a pain assessment was completed, vital signs monitored, or care and safety needs reviewed as part of recommended incident management processes. It appears the event was reviewed by an RN on 26 March, with a comment of outcomes resolved; however, it is unclear if falls risk was reviewed, if any contributing factors were identified, and what corrective actions were implemented.

Lack of evidence-based, event documentation would be considered a moderate to serious departure from accepted practice standards for incident management and falls prevention and management processes. The Health Quality & Safety Commission's Frailty Care Guides are recommended resources for care home teams to utilise, in addition to existing organisational policies, and provide clear information regarding accepted post-fall protocols, including a flow chart to guide actions, decision-making and incident reporting pathways (HQSC, 2019).

b) Do you consider the level of communication with the GP practice and or after-hours surgery during this period, given the relevant symptoms and presentation of [Mrs B], to be consistent with accepted nursing practice?

Entries in the care record and copies of email communications indicate that the RN team escalated their concerns to the GP via fax or email, which is usual practice. It is unclear what the service provider agreement was between the organisation and medical practice regarding planned visits and on-call or after-hours support, but I note that [Mrs B] transferred from her own GP to the care home GP during the timeframe in question, which may have allowed access to more regular medical care. There are opportunities for strengthening communication pathways using the ISBAR tool to support coordination of GP visits and any follow-up processes to ensure resident care is safely and collaboratively managed.

From the evidence reviewed to respond to this question, it appears there were identified delays in recognising resident decline, timely communication, and follow-up with the GP practice; however, medical records show there was also a high level of GP oversight in [Mrs B]'s care during the timeframe in question, with no apparent concerns raised by the practice regarding this process.

Departure from accepted practice: Mild

c) Do you consider the transportation of [Mrs B] to her Specsavers appointment and the outcome of returning to the facility following her reported event to be acceptable from a clinical perspective?

According to the complaint communication and progress note information, [Mrs B] had an eye appointment booked for 26 February 2021. The complaint letter reflects that a staff member drove [Mrs B] to the appointment in the care home vehicle, which is confirmed in a progress note entry. During the visit, [Mrs B] reportedly became unwell and was transported back to the care home.

The complaint letter expressed concern for [Mrs B]'s wellbeing at the time, stating that a request was made to the staff member for [Mrs B] be assessed by an RN on her return to the care home, which did not appear to occur.

The ARRC agreement (D5.4; D20.2) outlines provider responsibilities and policy requirements for transporting residents to attend clinical and non-clinical services.

Section (D20.4) states that, where possible, residents will be accompanied by a relative or nominated representative as a support person to health appointments, or if they are unavailable, by care home staff. The organisation's Transportation Policy (SAE24, September 2019) provides discussion of driver requirements, vehicle use and conduct, [and] health and safety responsibilities. The driver is required to hold a first aid certificate, to carry a cell phone at all times, and to ensure timely communication with the care home should concerns arise. The policy states that relatives and friends are encouraged to take residents to outside appointments, but if no one is available then the care home will transport the resident.

The Transportation policy states that should a resident/staff member become unwell during an outing, to safely stop the vehicle and seek assistance as necessary. It is unclear why an ambulance was not called to assess [Mrs B] at the time of the event, the care

home was not contacted or concerns not handed over to the duty RN on return to the care home. Progress notes discuss the eye appointment, but there is no discussion of the health event reported in the care record. There is no indication that staff were aware that [Mrs B] had been unwell while away from the care home. The RN entry on 26 February reported that [Mrs B] was settled during the afternoon shift, regular medications were given, eating and drinking well, with nil concerns. As discussed in a), [Mrs B] was seen by her GP the next day due to family concerns regarding health decline.

It is unclear what the organisation's expectations are regarding staff accompanying residents to appointments, communication of resident information to service providers, or the handing over of healthcare information on return to the care home. There is no reference within the Transportation policy to other policy information regarding communication responsibilities or handover processes on return to the care home, or handling of confidential health information following resident appointments, which may present an improvement opportunity.

From the evidence reviewed to respond to this question, there appear to be inconsistencies with care, communication, and documentation responsibilities.

Usual reporting practice would be to document the time a resident was returned to the care home, noting any relevant information handed over from a health appointment by the service provider or the resident's support person. Given a possible medical event occurred while offsite, accepted practice would be to take an event history, assess the resident, and seek GP or paramedic support as clinically indicated.

From the evidence reviewed to respond to this question, it appears the care provided to [Mrs B] met the minimum standard of accepted practice in the circumstances, with departures noted in communication, nursing assessment, and documentation standards, which would be viewed similarly by my peers.

Departure from accepted practice: Mild to moderate

5. Clinical advice

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

Based on this review, I recommend the care home team complete additional education on communication with and about older people and their family/whānau, including strategies for ensuring changes in resident needs are safely documented and appropriately communicated to minimise the risk of a similar occurrence in the future. I recommend discussion with the RN team regarding the importance of accurately recording all concerns raised by the family in the resident's clinical record and implementing the use of the ISBAR communication tool to better inform clinical assessments, actions, and safe, evidence-based decision-making.

To support this approach, I recommend that the care home team complete the new online modules for further learning: https://www.hdc.org.nz/education/online-learning/

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Nurse Advisor (Aged Care)

Health and Disability Commissioner

References

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