CAS-14310-J1D2D9
24 June 2026

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care of man by aged residential care provider following surgery for hip fracture

Executive Summary

1. Mr B resided at Kumeu Village Rest Home (KVRH), operated by Kumeu Village Aged Care Limited, from 18 November 2021 until his death in early January 2022.

2. The family of Mr B complained to the Health and Disability Commissioner (HDC) about the care Mr B received while at KVRH. Shortly after he was admitted, Mr B experienced a fall and underwent surgery at North Shore Hospital for a fractured hip. He was discharged back to KVRH on 26 November 2021, and his health declined over the following weeks before he passed away.

3. Mr B's family raised multiple concerns about the post-discharge care provided to Mr B at KVRH. In particular, Mr B's family were concerned that the discharge information from the hospital did not inform his care planning, his pain relief needs were not met, he was given quetiapine without it being indicated, his weight loss and dehydration were not treated, he did not receive an air mattress for his bed, and he was encouraged to weight bear when this was not appropriate.

4. I find Kumeu Village Aged Care Limited in breach of Right 4(1)[1] of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services to Mr B with reasonable care and skill. There was inadequate assessment of Mr B's pain, Mr B was not provided a pressure-relieving air mattress in a timely manner, and there was poor communication with Mr B's enduring power of attorney (EPOA) for personal care and welfare (his daughter, Ms A).

5. I also make adverse comment about Dr C, Mr B's general practitioner (GP), for the absence of a structured plan to review Mr B's diuretic (furosemide) as recommended by the hospital on discharge, and for failing to document and provide rationale for prescribing antibiotics.

Recommendations

6. There has been a change of management at KVRH since these events occurred. The new management advised HDC that they had reviewed the care Mr B received at KVRH. They accepted there were "areas where the standard of care could have been improved" and implemented a corrective action plan, which included:

- ensuring a process for assessment and follow-up for all residents after discharge from hospital;
- undertaking staff training on pain management, including assessment, monitoring, and evaluation;

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

Names have been removed (except Kumeu Village Aged Care Limited and the expert advisors on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- undertaking a case study from this complaint and sharing learning with staff;
- reviewing the procedure for food and fluid charts, including responsibilities;
- reviewing the procedure for monitoring weight, including responsibilities;
- reviewing the procedure for residents requiring turning, including instructions and completion of repositioning charts;
- undertaking registered nurse (RN) training on clinical assessments, communication to GP, and clinical reasoning;
- reviewing coordination of care for each resident and ensuring staff are aware of the process and responsibilities;
- auditing a new process for when a resident requires an air mattress.

7. I acknowledge the changes KVRH has made as a result of Mr B's experience, and I consider these to be appropriate in the circumstances.

8. In their response to my provisional opinion, Mr B's family expressed concern about whether KVRH would implement the necessary changes to improve care provision. To address these concerns and ensure accountability, I recommend KVRH:

- Provide a written apology to Mr B's family for the deficiencies and breach of the Code identified in this report. The apology is to be sent to HDC, for forwarding to Mr B's family, within **three weeks** of the date of this report;

- Provide updated evidence of all improvement activities (revised protocols and guidelines and staff training content and completion) undertaken as a result of Mr B's experience since completion of the corrective action plan. This update is to be sent to HDC within **three weeks** of the date of this report.

Background

9. On 18 November 2021, Mr B was admitted to the Memory Assist Unit at KVRH to receive dementia-level care. On 20 November 2021, 36 hours after admission, Mr B was found on the floor on his right side with a suspected hip or leg fracture.

10. Mr B had an operation on 22 November 2021 at North Shore Hospital to repair the fracture. His recovery was complicated by pneumonia (treated with intravenous then oral antibiotics) and fluid overload. For the fluid overload, his furosemide dose was increased to 80mg each morning. Mr B was discharged on 26 November 2021 back to KVRH, where he moved to hospital-level care.

11. Additional new medications on discharge included quetiapine 12.5mg each night, started for dementia-related agitation (sundowning), and paracetamol 1g as needed, up to four times daily, for pain. The discharge summary, which was sent to KVRH, included a recommendation for a GP review of the furosemide dose in one to two weeks and for the GP to consider weaning quetiapine in one month.

12. On 28 November 2021, the nurses at KVRH identified some blanching redness on Mr B's bottom and determined a pressure-relieving air mattress was needed. This was documented in the 'maintenance book'. However, it was not ordered until 3 December 2021, and the progress notes show that, on 9 December 2021, Mr B was still waiting for the mattress. The records do not show that an air mattress was provided.

13. Dr C reviewed Mr B on 1 December 2021. The notes from this review do not indicate that Mr B's hydration status was reviewed at this point. On 8 December 2021, Dr C's notes record that Mr B's daughter requested review of Mr B's electrolytes and pain levels. Dr C requested Mr B have a blood test.

14. The blood test results of 10 December 2021 showed Mr B was hypernatremic (high sodium levels). On 13 December 2021, Dr C recorded that Mr B had lost 10kg[2] since his fall and hospital admission and was dehydrated and struggling to eat. Dr C reduced the furosemide dose to 40mg daily for two days and then it was stopped.

15. The nursing notes for 13 December 2021 record that Dr C prescribed antibiotics for Mr B. This is not recorded in Dr C's GP notes.

16. The progress notes for 17 December 2021 show that quetiapine was withheld at the request of Mr B's EPOA. It is not clear that Dr C had any input into this decision.

17. On 31 December 2021, Dr C prescribed paracetamol to be administered four times daily on the request of Mr B's EPOA who noted Mr B wincing in pain when adjusting himself in his chair. There are no records indicating that Mr B was given regular pain relief before 31 December 2021 despite the post-hospital discharge prescription including paracetamol 1g PRN (as needed).

18. Mr B's condition deteriorated on 5 January 2022. He was provided pain relief for comfort and, sadly, he died not long after.

Further information

19. Dr C advised HDC that the consultations from 13 December 2021 were conducted virtually because of the COVID-19 pandemic. Dr C further advised that, at this time, he was unwell with COVID-19, which explained why his note-taking was inadequate.

20. Dr C highlighted that this was a very stressful time for KVRH because of the challenges that were apparent during the COVID-19 pandemic.

In-house clinical advice

21. I sought advice from my in-house nursing advisor, RN Hilda Johnson-Bogaerts (**Appendix B**), who reached the following conclusions after reviewing the care provided to Mr B.

[2] Mr B's weight was recorded by Kumeu Village as 93.8kg on 18 November 2021 and 83.7kg on 10 December 2021.

- The care provided to Mr B in the first days of his admission to KVRH, and the management of his fall, were in line with accepted practice.
- Mr B's weight was not measured in the days following his discharge from hospital or during days when he had low food intake, representing a mild deviation from accepted practice.
- The delay in provision of an air mattress, which is a standard intervention to prevent pressure ulcers in residents identified as being at high risk for developing pressure injuries, is a moderate to significant deviation from accepted practice. In RN Johnson-Bogaerts's opinion, this should have been available the day after the request, at the latest.
- Following Mr B's return to KVRH on 26 November 2021, no pain monitoring was initiated, and no paracetamol was administered before 31 December 2021. The absence of a structured pain monitoring process using a validated tool for individuals with dementia meant that potential pain may have gone unrecognised and untreated. This is a mild to moderate departure from accepted standards.
- The communication with Mr B's EPOA was suboptimal, and no Te Ara Whakapiri/Last Days of Life care plan was created, which would have allowed for discussion and documentation of what mattered most to Mr B and his family. This was a moderate departure from accepted practice.
- Although no Te Ara Whakapiri/Last Days of Life care plan was created, the progress notes do reflect relevant instructions and progress notes for his care during this critical period.

22. I sought in-house clinical advice from GP Dr David Maplesden (**Appendix A**), who reached the following conclusions about the care provided to Mr B by Dr C.

- Dr C did undertake a review of Mr B's diuretic use around two weeks after discharge from North Shore Hospital (as recommended in the discharge summary), but it seems this was a reaction to concerns expressed by Mr B's daughter rather than part of a planned review. Dr Maplesden is mildly critical of the absence of a structured plan to review Mr B's furosemide dose.
- It was reasonable for Dr C to assume the PRN paracetamol regimen in place on discharge was appropriate, and it appears the first notification received by Dr C that Mr B's pain regimen might require review was from Mr B's EPOA on 31 December 2021.
- Dr Maplesden is mildly critical that the prescription of antibiotics on 13 December 2021 and the reason for this was not documented in the GP records.
- Dr C took reasonable steps to ensure Mr B had adequate symptom control as he entered the terminal phase of his illness from 5 December 2021.

Analysis

KVRH – breach

23. As a healthcare provider, KVRH is responsible for providing services in accordance with the Code. In reaching the opinion that KVRH has breached the Code, I have considered the

information provided by Mr B's family, KVRH, and in-house aged care advice provided by RN Johnson-Bogaerts.

24. I am very concerned that Mr B was not initiated on a pain monitoring chart following his return from hospital after surgery, using an assessment tool appropriate for individuals with dementia. This was important because it would have ensured that any pain or discomfort was identified and managed promptly. It was not until Mr B's EPOA discussed his pain requirements with Dr C a month after his discharge to KVRH that regular paracetamol was initiated. I accept RN Johnson-Bogaerts's advice that this was a departure from accepted practice.

25. Mr B was identified as needing an air mattress to manage a developing pressure area. This was not ordered for five days after the initial request, and there is no evidence it was ever provided. I accept RN Johnson-Bogaerts's advice that this should be available the next day at the latest, and that timely provision of such equipment is essential in maintaining skin integrity and comfort. I accept her view that this is a moderate to significant departure from accepted practice.

26. I am concerned that there was inadequate monitoring of Mr B's fluid status following his return from hospital. Mr B's weight was not regularly monitored by KVRH, and although a fluid balance chart was established, it was not consistently completed. Given fluid overload had been identified in hospital, and he was having ongoing treatment with furosemide, regular weight monitoring and fluid balance recording were important to be able to assess his response to the furosemide treatment. I accept RN Johnson-Bogaerts's advice that the lack of weight monitoring represented a deviation from accepted practice.

27. Finally, the communication with Mr B's EPOA was suboptimal. KVRH has acknowledged this. There is evidence from my review of Mr B's care that the EPOA had to advocate for interventions, including pain relief and cessation of quetiapine. Some changes to Mr B's care were only made because of these requests, rather than the changes being made directly in response to Mr B's needs by KVRH. A Last Days of Life care plan was also absent, and this would have provided an opportunity to collaborate with the family about Mr B's needs.

28. For the reasons outlined above, I consider that Kumeu Village Aged Care Limited has not provided services to Mr B with reasonable care and skill. Accordingly, I find Kumeu Village Aged Care Limited in breach of Right 4(1) of the Code.

Dr C – adverse comment

29. I accept Dr Maplesden's advice regarding Dr C. I am concerned that there was no structured plan to review Mr B's furosemide regimen after his discharge from hospital and that a reduction in the diuretic appears to have only been initiated after a request from Mr B's EPOA.

30. In addition, I am critical that Dr C's rationale for prescribing antibiotics was not documented in the clinical record.

Follow-up actions

31. A copy of the final report with details identifying the parties removed, except Kumeu Village Aged Care Limited and my expert advisors, will be sent to HealthCERT and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Erin James
Aged Care Commissioner

Appendix A: In-house clinical advice to the Commissioner

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

'1. My name is David Maplesden. I am a graduate of Auckland University Medical School, and I am a vocationally registered GP holding a current APC. My qualifications are MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP 2003. Thank you for the request that I provide clinical advice in relation to the complaint from the family of the late Mr [B] about the care provided to him by Dr [C]. 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 the family of the late Mr [B]
- Response and care notes from Kumeu Village Rest Home & Hospital (KVRH)
- Response (limited) and clinical records from [medical centre2]
- Clinical notes from North Shore Hospital (NSH)

3. [Mr B] (B:1944) was admitted to KVRH for dementia-level care on 18 November 2021. Medical history included cerebrovascular disease, previous stroke and vascular dementia, atrial fibrillation, obesity, impaired glucose tolerance, dyslipidaemia, and sarcoidosis with persistent pleural effusion. Activated EPoA for personal care and welfare was held by a daughter ([Ms A]). Medications on admission were atorvastatin 10mg daily, donepezil 5mg daily, frusemide 60mg mane, metoprolol 23.75mg daily, loperamide 2m BD and rivaroxaban 20mg mane [in the morning]. On 20 November 2021, [Mr B] had a fall resulting in a fractured left neck of femur (NOF) and was admitted to NSH. He underwent surgical fixation of the fracture (gamma nail) on 22 November 2021. Recovery was complicated by pneumonia (treated with intravenous then oral antibiotics) and fluid overload (furosemide dose increased to 80mg mane). Additional new medications on discharge were quetiapine 12.5mg nocte [at night] (started for dementia-related agitation (sundowning)), paracetamol 1g QID PRN [four times daily, as needed] for pain, vitamin D (cholecalciferol 4.8mL on the 24th of each month), multivitamin tabs, and senna-based laxative and Molaxole for constipation. Loperamide was stopped. The discharge summary indicates a one-month supply of medications was provided on discharge. Prior to discharge, [Mr B] was assessed as requiring permanent hospital-level care and was discharged to this level of care at KVRH on 26 November 2021.

4. While the discharge summary was addressed to [Mr B]'s GP at [his local] [m]edical [c]entre, it appears a copy was faxed to KVRH on 26 November 2021. Management plan included some recommendations for the GP, including:

- *PH GP to review wean of quetiapine in one month if appropriate*
- *GP to review frusemide dose in one to two weeks with fluid review (increased from 60mg to 80mg PO OD* [orally, once daily]*)*
- *Monthly vitamin D liquid (swallowing difficulties), last given on the 24th of November*

- *GP to consider Aclasta* [one-off zoledronic acid infusion for bone protection] *in 6 weeks*
- *Script for medications provided*

5. The complaint relates to [Mr B]'s management in KVRH following his discharge from NSH. With respect to GP care, the family list the following concerns:

- *lack of reading critical information, that being Dad's discharge notes from North Shore Hospital, meaning no plans were made for Dad's current needs, or needs going forward, resulting in neglect (late review of Furosemide causing significant harm)*
- *no pain relief given after such a hideous and painful injury and operation*
- *giving quetiapine with no clinical need or clinical assessment, no disclosure about giving this medicine*
- *no treatment of Dad's dehydration and dramatic, severe weight loss.*

6. The KVRH response notes Dr [C] was providing GP care for [Mr B] but some of the care was provided virtually due to [Dr C] having been exposed to COVID-19. KVRH states: *If* [Dr C] *is unwell, we contact* [medical centre2*, a GP from medical centre[2] will come to cover him. If Dr [C] goes on leave, he will find a cover or arrange a GP from his practice to attend acute cases.* The response notes also that there were administrative issues meaning a formal transfer of care and transfer of medical notes from [Mr B]'s previous GP at [his local] [m]edical [c]entre was delayed (unclear when transfer was completed). Medical centre2 response confirms they have no old notes on file for [Mr B] (including the NSH discharge summary), who was registered there as a casual patient while awaiting formal transfer of care. Cover arrangements at the time were as noted above, with after-hours advice for KVRH staff available through the [medical centre2] after-hours providers (West Auckland Rural call roster and Whakarongorau Aotearoa national telehealth service). The KVRH response notes the impact COVID-19 restrictions and precautions had on primary care over the period in question.

7. [Dr C] was invited to provide input or further comment on the following issues:

- *North Shore Hospital's discharge summary from 26 November 2021 recommended undertaking of reviews and medication changes for [Mr B]. Please comment on the reasons for any delay in actioning these recommendations, and the rationale for decisions made in this regard;*
- *Communication with [Mr B]'s activated EPOA with respect to any alterations in [Mr B]'s management or prescribed medication;*
- *Management of [Mr B]'s pain over the period of his admission at the care home;*
- *Management of [Mr B]'s weight loss during the period of his admission at the care home;*
- *Communication with care home staff regarding any alterations in [Mr B]'s management or prescribed medication;*

Unfortunately, there was no additional information provided by [Dr C] or [medical centre2] regarding these issues, and I am relying largely on [Dr C]'s clinical notes and the KVRH response to assess [Mr B]'s GP management. Assessment is further hampered by lack of historical MediMap records, making it difficult to confirm the timing of various medication changes, although I have accessed medication administration records, which appear to run until 4 January 2022.

8. It appears on 1 December 2021 [Dr C] first reviewed [Mr B] on his return from NSH. I have assumed the new medications [Mr B] was prescribed at the time of discharge from NSH had been charted in MediMap, although I am unable to confirm this. Nevertheless, medication administration records indicate the new medications/doses were being administered, although there is no record of paracetamol administration (prescribed as PRN) until 31 December 2021. GP notes read: *Back from hospital. Sustained a subtrochanteric fracture of left hip. Has a nail in and cerclage wires. A lot of hiccups since discharge. He denies [any] problems P: Consider Largactil for hiccups.* It is unclear if this was a virtual or face-to-face consultation. Nurse notes refer to [Dr C] prescribing a trial of promethazine for hiccups. Preceding care notes refer to [Mr B] initially having reduced fluid intake, but this had more recently improved. There is no reference to nursing concerns regarding pain control.

Comment: I would expect [Dr C] to have accessed the NSH discharge summary and to be aware of the recommendations it contained regarding [Mr B]'s ongoing management. This review was an opportunity to assess [Mr B]'s hydration status with respect to the frusemide dose, and I am mildly critical there is no documentation to suggest this was undertaken or planned. However, there is no record of nursing concerns noted or expressed regarding [Mr B]'s current fluid intake or urinary output. If there were no nursing concerns raised regarding [Mr B]'s pain control, I believe it was reasonable for [Dr C] to assume the PRN paracetamol regimen currently in place was adequate. Gradual improvement in pain levels would normally be expected as [Mr B] recovered from his surgery, although once mobilization was to begin (weight bearing not recommended for several weeks), the situation might alter.

9. The next entry in the GP notes is dated 8 December 2021 and reads: *I had a discussion with [Mr B]'s daughter, and the family were wanting his goals to be comfort orientated, not for anything to prolong life. We discussed his medications and so we have stopped the donepezil and atorvastatin. It is unlikely that there will be significant benefit from him going to see the orthopaedic surgeons with regards to his surgical site/fractured femur. Apparently his electrolytes were low when he was in hospital, and his daughter has asked that we check this as well as his pain, need for prns P: Not for orthopaedic appointment, stop meds as outlined above, get bloods on Friday.*

Blood tests dated 10 December 2021 (Friday) showed [Mr B] to be hypernatremic (sodium 155 mmol/L, reference range 135–145) with normal renal function otherwise and pathologist comment *The most likely cause is dehydration.* On 13 December 2021, [Dr C] recorded:

[Mr B] has had a 10kg loss of weight. Sodium is high and so it is likely that he is dehydrated. P: Decrease furosemide to 1 tablet daily and on 15 December 2021 he recorded: *[Mr B] is struggling to eat. He is losing weight. His sodium was high on Friday. I think he is dehydrated. P: Stop furosemide, push fluids, Micreme for rash. Get renal function and electrolytes tomorrow.*

Medication administration records show [Mr B] was taking frusemide 80mg daily up to and including 13 December 2021 then 40mg on 14 and 15 December 2021 with the drug subsequently stopped. Sodium level on 17 December 2021 was 153 mmol/L.

Comment: It appears [Dr C] did undertake a review of [Mr B]'s diuretic use around two weeks following discharge from NSH (as recommended in the discharge summary), but it seems this was a reaction to concerns expressed by [Mr B]'s daughter rather than being part of a planned review. It is unclear why a check of renal function was deferred for two days (to a Friday when results might not be available until after the weekend) following [Dr C] acknowledging the daughter's concerns. Nevertheless, nursing notes do not indicate any concerns regarding [Mr B]'s hydration, weight loss or general condition between 1 and 13 December 2021. There is reference in the nursing notes to [Dr C] prescribing [Mr B] antibiotics on 13 December 2021 (blood count had shown a neutrophil leukocytosis and CRP [C-reactive protein] was moderately elevated), which is not evident from the GP notes. There is no reference in the nursing notes to concerns regarding [Mr B]'s pain levels. I am unable to determine whether the consultations reviewed were virtual or in-person, but given there were no apparent nursing concerns regarding [Mr B]'s overall condition, and taking account of the COVID-19 situation, I would not be critical if the consultations were virtual. I remain mildly critical of the apparent absence of a structured plan to review [Mr B]'s frusemide dose as recommended in the discharge summary, and if [Dr C] did prescribe antibiotics for [Mr B] on 13 December 2021 I would be mildly critical that this action, including the rationale for the action, was not documented in his clinical notes, acknowledging the nursing notes did contain some record of the prescribing. It appears nursing staff did convey to [Mr B]'s EPoA the various interventions undertaken by [Dr C], and it was very reasonable for [Dr C] to establish with the EPoA an agreed focus of care for [Mr B], which resulted in removal of some of his regular medications and a decision not to attend the scheduled follow-up orthopaedic appointment. There is no reference in the nursing notes at this time to any particular issues with [Mr B]'s behaviours (with respect to ongoing use of quetiapine). However, on 17 December 2021 there is reference to a discussion between the EPoA and nursing staff regarding the EPoA's concerns that [Mr B] *was distant and spaced out on her last visit … and does he really need* [quetiapine]. The decision was to withhold the medication for five days and *have it reviewed by the doctor.* It is unclear what input [Dr C] had to this decision and subsequent review, but there was no further quetiapine administered. I note the quetiapine was not commenced in KVRH and was stopped within the timeframe recommended in the hospital discharge summary, albeit at the request of the EPoA rather than being initiated by [Dr C]. With respect to weight loss, it was probably reasonable to attribute this to fluid loss initially, but if the loss continued despite cessation of diuretics, use of a nutritional supplement might have been considered. Regular monitoring of weight and food intake, and reporting of this to the GP if there were ongoing concerns, might be assumed. It

appears [Mr B]'s weight was relatively stable from 15 December (82.2kg) to 31 December (81.6kg).

10. On 31 December 2021, [Dr C] has recorded a conversation with the EPoA regarding COVID-19 vaccination for [Mr B]. The note includes: *Also on spending time with [Mr B], [Ms A] says that he is wincing when he is trying to adjust himself in his chair and she asked that he be given paracetamol for comfort.* It appears (from medication administration records) that regular paracetamol (1g QID) was commenced from this date. There is no record of nursing staff having raised concerns with [Dr C] about [Mr B]'s pain control prior to this date. From 1 January 2022, nursing notes suggest gradual deterioration in [Mr B]'s condition with decreased food and fluid intake. [Dr C] reviewed [Mr B] on 5 January 2022M noting:

[Mr B] has seemed to have deteriorated. He is holding food, fluids and medications in his mouth. Oral intake has decreased. RNs have been talking with his wife and she is distressed. EPOA coming in later today. Will trial SC fluids and prn analgesia for now and await instructions from EPOA. Pulse 139/min, SAO2 95% RA, temp 36.7, BP 130/80 Not had his medications today as he seems to be holding things in his mouth. Not had his metoprolol or other meds today so likely a combination of dehydration and not taking B Blocker causing tachycardia.

Subcut fluids were commenced and SC morphine charted (2.5–5mg PRN) for comfort and administered around midday on 5 January 2022 and at 10.24am (2.5mg) and 1.39pm on 6 January 2022. Midazolam nasal spray was administered at 1.41pm on 6 January 2022, and I assume this had been charted the previous day. [Dr C] reviewed [Mr B] again on 6 January 2022, noting:

Pulse today is 156/min, not swallowing, chesty but he seems to be more awake. Nursing staff discussed with EPOA and for comfort cares, not for hospitalisation. P: Stop all oral meds, chart syringe driver, prn meds charted as well.

Medications charted per syringe driver on 6 January 2022 were morphine 10mg, haloperidol 5mg and hyoscine butylbromide 40mg with the infusion commenced around 7.30pm. Nursing notes record [Mr B] passing peacefully at 1.15am on […] January 2022. Death certification was completed by [Dr C] later that day.

Comment: It appears the first notification received by [Dr C] that [Mr B]'s pain regimen might require review was from [Mr B]'s EPoA on 31 December 2021. It was appropriate to trial regular paracetamol initially and, based on nursing observations, this regimen appeared effective, at least initially. As [Mr B]'s general condition deteriorated, it was apparently agreed with the EPoA that a comfort care approach was reasonable, and this appears to have been implemented appropriately. It does not appear to me that commencing an end-of-life medication regimen for [Mr B] was indicated on 31 December 2021, or that Dr [C] was asked by nursing staff to review [Mr B] with respect to his deterioration prior to 5 January 2022. Following the review on 5 December 2022, I believe [Dr C] took reasonable steps to ensure [Mr B] had adequate symptom control as he

entered the terminal phase of his illness. I note [Mr B] had received the monthly cholecalciferol dose recommended in the discharge summary. The deterioration in [Mr B]'s general condition made consideration of Aclasta infusion (due mid-January 2022) inappropriate.

Appendix B: In-house clinical advice to the Commissioner

The following in-house advice was obtained from RN Hilda Johnson-Bogaerts:

1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Kumeu Village (KMV). 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**
    - Provider response dated 21 April 2022
    - Provider's notes from family communications
    - Progress notes
    - Behaviour charts
    - Care plan
    - Doctor's notes
    - Food and fluid charts
    - Weight chart

3. **Complaint as presented to me**
    This complaint relates to the care provided to [Mr B] in the last six weeks of his life at KMV, where he lived from November 2021 until his death [in early] January 2022. The concerns include falls management, failure to complete discharge actions, lack of care planning, and poor communication with the family/EPOA.

    I am asked to review the clinical documentation and advise whether there are any issues with the standard of care provided as well as the appropriateness of the remedial actions taken by KMV in response to the complaint.

    I was also asked to review additional information provided during April 2024 and advise whether pain management throughout December 2021 post fracture was in line with accepted practice.

    I was also asked to review additional information relating to weight monitoring and food and fluid intake charts and the follow-up with the GP and advise whether nutritional oversight was in line with accepted practice.

4. **Review of provider response and clinical records**
    I express my sincere condolences to [Mr B]'s family.

    [Mr B] moved into KMV on 18 November 2022 to receive dementia-level care. At the time of his moving into KMV Memory Support, his medical diagnosis included, among other long-term conditions, advanced vascular dementia (since 2015), resulting in significant difficulty expressing himself, and general frailty. His care plan includes that

generally he was "*a gentle man and is easy going",* during times of personal cares; however, he could get agitated. At the time of moving into care, he was able to mobilise independently. As it is good practice, staff started an intensive three-day observation to familiarise themselves with his routines and triggers of unmet need. Two days into his stay, he suffered an unwitnessed fall near the toilet and was transferred to hospital with a fractured left hip; he was also diagnosed with pneumonia, which may have been a contributing factor to his fall. After the operation to his left hip, he was discharged back to KMV, now needing hospital-level care. [Mr B] had a very supportive family who were very involved in his care. Unfortunately, his health deteriorated quickly, and he passed away [in early] January 2022.

Reading the complaint and the provider response, it seems that the family expressed a number of care-related concerns. KMV explained in their response that enrolled nurse (EN) […], who was involved in his care was in communication with the family and that most of the concerns about the provided care were not known until February 2022, when the family formally expressed concerns. The provider acknowledges that, throughout the time when [Mr B]'s health was quickly declining, they should have communicated better with the family, in particular about his medication, weight loss, and socialisation opportunities, visiting hours, etc. Specifically, the provider acknowledges that [Mr B]'s key RN should have been more involved with the family at the time and have communicated the results from GP visits, changes in medication, results from blood tests, etc.

Review of clinical notes

Reviewing the clinical documentation, [Mr B] showed several symptoms of late-stage dementia. The care for a resident with late-stage dementia should prioritise:

- Close collaboration with the EPOA/family/whānau, involving them in decision-making is crucial for person-centred care.
- Environmental care and safety: Creating a safe and comfortable environment to prevent harm and promote wellbeing.
- Supportive interpersonal care: Providing emotional support and ensuring the patient's psychological needs are met.
- Attentive nursing care: Monitoring the patient's condition and responding to their needs promptly. Be alert to non-verbal cues of unmet need such as pain. Prompt escalation of relevant issues to GP.
- Falls prevention: Implementing strategies to reduce the risk of falls, which are common in patients with dementia.
- Raising the deliriant threshold: Minimising factors that could exacerbate confusion or delirium, such as infections.
- Symptom relief: Monitor for symptoms of discomfort and pain and administer medication as indicated, alleviating restlessness due to unmet need and pain.

It is good practice for nurses and care staff to focus on and give extra time to a new resident in the first days of their admission. Each person affected by dementia has

different routines, functional capability, needs and triggers that may cause behaviours that challenge.

Reviewing the behaviour chart completed at the time of [Mr B]'s move into KMV, I note there were two entries on 19 November 2021 relating to [Mr B] strongly resisting hygiene cares and changing, otherwise he had been settled and enjoying the outside. The progress notes of these first days include observations and notes on observations. On his first night, he was provided a sensor mat besides his bed and had night lights on to prevent falls at night when he gets up to go to the toilet.

On the morning of 20 November 2021, he was found on the floor on his right side with symptoms indicating a fractured hip or leg. The incident report indicates that it looked like he had been trying to open the toilet door. He was transferred to hospital, where he was also diagnosed with pneumonia; family were informed at the earliest time possible. Reviewing the documentation, it seems the care provided at these first days and the management of the fall were in line with accepted practice.

[Mr B] returned to KMV on 26 November 2021. The clinical documentation includes notes from EN [D] and from RN […], both implementing strategies of care relating to the new situation where [Mr B] now is unable to mobilise; he was also often refusing to drink and take his medication.

It is likely that [Mr B]'s refusal to eat and drink was related to an unmet need, potentially stemming from a change in his environment or the presence of pain. Communication with his family regarding this issue was documented, and his fluid intake was monitored with the note that "*the GP might want to review his Frusemide medication.*" The records also mention that he experienced intermittent hiccups during the first few days and that care staff needed to encourage him to drink.

Upon reviewing [Mr B]'s care plan, it is concerning to note that, in the circumstances, no pain monitoring was initiated by the RNs. The discharge prescription included paracetamol 1g PRN (as needed); however, a review of his medication administration chart shows that no paracetamol was administered before 31 December 2021. It is also recorded in the RN notes from 28 November 2021, that "*he has not displayed any signs of pain or discomfort*." I did, however, not find regular inclusions of pain monitoring in the notes.

Given the circumstances, it would have been appropriate to initiate a pain monitoring chart, using a tool designed for individuals with dementia who may have difficulty expressing pain. Implementing such a non-verbal pain assessment tool could have ensured that any pain or discomfort was identified and managed promptly. This practice aligns with the standards recommended in the Frailty Care Guides provided by the Health Quality & Safety Commission Te Tāhū Hauora (HQSC) New Zealand. The care guides emphasise the importance of regular pain assessment, particularly for those with cognitive impairments, to ensure that all potential sources of distress are adequately addressed.

On 29 November 2021, the nurses identified some blanching redness on his bottom and implemented regular turning; however, this was not well accepted by [Mr B], and therefore RN […] decided he needed an air mattress – which she "*placed in the maintenance book*". The next day, RN […] notes the same in the progress notes: "*need an air mattress for him*". The notes do not include conversations with the EPOA regarding this. On 1 December 2021, he received a GP review, who prescribed pain-relieving medication as required and at the request of his daughter, who expressed concern that he might not express his pain. It is noted that staff assured her that staff observe for pain and discomfort. I did not find evidence in the clinical documentation of regular pain assessments completed by staff. Medication administration charts do not show the administration of pain relief. The notes include that he is drinking well now and by himself. They can, however, not transfer him to the chair yet because *he doesn't tolerate the hoist*.

On 2 December and 3 December 2021, the notes include a communication with the family in which the air mattress yet to be applied was discussed.

7 December 2021: the notes include that the family note [Mr B] is deteriorating and that the nurse asked the GP to review his medication and have a blood test.

9 December 2021: the notes include that they were still waiting for an air mattress. On 10 December 2021, he gets to be transferred for the first time onto a chair, EN [D] asks for pressure-relieving cushion for his chair.

13 December 2021 includes a family communication note relating to the GP review, and blood results, Frusemide decrease and weight loss is noted (see more details later). The notes also include that [Mr B] is increasingly restless. The GP prescribed antibiotics because the blood results point in the direction of an infection; however, no clinical evidence to suggest what is causing the infection. I note the RN entered an 'infection record' with a plan to monitor for signs of an infection. On 14 December 2021, the notes include a discussion with the family, including the medication, increasing restlessness, and strategies to keep him safe from falling without the use of physical restraints.

Weight loss is documented that day. Reviewing his weight chart, I note that [Mr B]'s weight had not been measured since his return from hospital until the concern was raised by the family. It was found that, since his fall and admission to hospital, he lost 10kg (93kg, BMI [body mass index] 33 to 83kg, BMI 27). The notes include that this was communicated to the GP, who noted a high sodium level and likely due to dehydration. Furosemide was decreased. The GP asked to encourage fluid intake. The weight chart shows his weight was measured every other day from then on and remained relatively stable. A food and fluid monitoring chart had been in place documenting his intake, which seems intermittent. The progress notes show a good focus on food and fluid intake and report that fluids were offered hourly in the days following the GP advice. Some days, the progress notes include that he refuses food and fluids, with other days noting that he eats independently. The nurses monitored his weight at alternate days, with some days that he refused. It would appear his weight varied moderately,

potentially relating to fluid intake. The Food and Fluid Chart continued to be completed by staff recording the amount of fluid intake and describing his food intake. I consider the nutritional oversight to have been adequate and am concerned that [Mr B]'s weight was not measured on the days following his return from hospital and while having days with low food intake.

17 December 2021: the notes include a conversation between EN [D] and the EPOA requesting to withhold quetiapine (which was started while he was in hospital) and see if it is still needed and have it reviewed by the GP. On 21 December 2022, physiotherapy commences with a view to do sit-to-stand retraining.

31 December 2021: [Mr B] received a doctor's visit. The GP had a phone discussion about his findings with the EPOA – it was decided not to give him a COVID booster due to his frailty. Paracetamol was prescribed and administered four times per day on request of his daughter who noted "wincing when he is trying to adjust himself in his chair" as a clear sign he was in pain. [Mr B]'s care plan includes specific wishes for his care to be comfort care only and for him to be pain free, as discussed with his daughter and welfare EPOA.

On 5 January 2022, [Mr B] received another visit from the GP due to a sudden deterioration in his condition. At this time, he was unable to swallow, appeared very weak, and was only rousable to sound and touch. These symptoms strongly indicated that he had entered the end-of-life stage. The care notes confirm that this information was communicated to his family.

To ensure his comfort, subcutaneous fluids with analgesia were initiated, followed the next day by the administration of analgesia through a syringe driver. His family was present during this time as his condition continued to decline. [Mr B] passed away that night, around 1am on […] January 2022.

Although the care notes did not include a specific 'Last Days of Life' care plan, the progress notes do reflect relevant instructions and progress notes for his care during this critical period. While a formalised care plan better ensures a structured approach, I note that the progress notes capture the essential aspects of his care, indicating a good focus on his comfort and dignity in his final moments.

On 16 February 2022, a family meeting was held where the family brought up concerns they had regarding the care. KMV acknowledged that there were areas where they should have done better.

Conclusion

Regarding the standard of nursing care provided by KMV, I am concerned about the timeliness of providing a pressure-relieving air mattress, the close collaboration with EPOA by the key RN, and the adequacy of postoperative pain management. In the circumstances, I consider the nutritional oversight and weight monitoring to have been a mild deviation from accepted practice.

1. Timeliness of providing a pressure-relieving air mattress as identified by RN

It's important to note that pressure-relieving air mattresses are a standard intervention to prevent pressure ulcers in residents identified as being at high risk for developing pressure injuries. Timely provision of such equipment is essential in maintaining skin integrity and comfort. The standard response time for such equipment in a care setting can vary depending on the availability of equipment in the care home. Generally, such equipment is provided within two hours or maximum next day in case one needs to be sourced externally, purchased or rented.

I am concerned KMV "maintenance", who were asked to provide an air mattress, did not respond in a timely manner. The care home is required to provide this equipment whenever requested by an RN. No valid reason was provided for the delay. **I consider the delay of provision of this equipment to have been a moderate to significant deviation from accepted practice.**

2. Close collaboration and communication with EPOA

I agree with KMV's own assessment that the communication with the EPOA was suboptimal, a sentiment expressed during the family meeting on 16 February 2022. It is imperative that the EPOA is engaged in accordance with their preferences, particularly in being informed and involved in all significant changes in symptoms, health status and care interventions. This involvement is crucial to ensure they can provide informed consent as events unfold and clinical decisions are made. It is vital for the EPOA to have a comprehensive understanding of the illness trajectories to better manage expectations and exert control over the decisions. This is typically facilitated through discussions during family meetings where care plans are deliberated and agreed upon, facilitated by the RN, and by maintaining open lines of communication.

Upon reviewing the documentation, it is evident that there were numerous interactions with the EPOA. Nonetheless, these interactions could have been more effectively tailored to meet the specific needs of this family and should have involved the appropriate RN to ensure clarity, accuracy of information, translation of decisions into care planning, and timely follow-up on concerns, requests and observations from the family.

I note that the documentation did not include a Te Ara Whakapiri/Last days of life or similar pathway for care in the last days of life, although there is evidence in the care notes that family confirmed comfort cares only. The development of such a care plan would have enabled discussion and documentation of what matters most to the resident and their family and would have been expected at that time. **Therefore, I consider that, in the circumstances, the collaboration and communication with the EPOA deviated moderately from the accepted practice.**

3. The adequacy of pain monitoring

I am concerned about the lack of proactive pain monitoring in the first few weeks after [Mr B]'s return to KMV from hospital. Although pain management was appropriately addressed during his final days, with the initiation of analgesia, there was a notable

lack of systematic pain assessment throughout his stay. The absence of a structured pain monitoring process, especially using a validated tool for individuals with dementia, meant that potential pain may have gone unrecognised and untreated. This reactive approach did not fully align with accepted practices, which emphasises the importance of regular and proactive pain assessments to ensure comfort, especially for those who cannot easily communicate their discomfort. **Therefore, I consider that, in the circumstances, the pain monitoring deviated mild to moderately from the accepted practice.**

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus

Nurse Advisor (Aged Care)

Health and Disability Commissioner