HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failures in care for woman in rest home, including during COVID-19 pandemic

Introduction

1. This report relates to two complaints, made on 9 March 2022 and 20 June 2023, by Mrs A regarding the care provided to her mother, Mrs B, while she was a resident at Avondale Lifecare Limited, t/a Avondale Lifecare, in Auckland. The first element of this report relates to concerns that Mrs B did not receive appropriate care in relation to the provision of the COVID-19 vaccine, that infection prevention control practices were not aligned with the COVID-19 Protection Guidelines, and that communication between December 2021 and March 2022 was poor. The second element of this report relates to concerns about the care provided to Mrs B regarding medication management, clinical oversight, pressure injury prevention and management, nutritional needs, and delivery of person-centred care during 2022 up until August 2022 when, sadly, she passed away at the age of 86.

2. At the outset, I would like to extend my sincere condolences to Mrs A and the rest of her family on the loss of Mrs B. I also acknowledge the emotional distress these events have caused them.

3. Having considered the concerns raised in the complaints from Mrs A, for the reasons below, I find Avondale Lifecare in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code). I have also made an educational comment for Avondale Lifecare's general practitioner (GP), Dr C.

Recommendations

4. Noting the substantive changes made by Avondale Lifecare as part of its corrective action plan, I recommend:

   a. Avondale Lifecare provide an apology in writing to Mrs B's family for the breach of the Code identified in this report. The apology is to be provided within three weeks of the date of this report for forwarding to Mrs B's family.

   b. Avondale Lifecare provide the Health and Disability Commissioner (HDC) with an update on the corrective action plan and whether this was further reviewed/updated and confirmation that training is ongoing, where necessary. This information is to be provided to HDC within six months of the date of this report.

   c. Avondale Lifecare provide additional education to its nursing staff on communication with and about older people and their families, 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. Evidence of the training occurring, in the form of training material and staff attendance records, should be provided to HDC within six months of the date of this report.

d. Avondale Lifecare carry out discussions with its nursing team about the importance of accurately recording all concerns that families raise in the residents' clinical records. Confirmation that such discussions have taken place should be provided to HDC within three months of the date of this report.

e. Avondale Lifecare implement the use of the ISBAR[1] communication tool to better inform clinical assessments, actions, and safe, evidence-based decision-making. Evidence of the discussions, which can be by way of meeting notes, should be provided to HDC within three months of the date of this report.

f. If not already done, Avondale Lifecare register interest with the Health Quality & Safety Commission to adopt the use of DEWS[2] to support staff to identify and respond to possible acute deterioration. Evidence of the use of the DEWS framework, which can be by way of training materials and updated policy and processes, should be provided to HDC within six months of the date of this report.

g. Nursing and clinical staff of Avondale Lifecare complete HDC's online modules for further learning.[3] Evidence of the training is to be provided by way of a list of staff who have completed the training and when within three months of the date of this report.

Background

5. Mrs B was a resident of Avondale Lifecare from December 2017 until August 2022 receiving hospital-level care and requiring a high level of assistance to meet her daily living needs. Mrs B was bed and chair bound and required two-person assistance for all cares. Mrs A was her mother's Enduring Power of Attorney (EPOA). Mrs B's medical history included cerebrovascular disease, chronic lower back pain, dementia, type 2 diabetes, hypertension, osteoarthritis, and recurrent urinary tract infections (UTIs).

Care provided during the COVID-19 Protection Framework during December 2021 and March 2022

6. While Mrs B was residing at Avondale Lifecare, they were operating under the COVID-19 Protection Framework.[4] As such, they were required to follow the recommended guidance for aged care providers developed by Health New Zealand | Te Whatu Ora (Health NZ COVID-19 guidance) at the time, which outlined the infection, prevention, and control processes to be followed.

7. On 29 October 2021, Mrs A emailed Avondale Lifecare about her concerns over its compliance with the COVID-19 Protection Framework. Avondale Lifecare replied the same day and assured Mrs A that they were 'maintaining very strict infection control and following all mandated measures to ensure the safety of our residents.'

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[1] ISBAR stands for 'Identify, Situation, Background, Assessment and Recommendation' and is a tool used to help medical staff communicate critical information clearly and consistently.

[2] DEWS stands for 'Deterioration Early Warning System' and is a tool designed to support health care staff working in aged residential care to identify and respond to a person who could be acutely unwell.

[3] Online learning — Health & Disability Commissioner

[4] Aotearoa New Zealand Strategic Framework for Managing COVID-19

8. On 1 December 2021, an Avondale Lifecare Registered Nurse (RN) emailed Mrs A to notify her that Mrs B was eligible for her COVID-19 booster vaccination, which would be available for residents at Avondale Lifecare 'soon', and asking for Mrs A's consent. Mrs B had received the first two COVID-19 vaccine doses on 28 May 2021 and 1 July 2021. At this time, Mrs A declined the booster for Mrs B.

9. There was no evidence of the 1 December 2021 email in Mrs B's clinical records, though Avondale Lifecare has since given a copy of the email to HDC.

10. On 20 December 2021, Mrs A emailed the RN team to give consent for Mrs B to receive the COVID-19 booster vaccination, which she asked to be acknowledged. Mrs A's email was not acknowledged, and Avondale Lifecare have since confirmed that this information was not recorded in Mrs B's progress notes and not passed on to the Clinical Nurse Leader.

11. On 22 December 2021, the Manager distributed an Avondale Lifecare visitors update publication to residents' family/whānau. The update stated that they had been managing a situation where residents and staff had been unwell from a suspected respiratory outbreak and reminded family to return consent forms for the COVID-19 booster programme by 10am on 23 December 2021. The update also outlined precautions for visiting Avondale Lifecare, which included that 'Hospital residents' visits will require full P[ersonal] P[rotective] E[quipment] (PPE) due to entry into the main hospital wing to residents' rooms.'

12. Mrs A stated that she was under the impression that Mrs B had received the booster on 23 December 2021 after following up with Avondale Lifecare. She said a staff member had told her that her email of 20 December 2021 had been received and that Mrs B had been given the COVID-19 booster. However, Avondale Lifecare has been unable to identify any staff member working on that day who had this call with Mrs A.

13. On 23 December 2021, Mrs A visited Mrs B and was concerned that Avondale Lifecare was not following the COVID-19 Protection Framework: staff were not wearing appropriate COVID-19 PPE in Mrs B's hospital wing, despite this being outlined in their visitors' update dated 22 December 2021. Mrs A emailed Avondale Lifecare on 4 January 2022 expressing these concerns. Mrs A told HDC that she did not receive a reply and so followed up with a further email dated 5 January 2022.

14. Mrs A stated that she rang the Clinical Manager at Avondale Lifecare because she had not received a reply to either of her emails. She stated that, during this discussion, the Clinical Manager apologised for not replying and for the lack of compliance with infection control. Mrs A said the Clinical Manager assured her that procedures were in place to make sure it did not happen again. The Clinical Manager followed up by emailing Mrs B's other daughter on 6 January 2022 outlining that, because of the lack of compliance, appropriate action had been taken regarding staff concerned. They also confirmed a more 'streamlined and effective screening process for all visitors' was in place and that staff had been trained so they were 'compliant with managing COVID-19 screening and maintaining a high standard of infection control.'

15. On 20 February 2022, Mrs A visited Mrs B and noted that Avondale Lifecare staff were not wearing masks appropriately and that she was not asked appropriate questions, such as who she had been in close contact with and whether she had been vaccinated.

16. Mrs A told HDC that she received a call from the Clinical Manager at Avondale Lifecare asking whether they still wanted Mrs B to have the COVID-19 booster. The Clinical Manager explained that it had not been given on 23 December 2021 because Mrs A replied the day before the boosters were to be given, which meant they did not have enough time to give the booster and they did not have enough booster vaccinations, even though the Visitor Update stated that the cut-off for this was 10am on 23 December 2021. Mrs A advised that, had the family known this, they would have organised the booster themselves.

17. Avondale Lifecare confirmed that the rescheduled date for Mrs B's COVID-19 booster was 23 February 2022. However, COVID-19-related pharmacy staff illnesses led to it being postponed until 16 March 2022.

18. On 1 March 2022, Mrs A emailed Avondale Lifecare asking when Mrs B would have the COVID-19 booster. As she did not receive a reply, she sent a follow-up email on 4 March 2022 requesting a response. However, as this email also did not result in a response, she left a voicemail asking the Clinical Manager to contact her urgently.

19. Mrs B tested positive for COVID-19 on 5 March 2022.

20. On 6 March 2022, Mrs A received a call from the Manager at Avondale Lifecare to advise that Mrs B had tested positive for COVID-19. This Manager was unaware of the discussions Mrs A had had with the Clinical Manager. Avondale Lifecare told HDC that this was at a time where there was 'a significant outbreak of COVID-19' affecting both staff and residents, lasting 36 days. Mrs A stated that, in this call, the Manager confirmed that Mrs B had still not had the COVID-19 booster. This call was not recorded in Mrs B's clinical records, the GP was not informed, and no short-term nursing plan outlining isolation and interim care requirements was commenced.

21. On 7 March 2022, on the advice of Avondale Lifecare's GP, an ambulance was called for Mrs B because her health and wellbeing had declined after contracting COVID-19 and she had shortness of breath and chest pain. Mrs A was updated about this. A formal complaint was made by Mrs A and her siblings to the Ministry of Health (MOH) on this date (7 March 2022), which was forwarded to Avondale Lifecare. The formal complaint outlined Mrs B's family's concerns regarding the care provided by Avondale Lifecare during the COVID-19 period.

22. Mrs B returned to Avondale Lifecare from hospital on 15 March 2022.

23. On 17 March 2022, Mrs A received a response to her complaint of 7 March 2022 from the Manager at Avondale Lifecare, which apologised for the lack of compliance with the COVID-19 Protection Framework and acknowledged that residents and staff had been placed at 'additional risk.' It also recognised the poor communication that had resulted in Mrs B not receiving her COVID-19 booster at the earliest opportunity despite consent having been

provided and advised that additional senior clinical support had been put in place. Mrs B's care plan was also reviewed on this date.

24. Avondale Lifecare, in its response to HDC, confirmed that Mrs B was finally given her COVID-19 booster on 25 May 2022.

25. On 9 August 2022, Health New Zealand | Te Whatu Ora – Te Toka Tumai Auckland wrote to Avondale Lifecare to advise that it found some of the complaints made by Mrs A (in relation to the COVID-19 Protection Framework and Mrs B's vaccination and booster status) were substantiated, and concluding remarks referred to 'poor communication.' As a result, Avondale Lifecare was asked to include further corrective actions to their corrective action plan referred to in the 'Changes made' section of this report.

Other care provided during 2022 until 19 August 2022

26. Noting Mrs B's high level of care needs, Avondale Lifecare had a duty to ensure it met its own policies in relation to her long-term care plan (referred to as 'the care plan', this is usually created from formal nursing assessments, resident and family feedback, and related health information). The care plan was implemented in September 2019 and reviewed throughout her stay. In accordance with the care plan, Mrs B's monitoring included her nutrition and hydration; monthly recording of vital signs and weight; requirements and needs in relation to her hygiene and skin integrity; risks such as that of recurrent stroke, heart failure, and recurrent UTIs; and instructions to report signs of health concerns, changes in normal blood pressure range and/or vital signs, respiratory distress, and any significant weight loss to Avondale Lifecare's GP.

27. In relation to Mrs B's dementia, among other nursing interventions, the care plan outlines that nursing staff can 'Provide PRN [as needed] quetiapine [an antipsychotic medication] 25mg tablet for any behaviour issues.' However, in Avondale Lifecare's GP notes for 12 August 2019, it states to 'Stop quetiapine', and there are no updates on the care plan reflecting this.

28. The care plan was due to be reviewed every six months, and Mrs B was to be seen by the GP every three months. The care plan notes Mrs B's good relationship with her children, and it specifies that Mrs A is 'to be contacted should she become unwell' and for her to be informed of 'any changes in [Mrs B's] health status.'

29. Mrs B's care plan was redeveloped in 2019 and signed in agreement with Mrs A. The care plan stated that Mrs A, as her mother's EPOA, wanted to be notified of every event or any changes in health status as soon as possible. For the period 2020–2021, Mrs B's care plan evaluation commented that she was considered 'clinically stable.' Although Mrs A signed Mrs B's care plan in 2019, there is no evidence that Mrs A was given an opportunity to review and/or comment on it between 2020 and 2022.

30. On 7 February 2019, clinical records for Mrs B reflect that her GP saw her, reviewed her medications, and discontinued her antihypertensive medications (required for hypertension and a previous stroke). As a result, Mrs B's care plan was updated to ensure her blood pressure and vital signs were checked monthly or if clinically unwell. In his response to HDC,

Dr C stated that he did not update Mrs A, the EPOA, about this medication change and felt that it 'would have been communicated by nursing staff as part of routine care updates.'

31. During 2022, Mrs B's monthly monitoring records note that her blood pressure readings were high.[5] However, no evidence has been provided that underlying contributing factors such as pain, unwellness, or signs of distress were considered and/or followed up by the RN team at Avondale Lifecare. Mrs A has also told HDC that neither she nor the rest of Mrs B's family were aware of these high blood pressure readings at the time.

32. During 2022, the clinical records also reflect that Mrs B had unintended weight loss. Mrs B's initial weight on arrival at Avondale Lifecare on 20 December 2017 was 89.5kg. In January 2019, Mrs B's weight was 87.2kg, with a gradual decline from 76.3kg in January 2021 to 51.9kg in August 2022 and a total weight loss between 2021 and 2022 of nearly 25kg. As a result, on 17 March 2022, Mrs B's care plan was updated to note that she had been prescribed Ensure, a nutritional supplement, and her GP advised that she should be 'Assisted when feeding' and that staff were to continue monitoring her 'Food and fluid intake'. Formal 'weight loss report' forms, completed by staff of Avondale Lifecare to notify the GP of concerns regarding her weight loss, were dated 11 May 2022 and 26 August 2022 and counter-signed by the GP (noting the 'GP Response' part on both forms was signed by Avondale Lifecare's GP and dated 29 August 2022, after Mrs B had passed away, which the GP confirmed must have been incorrectly dated).

33. Despite Mrs B's weight loss over this time, Mrs A and the rest of her family told HDC they were not kept updated about Mrs B's progression of frailty after COVID-19. The only notes on the family communication records provided by Avondale Lifecare reflected a call made to Mrs A on 14 February 2022 about Mrs B's weight loss and a note on Mrs B's care plan that Mrs A was informed about the 17 March 2022 change in her care plan.

34. After Mrs B contracted COVID-19 in March 2022, her clinical records show that her health and wellbeing declined and, as noted in paragraphs 21 and 22, she spent time in Auckland Hospital between 7 and 15 March 2022. During this time, Mrs B's medications were reviewed, but there was no evidence that weighing frequency was increased or that a short-term care plan to monitor Mrs B's care was put in place on her return, in accordance with Avondale Lifecare's policy guidance.

35. Clinical advice on Mrs B's discharge from hospital on 15 March 2022 was that the quetiapine medication should no longer be prescribed or given to Mrs B and that haloperidol be changed to PRN [as needed]. Mrs A told HDC that clinicians were concerned that Mrs B was being given quetiapine medication on a daily basis and that, as EPOA for her mother, she had not consented to and/or been made aware of this. Although Mrs B's discharge notes from Auckland hospital advised that she should no longer receive quetiapine and haloperidol only as required, an entry on Mrs B's care plan on 17 March 2022 in relation to her dementia needs stated, 'was managed with regular quetiapine but now she is on PRN.'

[5] With the two highest recordings being for April 2022 (187/97) and July 2022 (190/71) compared with January to March 2022 readings of 147/74, 140/80, and 145/80.

36. On 24 March 2022, Mrs B's family wrote to Avondale Lifecare in response to their letter dated 17 March 2022 (see paragraph 23). As well as asking further questions about Mrs B's care regarding its acknowledgment of failures during the COVID-19 period, they also raised concerns about other elements of Mrs B's care, including not being made aware of changes to her medication.

37. On 31 March 2022, the Avondale Lifecare GP conducted a medical review for Mrs B and noted 'Progression of frailty post COVID[-19].' Mrs B's progress notes record that the RN team called Mrs A to advise her of this. Despite this, there is no evidence that the nursing team carried out any further assessments or reviewed her care plan.

38. On 30 May 2022, progress notes for Mrs B note that she presented with signs of vaginal discharge. One of the RN team was made aware of this and asked carers to monitor Mrs B, though it appears the RN did not complete a physical assessment. This was despite Mrs A having previously made the RN team aware that Mrs B had a history of recurrent UTI, which can be the cause of vaginal discharge. Mrs A was not made aware of the vaginal discharge.

39. On 31 May 2022, progress notes for Mrs B further note signs of vaginal discharge 'pale red in colour.'

40. On 2 June 2022, Mrs B saw her GP for a three-monthly review, and the clinical records query the cause of the vaginal discharge. The Assistant Manager of Avondale Lifecare contacted Mrs A that same day as Mrs A was concerned as to why blood tests had been requested when a vaginal swab had not. Mrs A subsequently received a further email on 3 June 2022 advising that a vaginal swab had been taken from Mrs B.

41. Mrs B's records show that she had three vaginal swabs taken: on 3, 10, and 15 June 2022. Mrs A told HDC that she was not notified about the swab taken on 10 June 2022. Avondale Lifecare had told her that the first two swabs had been lost, but her enquiries with the laboratory revealed that they were 'incorrect' when received from Avondale Lifecare. Although Mrs B's care plan was updated, her goals for care after this incident were not. The RN team also did not change their practices, despite guidance from the GP in relation to Mrs B's ongoing care.

42. On 21 June 2022, the GP was called because of discolouration of Mrs B's urine and vaginal discharge. On 25 July 2022 and 3, 11, and 13 August 2022, Mrs B's progress notes reflect that she still had a vaginal discharge. Mrs A and/or her family were not notified of this.

43. The progress notes from the morning of 18 August 2022 show that Mrs B had signs of fatigue and reduced appetite. In the afternoon, carers reported that Mrs B was also less responsive. An RN assessed Mrs B at 3.38pm and noted that her vital signs were elevated[6] and informed management. Although this information was escalated to Avondale Lifecare senior nursing staff, there is no record to show that her GP and/or Mrs A or her siblings were informed,

[6] Blood pressure 169/76, blood sugar 15.3mmol.

nor was a pain or neurological assessment completed, which may have identified signs of a stroke.

44. Mrs B continued to deteriorate. At 8.25pm, although the progress notes indicate that an RN was concerned about Mrs B being 'so qu[iet] not responding when talking to her', the RN team did not check her vital signs again until 10.00pm; there was also no escalation to the GP and/or Mrs A or her siblings.

45. Progress notes indicate that, at 1.30am on 19 August 2022, Mrs B's baseline observations 'continue[d] to increase.' As a result of the RN's concerns, an ambulance was called and Mrs B was taken to hospital at 3.05am. Mrs B's hospital admission records note that she was experiencing aphasia and hemiplegia[7] and 'known severe dementia.' Records reflect that phone messages were left for Mrs A only at 2.00am and 2.35am, just before the hospital transfer, to inform her that her mother was being transferred to hospital. However, Mrs A said that they were advised of the urgency of the situation only upon arrival at the hospital.

46. Mrs A told HDC that she was concerned that, despite the urgency of the situation for Mrs B between 18 and 19 August 2022 (classed as 'Code Red') and her deteriorating condition, messages were left on her phone, and other family members listed as emergency contacts for Avondale Lifecare were not called.

47. Sadly, Mrs B passed away from an ischaemic stroke (a stroke caused by the narrowing or blockage of a blood vessel supplying the brain) while in hospital in late August 2022.

48. Although Mrs A was involved in Mrs B's initial care plan up to 2019, despite Mrs B's changing needs, there is no evidence to demonstrate that Mrs A had the opportunity to review and provide feedback on the care plan at the required six-monthly intervals between 2019 and her passing in August 2022.

49. Mrs A and her family also told HDC that they were concerned Avondale Lifecare did not consult with them in relation to changes in Mrs B's medication and that another resident's name had been used on occasions on their mother's records in relation to her 'Intervention Care'. Mrs B's family also told HDC that they felt their mother was 'not treated with respect and her care was substandard.'

Changes made

50. Avondale Lifecare has confirmed that, in response to these complaints, it has made substantial changes towards improving its services around communication, complaint management, and documentation standards and processes. Appendix A includes Avondale Lifecare's corrective action plan outlining their substantive changes.

[7] Aphasia is a loss or impairment of the power to use or comprehend words, usually resulting from brain damage (such as from a stroke, head injury, or infection). Hemiplegia is total or partial paralysis of one side of the body that results from disease of or injury to the motor centres of the brain.

In-house aged care and clinical advice

51. To assist me in my assessment of these complaints, I sought in-house advice as follows:

a. From Jane Ferreira, former Nurse Advisor (Aged Care) for HDC (attached as Appendix B), who reported the following departures from the expected standard of care in relation to the nursing care that Avondale Lifecare provided to Mrs B during the COVID-19 pandemic between 1 December 2021 and 31 March 2022:

Mild–moderate departure – for infection control processes, mainly relating to a lack of evidence that key infection prevention and control steps were carried out.

Moderate–significant departure – relating to communication and documentation around the COVID-19 booster, including failing to respond to an email dated 20 December 2021 from the EPOA, Mrs A, giving consent to the booster, and failing to book in the booster or escalate concerns regarding the missed booster.

Moderate departure – relating to the care provided when COVID-19 was present and communication with the EPOA (also noting that there did not seem to be regular updates on Mrs B's health, evidence that the GP was informed or a short-term nursing plan commenced, or that any intentional rounding was put in place to ensure her care and safety needs were maintained).

b. From Ms Ferreira (attached as Appendix C), who reported the following departures from the expected standard of care in relation to other areas of nursing care provided to Mrs B during 2022, including her changing needs in care due to her unintended weight loss and declining health as well as for her diabetic management:

Mild departure – due to lack of clinical leadership and care oversight from the senior nurse, with apparent poor communication with family regarding her changing needs and goals for care.

Mild departure – regarding accuracy of documentation within care plan guidance and deviations in care planning processes.

Mild–moderate departure – as there appears to be minimal evidence of senior nurse oversight, data analysis, or regular nursing reviews to reduce clinical risk in relation to Mrs B's monthly monitoring.

Moderate–serious departure – relating to deviations in nursing processes regarding timely assessment, effective care planning, care partnership, and communication.

c. From Dr David Maplesden, GP (attached as Appendices D and E), who reported the following comments relating to the care provided by Dr C.

Comment – In relation to stopping Mrs B's antihypertensive medication (referred to in paragraph 30), Dr Maplesden stated that best practice would have been for Dr C to have had a direct discussion with Mrs A, as Mrs B's EPOA, rather than the nursing staff.

Comment – In relation to the management of Mrs B's antipsychotic medication, Dr Maplesden stated that Dr C's co-prescribing of quetiapine and haloperidol for the management of Mrs B's behavioural symptoms 'outside specific circumstances like brief cross-titration when changing medications' was inconsistent with accepted practice.

Comment – Dr Maplesden also stated that nursing staff continuing to administer quetiapine to Mrs B even though Dr C had ceased it and did not re-start it represents a departure from accepted nursing practice.

Responses to provisional decision

52. Mrs B's family were given an opportunity to respond to the provisional decision and expressed how distressed they were regarding the lack of discussions with them by Avondale Lifecare and Dr C about their mother's condition. Other information has been incorporated into this decision where relevant.

53. Avondale Lifecare was given an opportunity to respond to the provisional decision and confirmed it accepts the provisional decision and proposed course of action.

54. Dr C was also given an opportunity to respond to the provisional decision and accepted the comments made. Dr C confirmed he would incorporate the recommended learning points into his future practice when providing medical services to residents at Avondale Lifecare and elsewhere.

Decision

55. Mrs B was a vulnerable resident with many medical conditions, and she relied on Avondale Lifecare to provide appropriate services with regards to her care and safety. I commend Mrs B's family for bringing these concerns to HDC's attention and their reasons for doing so for the protection of others. Although I also acknowledge that the COVID-19 pandemic brought many challenges for health services, particularly for those in the aged care sector, guidance was in place and available that Avondale Lifecare should have ensured its staff were following.

Avondale Lifecare – breach

56. To achieve a timely and pragmatic resolution of the complaint, Avondale Lifecare was given copies of the in-house advice referred to in paragraph 51, and HDC proposed to find it in breach of Right 4(1) of the Code, which states that 'every consumer has the right to have services provided with reasonable care and skill.' I proposed this option, having accepted my Aged Care Advisor's findings of mild, moderate, and significant departures from the accepted standards of care by Avondale Lifecare under the COVID-19 Protection Framework in relation to its infection control processes, communication and documentation around the COVID-19 booster, and the care provided when Mrs B contracted COVID-19. I also accepted my Aged Care Advisor's findings that there were further mild, moderate, and serious departures in relation to other areas of care provided to Mrs B since 2022 in relation to the failure to reduce Mrs B's clinical risk and for deviations in nursing processes regarding timely assessment, effective care planning, care partnership, and communication. In response, Avondale Lifecare accepted the proposal of a breach finding of Right 4(1).

57. Since Avondale Lifecare accepted the proposed breach finding, I also obtained further advice in relation to the management of Mrs B's antipsychotic medications, quetiapine and haloperidol. I have also accepted Dr Maplesden's advice that nursing staff continuing to administer quetiapine to Mrs B even though Dr C had ceased the medication and not re-started it also represents a departure from accepted nursing practice.

58. Accordingly, I find that Avondale Lifecare did not provide services to Mrs B with reasonable care and skill and breached Right 4(1) of the Code in the care it provided between 1 December 2021 and 19 August 2022.

Dr C – educational comment

59. I note that Dr Maplesden made some comments that, although reasonable clinical decisions were made to consider stopping Mrs B's medication and to consider a conservative approach in relation to Mrs B's vaginal discharge, best practice would have been for Dr C to have had discussions with Mrs B's family/EPOA about these clinical decisions as well as in relation to his management of, and any changes to, Mrs B's antipsychotic medications, namely quetiapine and haloperidol, which I accept. I also accept Dr Maplesden's advice that co-prescribing quetiapine and haloperidol for Mrs B, unless in specific circumstances referenced in his advice above, and based on the principles of minimising antipsychotic use in dementia, was inconsistent with accepted practice. I recommend Dr C consider Dr Maplesden's comments if similar circumstances arise for a patient in the future and in relation to seeking informed consent from a patient or their EPOA/legal representative and documenting this information. I also recommend Dr C follow Dr Maplesden's advice in relation to reviewing the cited BPAC guidance.

60. Dr C explained that signing and dating the weight loss report form after Mrs B's passing was an administrative error on his part, and he apologised for the distress to Mrs B's family. In this regard, I recommend Dr C take care to ensure information in clinical records is recorded accurately and promptly given the distress this has caused Mrs B's family.

Follow-up actions

61. A copy of this report will be sent to Mrs A, Avondale Lifecare, and HealthCert.

62. A copy of this report with details identifying the parties removed, except Avondale Lifecare and my in-house advisors, will be sent to the Health New Zealand – Health of Older People Team and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Avondale Lifecare's corrective action plan

Corrective action plan

Service development item	Development work required/undertaken	Expected Outcome	Time frame	Priority High/med/ low	Accountability or Completion date
Compliance with Covid Protection Framework -	1.Provide additional senior clinical support	Additional support provided to CHM and staff.	Now	High	Completed 14/3/22
	2.Remove and replace current Clinical Nurse Leader (CNL)	Care home and staff will be able to move forward with improvements. Improved quality of clinical leadership will be provided.	By end of month	High	Completed. Assistant manager commencing 28/3/22
	3.Ensure all ICP are in place and followed consistently. IPC practices will be audited and reviewed and where necessary updated so that they are fit for purpose, understood by the team, and are followed.	That residents and staff are always kept safe. IPC are in place and consistently and diligently followed and used.	Now 2 weeks	High	CHM and senior clinical support
	4.Ensure training on ICP is undertaken so staff understand ICP principles and policies. Training, coaching and mentoring of all staff.	That all staff will show a clear understanding of ICP and will carry these out accurately and diligently.	By end of month and ongoing	High	CHM/ Senior clinical support
	Training and coaching to be delivered through staff meetings and organised training sessions. Training plan to be developed.	That staff will receive regular training and education.	By end of month	High	Senior clinical support

Service development item	Development work required/undertaken	Expected Outcome	Time frame	Priority High/med/ low	Accountability or Completion date
	Lunch bag/ toolbox training sessions delivered at beginning of shifts.	That training will happen even when there are constraints around time and human resources.	Now and Ongoing	Med	Senior clinical support
	Evidence to be sighted for ICC training held onsite . Information is available around the facility and is visible to staff.	A listing of training held to be included in investigation notes	Now	High	CHM and Senior clinical support
	RNs to take more responsibility on the floor – supervising HCA's. CNL to be more active on floor – supervising and supporting RN's and HCA's.	That there will be a higher level of oversight and monitoring on the floor for staff.			
Communication and information sharing	1.Responsibility for communication with families is to be returned to the Registered nurse on duty.	To ensure that information is given in a timely manner with all relevant details.	Now	High	CHM and Senior clinical support to ensure this is communicated and put into place.
	2.Requests for information from families are to be responded to in a timely manner – reminders and education to be provided to RNs on the importance of this information sharing. Processes to be audited and reviewed/updated.	That there will be a system in place to follow up on enquiries from families and others.	Now	High	Senior clinical support
	3.Methods and channels for information sharing between staff are reviewed and improved to ensure information is recorded and shared clearly, appropriately and in a timely manner.	All staff will report an improvement in their knowledge and confidence that they are now consistently aware of all information they need to care for our	1 week	High/med	CHM and Senior clinical support

Service development item	Development work required/undertaken	Expected Outcome	Time frame	Priority High/med/ low	Accountability or Completion date
		residents and their families to a high standard.			
Clearly understood and consistent instructions and processes for staff and visitors are available and in place	1.Education and training are to be provided to all staff on the correct process for admitting a visitor to the facility.	That all staff will know and understand the processes and will follow this consistently at all times of day(s).	2 weeks	Med	CHM and Senior clinical support
	2.A checklist is in place for staff to refer to.	They will have the resources they require to complete that task consistently.	2 weeks	Med	CHM, Senior clinical support and admin
	3.Signage is clear for visitors to explain the process, so they are aware of the requirements.	Visitors entering the facility will be fully informed of what to expect and what is required of them.	2 weeks	Med	CHM, Senior clinical support and admin

Appendix B: In-house clinical advice (aged care) to the Commissioner

The following in-house clinical advice was obtained from Nurse Advisor (Aged Care), Jane Ferreira, dated 21 June 2023 and 17 June 2025.

CLINICAL ADVICE – AGED CARE

CONSUMER : Mrs [B]

PROVIDER : Avondale Lifecare

FILE NUMBER : C22HDC00619

DATE : 21 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 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.
2. **Documents reviewed.**
   - Letter of complaint dated 9 March 2022
   - Provider response dated 25 August 2022
   - Clinical records, including progress notes, care, and communication records.
   - Organisational policies, including Outbreak Management, Pandemic Guidance and Management, and Infection Control Documentation Requirements.
   - Additional information received 17 April 2023, including updated organisational policies, infection control audit, staff training records, and a completed corrective action plan with evidence of sign off by Te Whatu Ora – Health New Zealand Te Toka Tumai Auckland District Quality and Monitoring Manager, 23 February 2023.
3. **Complaint**
   Mrs [B]'s daughter and Enduring Power of Attorney (EPOA) for personal care and welfare, Mrs [A], has raised concern regarding the care and communication provided to her mother, Mrs [B], while resident at the care home between 1 December 2021 and 31 March 2022.
4. **Review of clinical records**
   For each question, I am asked to advise on what is the standard of care and/or accepted practice? If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be? How would it be viewed by your peers? Recommendations for improvement that may help to prevent a similar occurrence in future.

In particular, comment on:

- The COVID-19 policy and procedures for the management of infection control and visitors
- The booster vaccination process
- Communication and complaint management processes
- Suitability of the corrective action plan.

Background

File information indicates that Mrs [B] was a resident in the hospital community at the care home and required regular support from carers to meet activities of daily living. Her medical history included dementia, type 2 diabetes, osteoarthritis, cardiovascular disease, hypertension, and chronic lower back pain.

Mrs [B]'s family have raised concern regarding the care home's COVID-19 booster vaccination schedule and related communication processes, which resulted in a missed dose for Mrs [B]. Mrs [B] then contracted COVID-19 in March 2022 and required hospitalisation. She returned to the care home on 15 March 2022 for further care.

- **Whether Avondale Lifecare adhered to COVID-19 policy and procedures for the management of infection control and visitations within the care home, as per the Ministry of Health guidelines current at the time of the complaint?**

The COVID-19 Protection Framework, or traffic light system, was introduced across Aotearoa New Zealand on 2 December 2021. On 30 December 2021, the Auckland region moved to the Orange alert level. On 23 January 2022, all New Zealand moved to Red in response to the first confirmed community case of Omicron, which remained in place for several weeks. During this time, different response phases were introduced, with changes made to contact tracing and reporting requirements. A supporting guidance document was developed by Te Whatu Ora Health New Zealand for aged care providers, which recommended that high levels of vigilance continued due to the vulnerable population of older adults living in care homes. This included the use of risk assessments, appropriate personal protective equipment (PPE) and hand hygiene, education, vaccination, and booster programmes.

The organisation's policies appear to relate to pandemic and outbreak management guidance and recommended practice standards, as outlined in the Aotearoa New Zealand Pandemic Response Policy for Aged Residential Care, which contained relevant guidance for service providers to inform their local pandemic response plans, in partnership with regional infection control and public health care teams. It is unclear from the limited evidence provided whether the care home leadership team sought or received support from their regional health colleagues regarding COVID-19 management. Progress notes reviewed for the time in question discuss care provided to Mrs [B] with evidence of medical assessment by her general practitioner (GP); however, there is no specific commentary made regarding infection control practices or specific visiting requirements. It is unclear if recommended precautionary screening measures occurred to monitor resident health and wellbeing, such as daily recording of resident

temperatures, or changes to vital sign observations during the time in question, with no supporting evidence sighted within submitted documentation.

As outlined in Te Whatu Ora | Health New Zealand COVID-19 guiding documents, infection prevention and control (IPC) processes are key responsibilities for service providers, with requirements to evidence safe practice in line with Health and Disability Service Standards, clinical governance, and quality improvement processes. The letter of complaint raises concern regarding IPC practices demonstrated by the care team. As outlined in COVID-19 guiding documents, effective IPC practice requires teamwork. The application of policy guidance to practice can be difficult during outbreaks and requires consistent operational and clinical leadership, with a range of educational sessions and training resources to prepare and support care home teams. The provider has submitted a completed corrective action plan outlining improvements in response to this complaint. The document contains relevant discussion of monthly data collection and reporting requirements related to resident incident and infection events, including staff education and training requirements. It is unclear if external health experts engaged in supporting the care home's internal education programme, which would be considered a recommended approach in the circumstances. The action plan provides discussion of IPC policy requirements and practice responsibilities for staff and visitors and completion of relevant audits in line with accepted quality improvement processes. The action plan was reviewed by Te Whatu Ora | Health New Zealand – Te Toka Tumai Auckland District Quality and Monitoring Manager, and criteria appear to meet the agreed health sector standards.

While the visitor's policy was not included in the evidence bundle, the organisation's Outbreak Management policy (Nov 2022) provides discussion regarding notifying nominated representatives, with reasons for limiting or allowing discretionary visitor access, which appears acceptable. It is unclear what individual level of communication regarding visiting requirements was shared with the resident's nominated representatives as there is minimal reflection with the family/whānau contact record or progress note entries in Mrs [B]'s care record, which would be considered accepted practice in the circumstances.

From the evidence reviewed to respond to this question, it appears the provider's policy information was acceptable in the circumstances; however, there appear to be opportunities for improvement related to the application of IPC policies to practice and related standards of nursing documentation to support evidence-based practice, which would be viewed similarly by my peers.

Departure from accepted practice standards: Mild to moderate

*As a comment, I note this question was investigated by Te Whatu Ora | Health New Zealand in a report dated 9 August 2022. It is unclear what improvements have been made to organisational IPC policies and processes based on the health district review.

- **Do you consider the oversight and subsequent delay of Mrs [B]'s booster vaccination to have been avoidable, and were there opportunities for residents to be vaccinated earlier than March 2022?**

File information indicates Mrs [B] had received two vaccine doses, per health guidelines at the time, and was eligible for a booster vaccination at the end of 2021. While evidence of IPC recordkeeping was not provided for review, email communication shows that information regarding the booster option was sent to Mrs [B]'s EPOA by registered nurses (RNs) on 1 December 2021.

On 20 December 2021, Mrs [B]'s daughter and EPOA, Mrs [A], sent an email to the RN team consenting for Mrs [B] to receive a booster vaccination, and requested acknowledgement of email receipt. There is no evidence in file records that RNs responded to the email or followed up with the EPOA to request a signed COVID-19 vaccination consent form for the agreed treatment, which would be accepted practice in the circumstances. There are no corresponding entries reflected in the family/whānau record or in nursing progress notes regarding email communication content, 1 December and 20 December, which is considered an accepted part of service provider and RN responsibilities.

The care home visitor update, 22 December 2021, indicates the care home had been managing a suspected respiratory outbreak at the time, with unwell residents and staff. The document includes an update regarding the COVID-19 booster programme and reminder to family/whānau to return consent forms by 10am, 23 December 2021. It is unclear if the care home or clinical manager, the nominated IPC lead or a delegated RN was responsible for facilitating the planned vaccination day. Usual nursing process would be to collate resident consent forms per care home community, check resident data is entered in relevant nursing and IPC records, and ensure anticipated vaccination numbers are reported to the health provider (pharmacist in this case) in a timely way to support their responsibilities to cold chain management.

It appears there may have been competing priorities for the RN team at the time, given accounts of the outbreak; however, it is unclear why the clinical team did not check email communications between 20 and 23 December, which is a usual RN process, or provide rationale for the oversight. It is also unclear why the care home's RN team did not act following receipt of Mrs [B]'s EPOA communication consenting to a COVID-19 booster and escalate concerns to the clinical or care home manager, which would be accepted practice in the circumstances. Usual nursing practice would be to record the entry in the resident's clinical file, communicate concerns regarding the missed booster with the clinical manager, GP, and EPOA, and seek alternative solutions; however, there is no evidence in clinical file records that this process occurred. Given the recent outbreak and potential risk to Mrs [B]'s health and wellbeing, it is unclear why an alternative approach, such as a rescheduled GP or pharmacy visit was not considered, or guidance sought from the regional IPC and public health team in the circumstances.

From the evidence reviewed to respond to this question, it appears communication and documentation standards were below accepted practice standards at the time and would be viewed similarly by my peers. The provider has acknowledged this may have contributed to Mrs [B]'s missed booster vaccination and apologised but has not provided discussion of improvements to care home processes to reduce the risk of future events.

Service providers are required to complete contemporaneous documentation of care, communication, and service delivery occurring between the resident, their nominated representative, and the care home team. This provides a continuous history of interaction and evidence of informed care partnerships. It is unclear from the evidence provided if the event and related communication was recorded in the complaint management system or reported within incident management frameworks, which would be accepted practice in the circumstances.

Departure from accepted practice standards: Moderate to significant

- **Do you consider the communication between the care home and the family to be consistent and open regarding COVID-19 management strategies and concerns raised to the senior management team? In this instance, was the complaints process followed on all occasions?**

The organisation's Outbreak Management policy states that the resident's nominated representative will be informed of a suspected outbreak either by phone, text, email, or letter. Clinical file records provide limited evidence of communication between Mrs [B]'s EPOA and the care home team during the timeframe in question. There is evidence of general updates provided to family/whānau by the care home manager at the time but little discussion of care concerns. The provider has included copies of communication sent to families; however, it is unclear what individual contact occurred with nominated representatives or if meeting minutes were recorded as part of quality management processes.

A statement within email communication refers to a phone call between the care home manager and Mrs [B]'s EPOA regarding the results of a positive rapid antigen test (RAT) on 6 March 2022; however, this communication is not reflected in Mrs [B]'s submitted care record, which would indicate a departure from accepted documentation and reporting standards. There is no evidence that the GP was informed, a short-term nursing care plan commenced outlining isolation and interim care requirements, such as increased monitoring of vital signs and nutritional requirements, particularly considering Mrs [B]'s diabetic status, or intentional rounding to ensure her care and safety needs were maintained, which would be accepted practice for a vulnerable resident.

It is unclear if Mrs [B]'s EPOA was regularly updated about the changes to her health status by the clinical manager or duty RN at this time, which would be considered accepted practice in the circumstances. The EPOA has the right to be fully informed about all aspects of care relating to the resident. The EPOA's role is to contribute to resident care planning in partnership with the service provider, to advocate for the resident, and provide informed consent to agreed care. Care partnerships are based on collaboration, which involves regular discussion, or consultation, with the EPOA and timely feedback to ensure the appropriate outcomes are achieved.

The communication policy was not provided in the evidence bundle; however, the corrective action plan indicates that communication processes were reviewed by Te Whatu Ora | Health New Zealand during the investigation process. The supporting action plan provides discussion regarding the escalation of complaints or clinical concerns with mention of improvement strategies.

From the evidence reviewed to respond to this question, it appears that the care and communication provided to Mrs [B] and her EPOA was below the accepted standard of practice in the circumstances and would be considered similarly by my peers.

Departure from accepted practice: Moderate

- **Do you consider the [District Health Board] (DHB) audit corrective action plan accurately reflects the deficits in the care home, and is there evidence these have been actioned to an acceptable standard in line with MOH guidelines?**

The provider response has highlighted challenges with the COVID-19 pandemic and related workforce issues that may have impacted the delivery of coordinated resident care at the time. The response letter has acknowledged concerns with communication, complaint management, and documentation standards and discussed strategies toward improvement as evidenced in the submitted corrective action plan. The corrective action plan has outlined improvements to care home processes, which were assessed as met by Te Whatu Ora | Health New Zealand – Te Toka Tumai Auckland District Quality and Monitoring Manager.

From the evidence reviewed to respond to this question, it appears the provider has considered areas for development, identified relevant actions, and introduced approaches to quality improvement that have been supported by the funder and deemed to have met the agreed criteria.

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 HDC online modules for further learning: https://www.hdc.org.nz/education/online-learning/

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

References

Health and Disability Commission. 2022. Online Learning. https://www.hdc.org.nz/education/online-learning/

Te Whatu Ora | Health New Zealand. 2022. COVID-19 information for aged residential care providers. https://www.tewhatuora.govt.nz/for-the-health-sector/covid-19-information-for-health-professionals/covid-19-information-for-specific-sectors/covid-19-aged-care-disability-and-hospice-providers/covid-19-aged-care-providers

Further in-house clinical advice from Nurse Advisor (Aged Care), Jane Ferreira:

CLINICAL ADVICE – AGED CARE

CONSUMER : Mrs [B]

PROVIDER : Avondale Lifecare

FILE NUMBER : C23HDC01619

DATE : 17 June 2025

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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 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.

2. **Documents reviewed**
   - Letter of complaint received 22 June 2023
   - Provider response dated 6 March 2024
   - Clinical records, including nursing assessments, care plans, progress notes, monitoring forms, health and communication records,
   - Organisational policies and information, including Nutrition and Hydration, Guidelines for Communication, GP Services, Adverse Events, Complaints, Training records, meeting minutes.
3. **Complaint**

   Mrs [B]'s family/whānau have expressed concern regarding the care provided to their mother while resident at the care home. Specific areas of concern relate to medication management, clinical oversight, pressure injury prevention and management, nutritional needs, and delivery of person-centred care.

   <u>Background</u>

   Mrs [B] was admitted to the care home in 2017 and resided at hospital-level care. Her medical history included dementia, type 2 diabetes, osteoarthritis, cardiovascular disease, hypertension, and chronic lower back pain. File information showed that Mrs [B] required a high level of assistance to meet all activities of daily living. Mrs [B]'s family/whānau have raised concern regarding aspects of nursing care, which I have been asked to review.

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

In particular:

a) Please comment on the nutritional oversight and weight management provided to Ms [B] between late 2021 and August 2022.

The Nutrition and Hydration policy provides guidance about meeting residents' nutritional needs, identification of risk and related role responsibilities. The policy states that residents will be weighed monthly unless directed by the general practitioner (GP) or registered nurse (RN). Where weight loss is identified, consider increased weight monitoring, fluid balance and food charts with goals and care interventions addressed in a short-term care plan (STCP). Guidance states that a nutritional plan is required to be in place for residents at high risk of weight loss, with criteria noted about GP and dietitian involvement.

Reviewed InterRAI clinical assessments (2018, 2019) and summary information (2020, 2021) suggest that Mrs [B] was at low risk of undernutrition. Supporting comments state that her weight was stable with body mass index (BMI) scores ranging between 36 and 29 across this timeframe. As outlined in health resources, scores lower than 18.5 may indicate clinical concern (HQSC, 2023).

Unfortunately, evidence of InterRAI records or additional nutritional assessments were not supplied for 2022 to inform further comment.

Mrs [B]'s long-term care plan, implemented in 2019, outlined her eating and drinking abilities, nutritional care and safety needs. Care monitoring interventions included monthly weight recordings with alerts to seek GP involvement regarding signs of weight loss or gain. Records show that care plan evaluations (2020) occurred regularly and discuss nutritional status, with entries indicating that Mrs [B]'s weight was trending slightly downwards. Evaluation comments (2021) state that Mrs [B] remained independent with eating and drinking and that she maintained a stable weight. Evaluation records in 2022 describe signs of increasing frailty and a need for further support.

Older people living with multiple comorbidities and identified frailty are considered to be at risk of clinical deterioration. Signs of decline may include health changes, reduced independence, weight loss and altered nutritional needs. Care planning is recommended to be holistic and person-centred, with realistic goals for care developed in partnership with the resident, family/whānau and healthcare team (HQSC, 2023).

Clinical observation records show that Mrs [B]'s vital signs and weight were generally recorded monthly per care plan guidance during the timeframe in question. However,

records (2021) suggest that her weight was not stable. Submitted data shows a gradual decline in weight between January (76.3kg) and August (71.5kg) followed by a further 9kg loss to December (62.5kg). Monitoring records (2022) report a decrease of almost 10kg between January (61kg) to August (51.9kg). It appears that the GP was informed of the unintended weight loss using the organisation's notification tool, with clinical instructions to continue the prescribed nutritional supplement. Medication administration records were not supplied to inform further comment.

Reviewed progress notes during the timeframe in question describe care occurring. Entries state that Mrs [B] was eating and drinking well with assistance, with no signs of nutritional concern reported until she was transferred to hospital on 7 March 2022. Further entries in the care record describe a decline in health and wellbeing post-COVID-19 exposure and hospital admission. Care comments discuss weight loss, increased assistance needed with eating and drinking, and commencement of a prescribed nutritional supplement. It appears that weighing frequency was not increased following hospital admission, with no rationale provided. There is no evidence to show that an STCP with nutritional monitoring forms was implemented to inform evidence-based care decisions, per policy guidance.

Records show that Mrs [B] was seen by a Gerontology Nurse Specialist on 8 April 2022 in response to raised clinical concerns during her hospital admission. The report stated that Mrs [B] was considered to be eating and drinking well, weight was reviewed with comments provided about a diabetic diet and monitoring of blood glucose levels. Health records report that Mrs [B] had type 2 diabetes, was on prescribed diabetic medications and required a special diet. I note the reviewed care plan provided poor guidance about her diabetic management, nutritional and clinical needs, and wider nursing responsibilities to safe resident care.

From the evidence reviewed to respond to this question, it appears that the care home had recognised systems and processes in place to direct resident care. However, while daily records show that routine care was occurring, there appears to be a lack of clinical leadership and care oversight provided by the senior nurse in Mrs [B]'s care, with apparent poor communication with whānau regarding her changing needs and goals for care. I acknowledge this was a difficult time with pandemic restrictions and competing priorities but still consider there to be mild deviations from accepted practice, and this would be viewed similarly by my peers.

- Departure from accepted practice. Mild in the circumstances

b) Please comment on the accuracy of documentation within care plan guidance.

The Age-Related Residential Care (ARRC) Services Agreement states that providers will acknowledge the significance of the resident's family/whānau or nominated representative and ensure they are involved in decisions affecting the resident's life. Section D (16.3;16.4) outlines contractual responsibilities to nursing assessment, care plan development, and evaluation processes, noting a requirement for partnership and involvement by the resident's nominated representatives.

It is considered accepted practice that a resident's care plan will be created from formal nursing assessments, resident and family/whānau feedback and related health information. Records show that following Mrs [B]'s admission to the care home, an initial InterRAI assessment was completed (2018) which referred to assessed levels of ability and required assistance. The report stated that information was gathered from Mrs [B], her daughter, file documents, qualified, care and allied team members. As outlined in the ARRC agreement, following the assessment process providers will ensure that nominated representatives are included in care plan development, care evaluation and resident review meetings. It would be considered accepted practice that, following the six-monthly care review process, the EPOA is invited to review the care plan, provide feedback and sign the document to reflect their agreement with the current approaches to care. Records show that Mrs [B]'s care plan was signed by her daughter/EPOA on redevelopment in 2019; however, the tool provides no evidence of EPOA review or involvement in further resident/family review processes, which is concerning. While meeting minutes were not supplied to reflect care partnership, communication records suggest that resident reviews were conducted remotely with nominated representatives due to pandemic restrictions in place at the time. It is unclear whether Mrs [B]'s EPOA was given the opportunity to review the long-term care plan and evaluation comments (2020–2022) at six-monthly intervals and provide a response regarding care interventions.

Records indicate that Mrs [B]'s needs were changing in 2022, with increased assistance required to reposition and manage daily activities. It would be considered accepted practice to ensure that essential care information was added to the care plan, including associated risk factors and personalised interventions, to guide delivery of appropriate resident care. From the evidence reviewed and discussion points, there appear to be deviations in care planning processes, which would be viewed similarly by my peers.

- Departure from accepted practice: Mild in the circumstances

c) Please comment on nursing oversight of blood pressure between 2019 and 2022 for Mrs [B] and whether follow-up of any alteration is within accepted practice.

Records show that Mrs [B]'s health history included hypertension and a previous stroke event. Progress notes from February 2019 state that she had been seen by her GP, with prescribed medications reviewed and antihypertensive medications discontinued. Clinical orders were documented in progress notes by a senior RN, which stated to check blood pressure (BP) recordings monthly. The care plan provided guidance for recording monthly observations, noting a baseline BP range. Medical notes show that Mrs [B] was seen at least three-monthly with current BP readings and weight reported in clinical notes. Records show that Mrs [B] was well known to the GP, who had been regularly involved with her care since her admission. Care plan evaluation comments 2020–2021 state that she was considered to be clinically stable.

Mrs [B]'s care plan stated that she was at risk of stroke with instructions to report signs of health concern or any change in normal BP range to her GP. Reviewed monthly

monitoring records appear to show that readings were at times notably higher than the suggested BP range. Corresponding progress notes provide no discussion of related nursing actions such as repeat recordings or escalation of concern to the GP for further guidance. Monitoring records 2022 report elevated BP readings across months, but there appears to be a lack of consideration of underlying contributing factors, such as pain, unwellness or signs of distress with no evidence of nursing follow-up or evaluation of care.

From the evidence reviewed, it appears that, while monthly monitoring records were completed, there is minimal evidence of senior nurse oversight, data analysis or regular nursing reviews occurring to reduce clinical risk. This would be considered a mild to moderate deviation from nursing responsibilities in the circumstances.

- Departure from accepted practice: Mild to moderate

d) Please comment on pressure injury management during the late 2021–2022 period of admission.

The Health Quality & Safety Commission Te Tāhū Hauora (HQSC) Frailty Care Guides provide information about prevention and treatment of pressure injuries to inform nursing practice. The tool includes a recommended bundle of care to guide clinical decisions and nursing actions based on assessed risk. Discussion points include use of pressure-relieving equipment (mattress, cushions, heel protectors), position changes, management of continence, visual skin checks, review of nutritional needs, with monitoring of food and fluid intake, and increased frequency of weight monitoring.

The organisation's Pressure Injury Prevention policy outlines a range of contributing factors to compromised skin integrity with discussion of assessment and care responsibilities. The policy states that a Pressure Area Risk Assessment will be completed on admission and assessments repeated at regular intervals.

InterRAI data and care plan information stated that Mrs [B] was considered to be at high risk of pressure injury. The care plan referred to a risk of incontinence-associated dermatitis with generic interventions in place to support good skin integrity. Pressure-relieving strategies are discussed, such as equipment use (air mattress, slide sheets) with instructions to inspect skin daily and report signs of change or concern to the RN. Progress note entries regularly discuss position changes, delivery of personal care and support with continence needs. File information refers to a chronic, recurring, irritable rash on Mrs [B]'s buttocks. Progress notes describe the regular application of barrier creams as a preventative strategy to protect the skin and restore moisture. Care plan evaluations comment on skin integrity over time with no discussion of an identified pressure injury. It appears that care strategies in place at the time were considered appropriate, with no changes made to the management of Mrs [B]'s skin integrity, or review of risk factors noted. Evidence of any short-term care plans and wound care records for pressure injury care were not sighted/supplied to inform further comment.

Records show that Mrs [B] became medically unwell and was transferred to hospital on 7 March 2022. Following treatment, she returned to the care home and was seen by a Gerontology Nurse Specialist on 8 April 2022. Clinical notes comment on a review of blanchable erythema on Mrs [B]'s buttocks. Care guidance was provided, which included discussion of pressure-relieving strategies, position changes every 30 mins, full daily skin checks and use of barrier creams. Corresponding progress notes discuss the visit and state 'happy with the cares provided'.

From the evidence reviewed to respond to this question, file information indicates that the care home had recognised systems and processes in place regarding the prevention and management of pressure injuries, which appears to be appropriate.

- Departure from accepted practice: Nil

e) Please comment on the assessment and follow up of most recent medical concerns (specific to COVID-19 March, vaginal discharge late May; and stroke in August 22), were these managed in a timely manner and aligned with accepted nursing practice.

COVID-19

RN entries in the progress notes of 7 March 2022 discuss signs of unwellness, vital sign monitoring, RN actions, care escalation and reporting processes that appear appropriate in the circumstances. An entry on 10 March 2022 reflects RN enquiry about Mrs [B]'s health and wellbeing, which shows responsibility for maintaining a professional care relationship. Records show that Mrs [B] returned to the care home on 15 March 2022, with progress notes discussing nursing actions, which included skin and vital sign assessments, and discussed communication with whānau. Records show that Mrs [B] was seen by the GP on 31 March 2022, with clinical notes reporting progression of frailty post-COVID. Supporting nursing notes outline the GP visit, noting no changes in medications and that family were updated. While there is evidence of care plan review on 17 March 2022, it appears that additional nursing assessments were not completed. Given the signs of increasing frailty, it would be recommended practice to complete a holistic review to ensure that essential elements of care remained current and aligned to goals of care.

Vaginal discharge

Respected health resources state that vaginal discharge in older women can be caused by conditions such as bacterial or urinary tract infections (BPAC, 2025). While age-related changes can contribute to discomfort, it is recommended to seek medical attention for symptoms of concern such as an unusual discharge (HQSC, 2023).

Progress notes state that Mrs [B] presented with signs of per vaginal (PV) discharge in late May 2022. Records state that an RN was informed who advised carers to monitor for further signs of concern. While further records reflect RN entries, there is no

discussion of any nursing assessments completed. It would be considered accepted practice for the RN to physically assess a resident at this time, ensuring that vital signs and a pain assessment were recorded, associated signs of confusion or fatigue considered, and bowel records reviewed for constipation risk. Records show that Mrs [B] had a history of recurrent urinary tract infections, and communication records show this was highlighted to the RN team by Mrs [B]'s EPOA, who knew her mother well. There is no evidence to show this was acted on or that an STCP was implemented to guide precautionary care requirements (such as increased oral fluids, good perineal care and further observations) at this time.

Mrs [B] was seen by her GP on 2 June 2022 for a three-monthly review with routine blood tests ordered. There appears to be some confusion regarding indications for and timely collection of a swab for laboratory analysis and responsibilities for providing appropriate care updates to family/whānau. This may present an opportunity to strengthen clinical systems and policy information.

Clinical records query the cause of the PV discharge and refer to conservative management in view of advanced frailty and poor prognosis. While the care plan reflects that evaluation occurred 17 March 2022, there is no evidence to show that Mrs [B]'s goals for care and related nursing interventions were updated to align with GP comments or discussed with her EPOA, which would be considered accepted practice.

Stroke

The care plan stated that Mrs [B] was at risk of recurrent stroke or heart failure related to her medical history. Interventions stated to monitor vital signs monthly or if clinically unwell. Baseline recordings are reflected (BP 120/80–145/80), with instructions to refer to the GP if Mrs [B] presented with signs or symptoms of concern. I note the care plan provides no guidance about signs of stroke, care responsibilities or when to seek emergency support.

Care records show that Mrs [B] presented with signs of fatigue and reduced appetite on the morning of 18 August 2022. Entries on the afternoon shift comment that while she had finished her dinner, she appeared less responsive, with carer concerns escalated to the team leader, which aligns to prompts on the Stop and Watch tool. Records show that Mrs [B] was assessed by an RN, who has provided a comprehensive entry about signs of unwellness, elevated recordings and nursing actions. The RN checked Mrs [B]'s vital signs at 1538hrs with BP (169/76) and blood sugar (15.3mmol) readings higher than baseline information recorded in the care plan. Clinical concerns were escalated to care home leaders, but there is no record to show that the GP was informed. It appears that a pain or neurological assessment was not completed at this time, which may have identified signs of stroke. Records state that vital signs were next checked at 2200hrs, which is a concerning delay in care timeframes given the identified signs of change/decline. While the frequency of vital sign monitoring had been increased to two-hourly intervals by the senior RN […], there is no discussion of escalation to the GP, which would be considered accepted practice. An RN entry at 0130hrs identified significant concern with Mrs [B]'s presentation. Records show that a nursing decision was made to seek ambulance

support and transfer Mrs [B] to hospital for further care. Records also show that family had not been informed of the observed health changes across the day, with a phone message left prior to hospital transfer by the night shift RN.

The Frailty Care Guides provide a clinical reasoning tool to support RN actions during acute events and guide decision-making. It is recommended that RNs promptly seek GP/[nurse practitioner] NP guidance when signs of deterioration are identified to allow an appropriate plan of care to be implemented. Mrs [B]'s care plan stated that her health was slowly declining related to her health background, and GP notes discussed a conservative treatment plan. Clinical file information did not specifically discuss a palliative care pathway, or provide guidance for last days of life, therefore it would be recommended that nurses sought urgent GP/NP involvement to inform care decisions. Partnered with this is a responsibility to ensure that family/whānau are kept well informed during health events and are given the opportunity to be involved, advocate and offer support. Mrs [B]'s care plan stated that her EPOA wanted to be notified for every event or any changes in health status as soon as possible. The provider has acknowledged there were delays in openly communicating with Mrs [B]'s EPOA and delayed care during this time and apologised.

Summary

From the evidence reviewed to respond to this question, it appears that the care home team knew Mrs [B] well and were generally responsive to her needs.

There appear to be deviations in nursing processes regarding timely assessment, effective care planning, care partnership and communication, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious

Jane Ferreira, RN, PGDipHC, MHlth

Nurse Advisor (Aged Care)

Health and Disability Commissioner

References

BPAC NZ. 2025. Urinary tract infections (UTIs) – an overview of lower UTI management in adults. https://bpac.org.nz/2025/uti.aspx

Health Quality & Safety Commission Te Tāhū Hauora. 2023. Frailty Care Guides. https://www.hqsc.govt.nz/resources/resource-library/frailty-care-guides-nga-aratohu-maimoa-hauwarea-2023-edition/

Appendix C: In-house clinical advice to the Commissioner

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

'CLINICAL ADVICE – MEDICAL FILE STEER

TO	**:**	[HDC Investigator]
FROM	**:**	David Maplesden
CONSUMER	**:**	Mrs [B] (dec)
PROVIDER	**:**	Dr [C]
FILE NUMBER	**:**	C23HDC01619
DATE	**:**	29 July 2025; **Addendum 9 September 2025 (s 5-8)**

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1. My name is David Maplesden. I am a graduate of Auckland University Medical School, and I am a vocationally registered general practitioner holding a current APC. My qualifications are MB ChB 1983, Dip Obs 1984, Certif Hyperbaric Med 1995, FRNZCGP (Dist) 2003. Thank you for the request that I provide clinical advice in relation to the complaint from the family of the late Mrs [B] about the care provided to her 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:

- Navigator report […] dated 6 June 2025
- Response and supporting documentation Avondale Lifecare (AL)

3. The Navigator report is comprehensive and provides what appears to be an adequate and accurate summary of the available information regarding Mrs [B]'s care in AL. I will refer below to aspects of this report relevant to the issues on which I have been asked to comment. These issues are:

(i) Please comment on the GP management of Mrs [B]'s blood pressure during 2019–2022 and provide comment on complaint concerns no antihypertensive medication was recommenced despite elevated systolic readings in 2021 and 2022.

(ii) Please comment on the GP nutritional management in relation to weight loss throughout Mrs [B]'s admission.

(iii) Please comment on the GP oversight and follow-up relevant to presentations of Mrs [B]'s vaginal discharge, June 2022.

4. I am unable to identify any response from the attending GP, Dr [C], currently on file. The available information does not enable any insight into the clinical rationale for the various decisions made by Dr [C] in relation to the issues noted above, and such information requires consideration when attempting to quantify any departure from accepted practice if such departures exist. Some issues such as hypertension management in the frail elderly are complex and controversial, with multiple factors requiring consideration in clinical decision-making.[8] I recommend further information is sought from Dr [C] prior to me completing this report.

5. ***Please clarify when you first became aware of Mrs [B]'s weight loss and outline your management plan to investigate or address the weight loss, including the clinical rationale for any management decisions. Please include any alteration to your plan as Mrs [B]'s weight loss progressed, including whether dietitian referral was ever considered. Please outline any discussions you had with Mrs [B]'s EPOA (either directly or deputised to nursing staff) regarding management of her weight loss.***

(i) Dr [C] notes Mrs [B]'s background history of severe dementia (EPOA activated approximately eight years prior), cerebrovascular disease, type 2 diabetes mellitus, hypertension, obesity (BMI —40 at baseline), osteoarthritis, chronic lower back pain and previous depression (2007) with a paracetamol overdose (2014). Dr [C] states *Functionally, Mrs [B] was profoundly dependent—bed and chair bound, requiring two-person assistance for all cares. She had double incontinence, required constant supervision while eating, and intermittently needed assistance with feeding. Despite her frailty, she continued to eat and drink adequately on a diabetic-appropriate diet.* Mrs [B] passed away at Auckland City Hospital [in late] August 2022 following a left anterior cerebral artery (ACA) territory infarct.

(ii) Dr [C] believes Mrs [B]'s weight loss was likely evident from early in her time at AL and was not unexpected given her pre-existing morbid obesity and adjustment to more regulated eating and a diabetic diet. He notes weight loss is common in patients with advanced dementia and often worsens as cognition declines, and that *At all times, I considered her nutritional status in the broader context of her overall functional decline and dementia trajectory.* Dr [C] notes Mrs [B]'s weight [and] BMI remained above the normal range throughout her residency (she was never clinically underweight) and serum albumin of 33g/L on 3 June 2022 was not suggestive of malnutrition. Ensure was charted as a nutritional supplement from 15 February 2022, and Dr [C] implies that facility nursing staff were empowered to make a dietitian referral as they saw fit, and he would have considered this if Mrs [B]'s nutritional status had continued to deteriorate. Dr [C] states that while he did not discuss these

[8] Li L, Duan L, Xu Y, Ruan H, Zhang M, Zheng Y, He S. Hypertension in frail older adults: current perspectives. *PeerJ* 2024;12:e17760 https://doi.org/10.7717/peerj.17760

aspects of Mrs [B]'s management directly with the EPOA, the standard practice at the facility was that senior nursing staff *would inform the EPOA of any changes to care plans or significant clinical developments.*

(iii) The extent and pattern of Mrs [B]'s weight loss is outlined in the Navigator file review and will not be reiterated here. On review of GP notes, while weight is recorded at many of the consultations there is no reference at any point to discussion of weight loss or weight loss management in these notes, including no reference to the decision to initiate nutritional supplements in February 2022 (although these were charted and administered from that time). There appears to be a formal 'weight loss report' form that AL staff use to notify the GP of concerns, and there are two of these on file – one dated 11 May 2022 and countersigned by Dr [C] (date of countersigning recorded 29 August 2022, which was after the time of Mrs [B]'s death in Auckland Hospital). The GP advice was *to be assisted when feeding, food and fluid intake monitoring* (she was taking Ensure at this time). The second form is dated 26 August 2022 and countersigned on 29 August 2022, these dates appearing to be in error.

(iv) My impression is that the approach to Mrs [B]'s weight loss took adequate and appropriate account of her comorbidities, prognosis and overall nutritional status (with respect to BMI), but more emphasis might have been placed on incorporating a dietitian assessment and advice (whether initiated by the GP or AL staff) and on more comprehensively documenting consideration of the weight loss pattern (GP notes) and interventions considered and undertaken. If there was an accepted arrangement in place for AL staff to communicate with the EPOA regarding Mrs [B]'s weight management, this was probably an acceptable situation provided there was clear communication to staff from Dr [C] regarding management recommendations.

6. ***You stopped Mrs [B]'s antihypertensive medication in February 2019, and this was never restarted. Please clarify your clinical rationale for stopping the medication and plan for ongoing management of hypertension should it recur (as it did). Did you have any blood pressure target at which antihypertensives might be recommenced and were you aware of the sequential readings recorded by nursing staff in the months following cessation of treatment? Was there ever any discussion with Mrs [B]'s EPOA (either directly or via nursing staff) of the risks and benefits of stopping and/or restarting antihypertensive medication?***

(i) Dr [C] notes in his response that in February 2019 Mrs [B] began declining felodipine, which had been recently started as an antihypertensive. GP consultation notes are provided from August 2019, so I did not review Dr [C]'s notes related to this decision, but the facility progress notes dated 7 February 2019 note cessation of the medication and *Continue to check BP with other obs on a monthly basis*, which was done except when Mrs [B] refused. Blood pressure was also recorded at many of Dr [C]'s regular reviews of Mrs [B]. Dr [C] states the rationale for ceasing Mrs [B]'s antihypertensives included: *Persistent patient refusal to take the medication; Fluctuating blood pressure readings, raising concern for postural hypotension and fall*

risk; Frailty and advanced dementia, where guidelines support a more permissive blood pressure target due to the risks associated with overtreatment.

The decision not to reintroduce antihypertensives aligns with best-practice geriatric principles. In older adults with cognitive impairment and limited life expectancy, tight blood pressure control has not demonstrated significant benefit and may increase morbidity from falls, syncope, and cerebral hypoperfusion.

(ii) Dr [C] notes there was no specific blood pressure target range established, although he *would have reconsidered treatment if sustained hypertension with end-organ risk had developed … Again, while I did not personally contact the EPOA regarding this medication change, it would have been communicated by nursing staff as part of routine care updates.* Blood pressures recorded at the GP consultations from August 2019 onwards show no concerning sustained elevation of blood pressure that might have necessitated recommencement of antihypertensives. I note that, on 24 June 2021, Dr [C] recorded *BP satisfactory if around <160/90.* Blood pressures recorded by nursing staff are quite variable, with occasional significant elevated results (e.g., September 2018: 186/99), but such readings were isolated with no sustained elevation evident and more readings being within the target range than outside it.

(iii) The decision to consider stopping Mrs [B]'s antihypertensive is consistent with accepted de-prescribing principles in frail older adults. One validated tool in considering such de-prescribing is the STOPPFrail tool (v2), [9] which notes: *Antihypertensive therapies: Carefully reduce or discontinue these drugs in patients with systolic blood pressure (SBP) persistently <130 mmHg. An appropriate SBP target in frail older people is 130–160 mmHg. Before stopping, consider whether the drug is treating additional conditions (e.g. beta-blocker for rate control in atrial fibrillation, diuretics for symptomatic heart failure).* HQSC has also developed local deprescribing guidance that references the STOPPFrail tool [10] but notes also that a reason to continue antihypertensives in a frail elderly person might be history of stroke (as Mrs [B] had). The general recommendation in a patient such as Mrs [B] with multiple comorbidities, including dementia, and limited life expectancy is to take an individualised approach considering individual goals of care, current blood pressure, risk of adverse effects, and patient/family preferences, with deprescribing considered when life expectancy is limited or adverse effects outweigh potential benefits. This requires communication with the patient (EPOA in this case) regarding the issues discussed above, and I believe best practice in this regard would be direct discussion between Dr [C] and the EPOA rather than nursing staff informing the EPOA regarding

[9] Curtin D, Gallagher P, O'Mahony D. Deprescribing in older people approaching end-of-life: development and validation of STOPPFrail version 2. Age and Ageing. 2021;50(2):465–471. https://doi.org/10.1093/ageing/afaa159

[10] Health Quality & Safety Commission Te Tāhū Hauora. Polypharmacy and deprescribing | Ngā rongoā maha me te whakakore tūtohu. Frailty care guides 2023. https://www.hqsc.govt.nz/resources/resource-library/polypharmacy-and-deprescribing-nga-rongoa-maha-me-te-whakakore-tutohu-frailty-care-guides-2023/ Accessed 9 September 2025

the management decision. The cited HQSC guide notes *It is important to take a whānau/family-centred approach when changing the medication of a kaumātua. This involves actions such as:*

- *including whānau/family in conversations*
- *providing opportunities for whānau/family to share their observations and insights and valuing their input*
- *allowing adequate time to discuss the matters with all parties involved*
- *thoroughly discussing and explaining the rationale for medication changes*

(iv) In summary, I believe it was a reasonable clinical decision to consider stopping Mrs [B]'s antihypertensive, and there was no clear indication to recommence the medication following cessation. However, I believe communication with the EPOA regarding the recommendation to stop the medication might have been improved and while deferring many management decisions to nursing staff to convey to or discuss with family is reasonable (and necessary when there are significant constraints on clinician availability), discussion of a non-urgent but relatively complex issue such as de-prescribing regular medications might be best undertaken by the (de)prescriber at a dedicated meeting with the patient and family.

7. ***In early June 2022, you became aware Mrs [B] had a blood-stained vaginal discharge. Please clarify your management plan for Mrs [B] in this regard, including ceiling of investigations and the degree to which this management plan was discussed with Mrs [B]'s EPOA.***

(i) Dr [C] comments that he was made aware Mrs [B] had a blood-stained vaginal discharge in June 2022, and an initial plan was for vaginal swab to exclude infection (result negative). Dr [C] states *Given her clinical context—advanced dementia, frailty, absence of pain or systemic symptoms, and a clear ceiling of care—I adopted a conservative "watch and wait" approach. This was a considered decision based on the understanding that further investigation (e.g., pelvic examination under anaesthesia or imaging) would likely require hospital transfer and cause undue distress without influencing management or outcome.* Dr [C] notes that even had Mrs [B] been diagnosed with a malignancy, she would not have been a candidate for other than a palliative approach to care and *As per facility protocol, the nursing staff were responsible for informing the EPOA about new clinical findings and the rationale for conservative management.*

(ii) I believe it was reasonable from a clinical perspective to consider a conservative approach to Mrs [B]'s management as an appropriate option for the reasons Dr [C] describes. Excluding by non-invasive means a readily treatable possible cause for the symptoms (infection) was appropriate. However, once infection had been excluded, I believe management options and recommendations required discussion with the EPOA rather than the EPOA being presented with a unilateral management decision (conservative management). While I believe best practice would be for Dr [C] to have

discussed the management options with the EPOA himself, allowing time for the EPOA to question and consider the possible outcomes of each option, I am very aware of the impact workforce constraints have on the ability for such discussion to occur. In this situation, deferring leadership of the discussion to well-informed nursing staff is not an unreasonable action provided the situation is presented as a discussion of management options (including the option recommended by Dr [C]) rather than merely notification of a management decision. I am unable to comment on whether the EPOA might have requested a different management option or, if the preference was for further investigation, referral for such investigation would have been accepted by secondary care.

8. ***If you have any relevant clinical notes from Mrs [B] held outside of Avondale Lifecare, could these please be provided.***

There were no clinical notes held outside of AL.

Appendix D: In-house clinical advice to the Commissioner

The following in-house advice was obtained from General Practitioner, Dr David Maplesden, dated 3 March 2026:

'CLINICAL ADVICE – MEDICAL MEMORANDUM

TO : [HDC Investigator]
FROM : David Maplesden
CONSUMER : Mrs [B]
PROVIDER : Dr [C]
FILE NUMBER : C22HDC00619
DATE : 3 March 2026

I have been asked to comment on the management of Mrs [B]'s antipsychotic medication. In the absence of a response from Dr [C] addressing his clinical rationale for any decisions made regarding such management, I can make only general and conditional comments. More definitive comments would require access to detailed administration records in addition to a prescriber response.

1. Available records indicate Mrs [B] was prescribed quetiapine regularly from 13 May 2019 (25mg midde [midday/lunchtime]). GP notes dated 12 August 2019 include *Stop quetiapine – no medication will stop calling and monitor for behaviour changes.* Medimap 'stopped medication' records indicate quetiapine was stopped on this date, but other records (medication list provided to Auckland Hospital) appear to indicate quetiapine was re-prescribed on 9 July 2020 although I can find no confirmation of this in the clinical notes. It appears that haloperidol was first prescribed as a short course medication (500mcg BD [twice daily] for 10 days) on 10 July 2020 as a trial for management of delirium. On 20 July 2020, the medication was charted as a regular nocte [at night/bedtime] dose of 500mcg, which was stopped on 15 March 2022. On this date, the haloperidol was changed to a PRN [as needed] medication, 500mcg daily if required for agitation. However, GP notes dated 16 November 2020 state ↑ *drowsiness after PRN dose therefore ↓ PRN haloperidol to ½ tab. Review if not effective*, so I presume at some point prior to 15 March 2022 Mrs [B] was prescribed PRN haloperidol in addition to her regular daily dose, although I am unable to confirm details of this.

2. An Auckland Hospital (AH) discharge summary dated 15 March 2022 notes Mrs [B] has been discharged on PRN haloperidol (500mcg) and includes the comment *Please note no more quetiapine.* The facility LTCF [long-term care facility] for challenging behaviour includes a comment dated 17 March 2022 *Was managed with regular quetiapine but now she is on PRN.* It is unclear if this latter comment refers specifically to PRN quetiapine or to PRN medication for challenging behaviour (in this case haloperidol per the AH discharge summary). However, there is certainly an implication that Mrs [B] was being administered

regular quetiapine immediately prior to her admission to AH, and possibly on a PRN basis following discharge. While the MediMap prescribing records provided do not indicate there was any co-prescribing of quetiapine and haloperidol or that quetiapine was prescribed after 12 August 2019 or following Mrs [B]'s discharge from AH, administration records would be required to confirm if quetiapine was administered at any stage despite not being prescribed.

3. I am unable to identify any clinical rationale or evidence-based support for co-prescribing quetiapine and haloperidol for the management of behavioural symptoms of dementia outside specific circumstances like brief cross-titration when changing medications. Local guidance on managing behavioural and psychological symptoms of dementia[1] refers to the generally accepted principles of minimizing antipsychotic use in dementia, avoiding polypharmacy, and using the lowest effective dose for the shortest possible duration. Unless there are compelling reasons for such co-prescribing, I believe it is inconsistent with accepted practice. Based on the records reviewed, it is possible there was co-prescribing by Dr [C] of quetiapine and haloperidol, and this may require confirmation. This would be best achieved by getting medication administration records and a response from Dr [C] specifically asking if he ever co-prescribed the drugs and, if so, his rationale for doing so. Unfortunately access to MediMap is currently restricted following a cyberattack, and this may impede Dr [C]'s ability to provide a response.

4. As noted above, it appears Dr [C] had an intention to stop Mrs [B]'s quetiapine on 12 August 2019. Accepted practice following this decision would be for the drug to be stopped in MediMap (which occurred) and nursing staff to cease administration of the drug. If there was a decision to restart the medication, I would expect this to be documented in the GP notes, and there is no such documentation. If nursing staff continued to administer Mrs [B] quetiapine following it being marked as ceased in MediMap, this represents a departure from accepted nursing practice.

5. Accepted practice following Mrs [B]'s discharge from AH in March 2022 would be for Dr [C] to reconcile Mrs [B]'s discharge medications with her regimen prior to admission and to make appropriate changes in MediMap to reflect her current prescribing. In this case, I would expect quetiapine to have been stopped and haloperidol to be prescribed only on a PRN basis, and this appears to have occurred. If Dr [C] had sound clinical reasons to prescribe quetiapine PRN in preference to haloperidol PRN (eg, Mrs [B] had shown a better tolerance or efficacy of one drug over the other in the past), this would not be inconsistent with accepted practice.

6. In summary, from a purely clinical perspective and based on the prescribing records, I believe Dr [C]'s prescribing of haloperidol and quetiapine was consistent with accepted practice, although the extent to which non-pharmacological strategies for management of behavioural and psychological symptoms of dementia (BPSD) were trialled is unclear, as is the degree to which ongoing use of antipsychotics was reviewed and monitored (per the

[1] BPAC. Managing the behavioural and psychological symptoms of dementia. 2020. https://bpac.org.nz/2020/bpsd.aspx Accessed 3 March 2026

cited BPAC guidance). The cited BPAC guidance does note that antipsychotics for BPSD should *be initiated only after informed consent has been obtained (and documented) from the patient or their legal representative*, and the comments I made in my original advice with respect to Dr [C]'s communication with the EPOA around more complex management issues affecting Mrs [B] apply also to this aspect of her care. I would be concerned if Mrs [B] was administered quetiapine at any time when there was no current prescription supporting such administration, but I am unable to confirm this ever occurred. I recommend Dr [C] review the cited BPAC guidance.