HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate care provided to vulnerable aged care resident

Executive summary

1. This report discusses the care provided to Mrs A by Avondale Lifecare Limited (Avondale Lifecare), part of New Zealand Aged Care Services Limited group. The concerns raised include the overall care provided and COVID-19-related restrictions that prevented Ms B, daughter of Mrs A, from visiting her mother.

2. I find that Avondale Lifecare breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code) for failing to provide services to Mrs A with reasonable care and skill. In addition, I have made adverse comments about Avondale Lifecare for preventing Ms B from visiting her mother during COVID-19 lockdowns in 2022.

Recommendations

Given the changes that have already been made, I recommend that Avondale Lifecare:

a. Apologise to Ms B and her whānau for the breach of the Code identified, for forwarding within three weeks of this report.

b. Develop a family/whānau communication strategy that outlines when and how the family/whānau/Enduring Power of Attorney (EPOA) are involved in a resident's care and decision-making to ensure that family meetings are held at regular intervals and that conversations that involve ceilings of care and interventions are addressed and recorded in applicable documents. The communication strategy should be completed within three months of this report and forwarded to the Health and Disability Commissioner (HDC).

Background

3. Mrs A was in her early 90s at the time of the events and was diagnosed with dementia, including challenging behaviours, and multiple comorbidities. She was admitted to Avondale Lifecare in September 2020, initially to the dementia wing but reassessed and moved to the hospital wing in December 2020. Clinical admission records note that Mrs A had skin tears on her lower left leg.

4. Mrs A passed away in a Health New Zealand | Te Whatu Ora (Health NZ) public hospital in late March 2022. I extend my sincere condolences to Mrs A's whānau for their loss.

The complaint

5. On 7 March 2022, this Office received a complaint from Mrs A's daughter, Ms B. The complaint raised concerns about the overall level of care provided by Avondale Lifecare and in particular the response to and management of Mrs A's urinary tract infection (UTI) and

lower leg wound. In addition, Ms B raised concerns that her unvaccinated status (to COVID-19) led to restrictions being placed on her visiting her mother in the care home.

Avondale Lifecare's response

6. In response to the complaint, Avondale Lifecare outlined the care they had provided to Mrs A, including 24/7 oversight by a Registered Nurse (RN) and physical and social care by its multidisciplinary team.

7. In response to concerns related to its management of Mrs A's lower leg wound, Avondale Lifecare stated that it had provided ongoing wound care management. It said that its 'wound care planning has shown a long commitment with intervention and treatment of Mrs A's low leg wound, with photographic visual receipts and wound care planning documentation to support the wound is healing.' Avondale Lifecare stated that Mrs A's leg wound had been clinically assessed and treated with interventions and evaluation over a 2-year period and that her risk profile was considered complex because of her tendency to touch and scratch the wound and to occasionally remove the dressing.

8. In response to the concerns raised about Mrs A's UTI, Avondale Lifecare advised:

> 'A UTI was confirmed during the January 2022 admission to [Auckland District Health Board] ADHB, admission on 10th January 2022 and discharged back to Avondale on the 26th January 2022. This UTI was treated with [intravenous antibiotics], and Mrs A was assessed as [contracting] hospital-acquired pneumonia, and further oral antibiotics were charted.'

9. In response to concerns raised related to whānau communication, Avondale Lifecare acknowledged that '[d]uring this investigation, it would be plausible to conclude that the lack of clinical documentation on whānau communications has been an oversight.'

10. In response to concerns that Ms B's COVID-19 unvaccinated status led to her being prevented from visiting her mother, Avondale Lifecare stated that, after the complaint (in July 2022), they had developed a visitor's policy that allowed unvaccinated relatives to visit residents if its safety protocols were adhered to.

Further information

11. Health New Zealand I Te Whatu Ora – Te Toka Tumai Auckland (Health NZ) advised HDC that it had received a complaint from Ms B stating that she had been unable to visit her mother because of Avondale Lifecare's COVID-19 lockdown policies, which restricted unvaccinated visitors. In February 2022, Health NZ wrote to Avondale Lifecare and outlined how they had tried to facilitate a resolution allowing Ms B to visit her mother. Despite Health NZ's efforts, Avondale Lifecare reiterated that they would not allow an unvaccinated person to visit the facility.

12. In response, Health NZ stated:

> 'The DHB was disappointed with your response, particularly as evidence emerges that careful consideration needs to be given to resident wellbeing and quality of life versus

safety and protection from COVID-19. This is an area coming under increasing scrutiny as the detrimental effects of lockdowns, including visitor restrictions, become apparent.'

Avondale Lifecare's response to nursing advice

13. On 4 December 2025, Avondale Lifecare was notified about the formal investigation into the complaint. On 4 February 2026, it was informed that HDC had obtained in-house clinical nursing advice from RN Richard Scrase. The nursing advice is attached as Appendix A and discussed further in the decision section.

14. Avondale Lifecare responded that it had 'nothing to add to the findings' and acknowledged and accepted the recommendations made by the nurse advisor. It stated that 'Avondale Lifecare and New Zealand Aged Care Services remain committed to continuously improving the quality of care we provide and identifying opportunities for further enhancement'.

Changes made as a result of the complaint

15. Avondale Lifecare has:

a. Uploaded the Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Frailty Care Guidelines on its central platform for Policies and Procedures. A printed copy is also available at the Nurses' Station for quick reference.
b. Provided training to staff members around the management of wounds, infections (including UTIs), and incontinence.
c. Reviewed and implemented the following policies:
    - Clinical Escalation Pathway Policy
    - Care Planning Policy and Procedure
    - Resident Review Policy
    - Outbreak and Pandemic Management Policy
    - COVID-19 Outbreak Management Guidelines

16. Avondale Lifecare and Ms B were both given the opportunity to respond to relevant parts of this report and confirmed that they had no further comments.

Decision

Avondale Lifecare Limited – breach

17. Avondale Lifecare has a duty to provide its vulnerable residents with an adequate standard of care, in line with their individual needs, while meeting contractual obligations and adhering to the Code.

18. Right 4(1) of the Code states that the consumer has the right to 'have services provided with reasonable care and skill', which unfortunately did not occur in Mrs A's case.

19. I commend Avondale Lifecare for considering how to, and for taking steps to, mitigate the risk of these types of events occurring again, as evidenced by the changes implemented since this complaint.

20. I have considered four key areas of concern in my assessment of the standard of care provided to Mrs A: the monitoring and escalation of care, the wound care, the management of the UTI, and the communication with the whānau. I also discuss the COVID-19 lockdown restrictions separately.

Monitoring and escalation of care

21. RN Scrase advised that the focus of Mrs A's care:

> 'appeared to be on responding to events rather than endeavouring to control issues within the parameters of an agreed framework. It is therefore my professional opinion that there was a **moderate departure** from accepted practice.'

22. I accept RN Scrase's advice and am critical that Avondale Lifecare failed to agree all appropriate interventions, escalations, and ceilings of care between the whānau/EPOA, general practitioner (GP), and the facility staff and instead provided 'reactive' care, which is far from ideal.

Management of wound care

23. RN Scrase advised that:

> 'In terms of the management of the wound, it is my professional opinion that there was a **severe departure** from accepted practice.'

24. I accept RN Scrase's advice and am critical that Avondale Lifecare did not seek specialist intervention earlier, as this may have improved the outcome for Mrs A, even if complete healing of the wound was unrealistic. In addition, I am concerned that no clear plan outlining time scales and expected outcomes for the wound healing was created and recorded.

Management of UTI

25. RN Scrase advised that:

> 'At the time the events occurred, the early warning signs were there that there were unexplained concerns that needed addressing. From a nursing perspective, the significantly reduced urine output would be of particular concern and one that needed acknowledging and addressing as soon as it was identified. While the GP was contacted and antibiotics commenced for a possible UTI, other clinical concerns did not appear to have been appropriately addressed, and, in particular, consideration of possible urinary retention when the clinical signs were there. I therefore consider there to have been a **severe departure** from accepted practice.'

26. I accept RN Scrase's advice and am critical that early warning signs, including reduced urine output and potential urine retention, were not addressed.

Communication with whānau

27. RN Scrase advised that:

> 'Documentation with the EPOA and indeed other family members was relatively infrequent. Although there was evidence of some communication with the family

> members, the focus appeared to be on reporting events rather than agreeing on appropriate interventions. It is therefore my professional opinion that there has been a **moderate departure** from accepted practice.'

28. I accept RN Scrase's advice and am critical that whānau/EPOA were not adequately involved in care discussions and decisions related to Mrs A's care, including end-of-life decisions. In addition, I am concerned that regular formal meetings between whānau/EPOA and Avondale Lifecare did not occur.

29. I note that Avondale Lifecare told HDC that regular meetings were held with the whānau/EPOA. However, the meetings were informal, and Avondale Lifecare has acknowledged that not all communication with the whānau has been reflected in the whānau record forms and that emails from whānau were not printed and added to the notes. Avondale Lifecare concluded that '[d]uring this investigation, it would be plausible to conclude that the lack of clinical documentation on whānau communications has been an oversight.'

Conclusion

30. The critical failures in this case included failure to agree all appropriate interventions, escalations, and ceilings of care between the whānau/EPOA, GP, and the facility staff; earlier specialist intervention regarding wound care was not sought; early warning signs related to the UTI were not addressed; and whānau/EPOA were not adequately involved in care discussions and decisions related to Mrs A's care, and, when they were involved, this was not always recorded.

31. For the reasons outlined above, I do not consider that Mrs A was provided services with reasonable care and skill, and accordingly I find Avondale Lifecare in breach of Right 4(1) of the Code.

COVID-19 lockdown restrictions – adverse comment

32. Right 8 of the Code states that 'every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's right may be unreasonable infringed.'

33. RN Scrase advised that:

> 'There was documented evidence of a Zoom call being organised between the unvaccinated family member and the resident. However, there were no policies in place regarding visits during this period, and the resulting restriction and lack of clarity on visitations, involved and impacted both the visitor and the resident concerned. It is therefore my professional opinion that this was a **moderate departure** from accepted practice.'

34. I accept RN Scrase's advice and am concerned that the visiting policy did not allow Ms B to visit her mother because of her unvaccinated status. I note that Ms B also lodged a complaint about this with Health NZ, who advised Avondale Lifecare that they were 'disappointed'

that, despite them 'trying to facilitate a resolution', Avondale Lifecare still would not change its policy and allow Ms B access.

35. I acknowledge Avondale Lifecare's statement that it was a challenging environment because of the COVID-19 pandemic and that it had what it considered to be an appropriate policy in place at the time of the events. While I accept the circumstances were difficult for service providers across the board, in my view Avondale Lifecare was not accommodating to the extent needed given the detrimental impact restrictive lockdowns and its associated social isolation measures were having on its residents. Social networks are crucial for the resident's wellbeing and help to control loneliness and mental distress. I note that the COVID-19 pandemic had been ongoing for almost two years, and there was both information and guidance available to aged care providers on strategies for managing the transmission of infections. This should have allowed Avondale Lifecare to develop a policy that was consistent with the national response to the pandemic at the time. So, while I acknowledge Avondale Lifecare's goal was to protect its vulnerable residents from COVID-19 infections, in the circumstances I consider they could have developed a policy that included safe visiting plans that would have appropriately mitigated the risk of the transmission of infection by an unvaccinated family member entering its facility to visit their relative. I note that my view aligns with Health NZ's statement.

36. However, I do not find that Avondale Lifecare breached Right 8 on this matter because I recognise the pressures Avondale Lifecare and other aged care facilities were facing, and I accept that their motivation was to safeguard residents.

Follow-up actions

37. A copy of this report will be sent to HealthCERT and Health NZ – as the Commissioning agency.

38. A copy of this report with details identifying the parties removed, except Avondale Lifecare Limited and my expert advisor, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Ms Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to the Commissioner

The following in-house clinical advice was obtained from RN Mr Richard Scrase:

CLINICAL ADVICE – AGED CARE

CONSUMER : [Mrs A]

PROVIDER : Avondale Lifecare

FILE NUMBER : 22HDC00579

DATE : 2 December 2025

Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Avondale Lifecare. 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.

1. **Documents reviewed**

During the course of reviewing this complaint, I reviewed the initial letter of complaint in addition to subsequent documentation sent by the complainant to HDC. I also reviewed the clinical notes for the period in question, which were sent by the provider. These included relevant assessments and care plans in addition to recorded clinical observations, documentation of care provided, and communication with relevant family members. Documentation reviewed also included relevant policies and procedures that related to the care provided to [Mrs A] for the period in question.

2. **Complaint**

[Ms B] has raised concerns that her COVID-19 unvaccinated status led to restrictions being placed on her ability to visit her mother. She also raised further concerns about the care provided to [Mrs A]. There were specific concerns about the management of and response to a fever, a bladder infection, and a lower leg wound.

3. **Review of clinical records**

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

4. I have specifically been asked to comment on:

- The monitoring and escalation of care leading up to hospitalisation in January 2022
- The management of wound care

- The management of the UTI and catheter in March 2022, and whether there was any indication of escalation prior to 21 March 2022
- What policies were in place for COVID visitations at the time of the events
- The communication with the family and EPOA and whether it was adequate.

Clinical advice

5. Review of documentation

[Mrs A] was admitted to Avondale Lifecare on 24 September 2020. Although initially admitted into the dementia wing, she was subsequently reassessed and then transferred to Aroha wing under hospital-level care in December 2020. In March 2021, [Mrs A]'s husband of many years passed away at the same facility.

The documentation confirms that, on admission, [Mrs A] had skin tears on her lower left leg and that she also presented with multiple comorbidities.

In this review, I have examined the documentation relating to [Mrs A]'s care from November 2021 onwards. I have also examined the notes here in chronological order rather than by specific concern because events frequently overlapped and there can be a degree of connectivity between issues in any person with multiple complex medical issues.

Review of the clinical notes confirms that there were numerous references to [Mrs A]'s leg wound throughout the documentation from the beginning of November 2021. The notes frequently referred to the wound bleeding, the dressing coming off, and linen being stained with blood.

On 2 December 2021, there is the first reference to the wound being covered with a plastic bag during showering. This is common practice when trying to protect and prevent a wound from becoming wet and potentially infected. However, there is no reference to this occurring prior to this date or what the rationale was for what was apparently a change in practice, albeit a reasonable one.

There were short-term care plans in place for the management of the lower leg wound. However, changes were made to dressings without always giving a rationale for the change, and the frequency of dressing changes did not always align with the severity of the documented exudate in the clinical notes. It is acknowledged that the management of the wounds would have been significantly impacted by [Mrs A]'s other health issues and in particular her peripheral vascular disease.

[Mrs A] was referred to specialist wound care services in February 2022, and there were two occasions identified when antibiotics were prescribed in order to address infection within the wound.

Food intake was often documented as being poor, but at the same time there was also documented evidence that [Mrs A] has eaten all her meals on some days. However, it

is acknowledged that there are often significant challenges with encouraging a resident with a significant diagnosis of dementia to eat nutritionally appropriate food, which is an important part of wound healing. It is also documented that nutritional supplements were given or at least offered over this time period.

There was documented evidence that [Mrs A]'s wound was increasing in severity in November 2021, with, for example, documentation on 15 November that stated, 'Raw areas noted on her wound*'.*

The GP visited the facility on 2 December 2021, when it was documented that [Mrs A]'s health was 'stable'.

On 14 December, nursing documentation noted 'heavy growth of staph' following a wound swab taken a few days earlier. Dressings were largely changed as per the care plans every three to four days. It is important to note that current clinical guidance also highlights that more frequent dressing changes than those documented does not necessarily result in improved outcomes or faster healing of the wound in question (https://nzwcs.org.nz).

On 6 December 2021, [Mrs A]'s weight was recorded as 52.5kg, which was a 6.8% drop from the previous month (56.34kg). Although there is no documented evidence of any intervention with respect to addressing this weight loss, which would be normal practice for an unexplained loss in weight of 5% or more, this needs to be seen in the context of the GP clinical note in October 2021 referring to end-of-life care with the prescribing of anticipatory palliative medications. This was also documented as being communicated to the family in the whānau notes. However, there is no clearly documented evidence of the agreed ceiling of care and appropriate medical interventions for [Mrs A]. Following a slight increase in weight, there was a further significant weight loss of 11.4% noted on 10 January 2022.

On the same day, the following was documented in the nursing notes:

> 10 Jan 11.30. Good food and fluid intake. Settled. Well.
>
> 10 Jan 21.00. Big noticeable lump on abdomen. Very sleepy and hard to wake.

As a result of the last entry, matters were escalated, and the clinical notes stated that, following the family's request to do so, [Mrs A] was taken to hospital where she was subsequently admitted for further investigation and treatment.

On admission to hospital, [Mrs A] was diagnosed with a urinary tract infection and subsequent urosepsis. After treatment with intravenous antibiotics, [Mrs A] was transferred back to her rest home with an indwelling catheter in place.

Following her discharge from hospital, [Mrs A] had reduced verbalisation and was on a pureed diet. Subsequent clinical notes highlight that she was reluctant to eat and required a lot of encouragement to do so. Food and fluid intake was monitored, but it

was not always clear as to the amount of urine being passed and over what time period. For example

> 27 Jan: 'Urine output was 100ml'

and then the next shift on the same day:

> 'very little urine output'.

Also, on 27 January, [Mrs A] was reviewed by the GP as a post-hospital-discharge follow-up. The GP notes state 'Leg wound not infected. Plan for palliative care. Very frail. Keep IDC, Encourage food and fluids'.

There is no documented evidence that the EPOA was involved in the decision regarding a palliative approach.

Subsequent clinical notes stated

> 28 Jan. 0645. 'Checked twice and gave 1/2 a cup of water. Urine output was 250ml at 0040 and 250ml at 0545'.

However, it was not stated whether the urine bag had been emptied in between these recordings or whether there had in effect been no urine output between 0040 hrs and 0545 hrs.

> 29 Jan. 'ate and drank very little'.

> 30 Jan. 'eating very little. Sleepy'

After this period, urine output and oral intake appeared to have improved, albeit food intake remained inconsistent.

In February, the clinical documentation began to highlight new issues with this resident's skin, particularly in the area of her groin and buttocks. However, I was unable to identify any documented evidence of pressure injury prevention, which would be expected practice given her frailty and clinical presentation.

In mid-February, there was further reference to the leg wound. This included the following:

> 19 February. The wound was described as containing a lot of pus with the dressing being changed to a silver-based dressing. Silver-based dressings are frequently used to treat or to prevent infection in wounds.

> 24 February. The silver dressing was stopped and replaced with another product and 'a large open area' was noted. This change in dressing may have been an entirely appropriate clinical decision, particularly given the apparent

deterioration in the wound, but the rationale for the change was not documented.

28 February. The wound had deteriorated further, with what was described as a yellow exudate and a large open area with a bloody discharge.

8 March. Most of the left lower leg was described as open.

12 March. 'Left lower leg open 90%. Re-dress 4/7'

I was unable to identify any evidence of the wound having been referred to an outside agency for advice and support over this period, which would in my view be accepted practice in the circumstances described above.

On 18 March, the clinical notes documented 'Clots in pad from ongoing PV bleeding. Obs taken, pulse 123 BP 134/78'

The catheter had been removed the day prior because of ongoing leakage, and, after consultation with the GP, antibiotics were commenced to manage a possible UTI.

[Mrs A] experienced further vaginal bleeding and reduced urine output in the days following the removal of the catheter. There is no documented evidence of consideration being given to urinary retention, which is not uncommon following the removal of a catheter, and [Mrs A] had a previous history of retention while in hospital in February. Reinsertion of a catheter to a female resident by an RN, assuming there were no other concerns to contraindicate this, would be accepted practice in this clinical setting.

Following the passing of some further blood clots and slight abdominal distention, [Mrs A] was admitted to hospital on 21 March 2022. This is the end of the period under review.

6. The monitoring and escalation of care leading up to hospitalisation in January 2022

What is the standard of care and/or accepted practice?

The period relating to this case aligns with when the Health and Disability Service Standards were changing from the previous standards (NZS 8134:2008) to the new standards, Ngā Paerewa NZS 8134:2021. This change occurred on 28 February 2022. For clarity, and because there was a lot of alignment between the two sets of standards, I refer to Ngā Paerewa NZS 8134:2021 throughout this review.

The standards relating to the monitoring and escalation of care are contained within Section 3 – Ngā Huarahi Ki Te Oranga/Pathways to Wellbeing and more specifically Subsection 3.2.3.

I am specifically examining the care provided up to the hospitalisation in January without considering later events, which may add an element of hindsight bias.

[Mrs A] was very frail and had multiple medical issues, including a diagnosis of dementia. It was clear from reading the nursing notes that [Mrs A] received regular care and support from the facility staff. However, it is accepted practice that all interventions, particularly in an aged care setting, must also involve a clear understanding of appropriate interventions, escalations, and ceilings of care, which need to be agreed between the GP, EPOA, and the facility staff. I could not identify any documented evidence of this understanding prior to her hospital admission in January 2022. It is this clear communication that is such an important part of ensuring that an individual's health journey is managed as well and as appropriately as possible, and which is accepted practice in aged care and all other health settings.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
After having read through the documentation made available to me, my professional opinion is that the facility provided [Mrs A] regular care but with no clear cohesive overarching plan that everyone involved in [Mrs A]'s care understood. This lack of an agreed overarching and cohesive plan was in my view a consistent issue throughout my review. In other words, rather than the focus being on, for example, dressing the leg wound, attention should have been given to and documenting the aim (is it healing or is it containment and avoiding deterioration?) and then for it to be cohesive alongside other important cares such as nutrition and its importance in wound healing, pressure injury prevention, pain management, and addressing weight loss.

[Mrs A]'s health and level of function was declining over the aforementioned period, which is all the more reason for a clear overarching holistic plan of care and an understanding of an appropriate ceiling of care.

Furthermore, although [Mrs A] was admitted with a urinary infection, the leg wound and weight loss were also areas of concern. In addition, although there was communication with the family, it was frequently involving reporting events rather than clarifying and agreeing on the way ahead.

In summary, it is my professional opinion that care was being provided but that the focus appeared to be on responding to events rather than endeavouring to control issues within the parameters of an agreed framework. It is therefore my professional opinion that there was a **moderate departure** from accepted practice.

How would it be viewed by your peers?
Having discussed this matter with my peers that are experienced in aged residential care, it was acknowledged that residents are becoming more clinically complex with multiple comorbidities. It is for this reason that there needs to be a holistic person-centred approach to the care provided with clearly documented communication between all parties involved in the care being provided.

Recommendations for improvement that may help to prevent a similar occurrence in future

Recommend implementation and embedding of the Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Frailty Care guidelines, which are available for both RNs and Healthcare Assistants. They provide extensive guidance on areas such as end-of-life care, pain management, and wound care.

Health Quality & Safety Commission. 2023. Frailty care guides | Ngā aratohu maimoa hauwarea (2023 edition). URL: www.hqsc.govt.nz/resources/resource-library/frailty-care-guides-nga-aratohu-maimoa-hauwarea

In addition, whilst acknowledging the challenges of the COVID-19 pandemic, regular and timely family meetings with clearly documented outcomes would be beneficial.

Cultural advice
Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in Nursing Education and Practice (Nursing Council of New Zealand, 2011) states: "Cultural safety is an outcome of nursing education [and nursing practice] that enables **safe service to be defined by those who receive the service**".

7. The management of wound care

What is the standard of care and/or accepted practice?
Ngā Paerewa NZS 8134:2021 subsection 3.2.3(g) states that, "Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention". It would be accepted practice that concerns such as the long-standing wound would be escalated appropriately. It is also important the RN in any setting is an autonomous critical thinker who is able to identify the issue and take appropriate action. In the case of a complex wound, this is not necessarily solely contacting the GP because, despite the GP's breadth of knowledge, wounds that are not healing or are getting worse require specialist wound care input, as outlined in the organisational policy on the matter. Although a referral to wound care specialists was done some months prior, it is not clear what, if any, further input was requested. The facility wound care policy also states that there must be a clinical rationale for any change in wound care product.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
The complex leg wound, which, in my view, required specialist intervention earlier than was the case, continued to be regularly dressed as per the care plan but with no improvement. There was evidence of interventions in what was a clinically complex situation, but a greater use of critical thinking in a nursing context should have led to the conclusion that early intervention and support was required, even if complete healing of the wound was not a realistic outcome. Furthermore, although there were regular dressing changes and changes in the dressings being used, there was no evidence of a clear plan involving time scales and expected outcomes. This can be summarised by the clinical notes on 12 March, which stated, 'left lower leg open 90%. Redress 4/7'. It is my professional opinion that solely redressing a wound of this

severity in four days' time is not an adequate plan for any individual, both at this stage and prior to this, regardless of their overall clinical trajectory and presentation.

In terms of the management of the wound, it is my professional opinion that there was a **severe departure** from accepted practice.

How would it be viewed by your peers?
Peers that I have discussed this with on a confidential basis agree that there has been a severe departure from accepted practice.

Recommendations for improvement that may help to prevent a similar occurrence in future.
My recommendations are as suggested for the section above.

8. The management of the UTI and catheter in March 2022, and whether there was any indication of escalation prior to 21 March 2022.

What is the standard of care and/or accepted practice?
As in the previous section, Ngā Paerewa NZS 8134:2021 subsection 3.2.3(g) applies, which states that, "Early warning signs and risks that may adversely affect a person's wellbeing are recorded, with a focus on prevention or escalation for appropriate intervention".

The clinical documentation states that, on 18 March 2022, [Mrs A] had blood clots in her pad and that she had a raised pulse rate. Prior to this, [Mrs A] had been pulling at her catheter, which is likely to have caused some trauma and could explain the bleeding. The actual quantity of blood loss is not clear, although reference to clotting does indicate that it was not a minimal amount. The GP was contacted, and [Mrs A] was commenced on antibiotics to address a possible UTI. In the following days, [Mrs A] experienced further bleeding and reduced urine output, which – although not always clear – was likely to have been identified by the fact that her pad was dry, given that she no longer had a catheter in place. [Mrs A] had also been presenting with reduced oral intake over this period. There is no documented evidence that consideration was given to urinary retention, which would be accepted practice given [Mrs A]'s history of retention, the recent removal of her catheter, and reduced urine output.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
At the time the events occurred, the early warning signs were there that there were unexplained concerns that needed addressing. From a nursing perspective, the significantly reduced urine output would be of particular concern and one that needed acknowledging and addressing as soon as it was identified. While the GP was contacted and antibiotics were commenced for a possible UTI, other clinical concerns did not appear to have been appropriately addressed, and in particular consideration of possible urinary retention when the clinical signs were there. I therefore consider there to have been a **severe departure** from accepted practice.

How would it be viewed by your peers?
My peers that I have discussed this with on a confidential basis agree that there has been a moderate departure from accepted practice.

Recommendations for improvement that may help to prevent a similar occurrence in future
Recommend implementation and embedding of the HQSC Frailty Care Guidelines which are available for both RNs and Healthcare Assistants. They provide guidance on management of catheters and of monitoring urine output

Health Quality & Safety Commission. 2023. Frailty care guides | Ngā aratohu maimoa hauwarea (2023 edition). URL: www.hqsc.govt.nz/resources/resource-library/frailty-care-guides-nga-aratohu-maimoa-hauwarea

The Stop and Watch early warning tool is also a useful aid for Healthcare Assistants. A link for this can also be found in the Frailty Care Guidelines.

9. What policies were in place for COVID visitations at the time of the events.

What is the standard of care and/or accepted practice?
Ngā Paerewa subsections 1.3 and 1.4 specifically refer to resident's rights and to service providers providing support in a way that is inclusive and respects an individual's identity.

It is noted that the events occurred during the COVID-19 pandemic period 2020–2022, and I would like to acknowledge the challenges and distress caused to residents, family/whānau, care teams, and health service providers during this time. This was an unprecedented and stressful period for everyone, and providers were navigating their way through a frequently changing situation and implementing measures in an effort to keep all the vulnerable population in aged care as safe as possible. That said, by the time of this particular event, there had been guidance provided on how best to support unvaccinated visitors as safely as possible. However, these broad guidelines also need to be seen in the context of individual facilities and how they could best manage a potential COVID-19 outbreak. The layout of the facility, staffing levels, and the local availability of additional staff and support are likely to have played a part in decisions made at a facility level relating to access to unvaccinated residents.

On 10 March, a Zoom meeting was held to enable an unvaccinated family member to connect with her mother; it is not known if there was any other. Alternative options would have been reasonable given [Mrs A]'s frailty and the knowledge and experience we as a health system had acquire two years into the pandemic. There was no documented evidence of a policy relating to the support of unvaccinated COVID-19 visitors to the facility. It would be accepted practice at this time to enable unvaccinated visitors to visit facilities, albeit considering the individual facility factors mentioned above. RAT tests on arrival and three days prior were in use, as were visits outside, weather permitting. Furthermore, this needs to be seen in the context of a resident who was unable to leave her room unaided and, as such, the risk of her

inadvertently spreading the COVID-19 virus in the event that she became infected was minimal given that staff could utilise recognised and embedded infection prevention and control measures.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
There was no documented evidence of a policy relating to the support of unvaccinated COVID-19 visitors to the facility. It would be accepted practice at this time to enable unvaccinated visitors to have some kind of facility-based contact with their relative, albeit considering the individual facility factors mentioned above. RAT tests on arrival and three days prior were in use, as were visits outside, weather permitting.

There was documented evidence of a Zoom call being organised between the unvaccinated family member and the resident. However, there were no policies in place regarding visits during this period, and the resulting restriction and lack of clarity on visitations involved and impacted both the visitor and the resident concerned. It is therefore my professional opinion that this was a **moderate departure** from accepted practice.

How would it be viewed by your peers?
Whilst acknowledging the challenges of the COVID-19 pandemic, my peers were in agreement with my findings.

Recommendations for improvement that may help to prevent a similar occurrence in future
In the event that this does not already exist, I would recommend the documentation and sharing to staff and residents of a clear policy regarding visitation during a pandemic.

10. The communication with the family and EPOA and whether it was adequate

What is the standard of care and/or accepted practice?
As highlighted in Ngā Paerewa Subsection 1.6, it is expected that there is regular effective communication between residents, family, and – importantly – the EPOA, when this is in place and activated, as was the case here. Review of the documentation highlights that communication occurred but that it was infrequent and often lacking in clarity. This was particularly the case when end-of-life decisions were being documented. It would be accepted practice that there would be family meetings being offered at such key points in a resident's life journey. Furthermore, when palliative care was documented by the GP in January 2022, it would be reasonable to expect a documented mutual understanding of what palliative care entails.

There also appeared to be limited documented communication with the assigned EPOA for Health and Welfare. The role of this person is to provide decisions about the individual's health and for there to be communication when these decisions needed to be made. There are occasions when the EPOA is unavailable and it is agreed that

the facility has to use another family member. It would be accepted practice that any discussions and any changes to who is first contacted is clearly documented.

If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?
Documentation [of discussions] with the EPOA and indeed other family members was relatively infrequent. Although there was evidence of some communication with the family members, the focus appeared to be on reporting events rather than agreeing on appropriate interventions. It is therefore my professional opinion that there has been a **moderate departure** from accepted practice.

How would it be viewed by your peers?
There was agreement about the importance of open discussion and understanding about care being provided and an acknowledgment that whenever possible, a plan needs to be in place before a crisis or medical event occurs.

Recommendations for improvement that may help to prevent a similar occurrence in future
It may be helpful to ensure that family meetings are held at regular intervals and that conversations that involve ceilings of care and interventions are addressed.

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Health and Disability Commissioner