Decision 22HDC02367
19 August 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate care provided to vulnerable consumer in residential care

Background

1. This report discusses the care provided to Mr B by Lonsdale Total Care Centre[1] (owned and operated by Lonsdale 2005 Limited).

2. Mr B was in his late twenties at the time of events and had been diagnosed with multiple sclerosis and mental health co-morbidities. Initially he was admitted to Lonsdale on 13 December 2021 for a hospital-level respite stay, but his stay was extended until May 2022. Mr B was sight impaired and required assistance to feed himself, to reposition himself, and to meet all activities of daily living.

3. In May 2022 Mr B choked whilst being fed by a healthcare assistant when he was sitting upright in bed. Sadly, he passed away during the event.

4. The concerns raised by Mr B's family include an overall query whether Mr B received an adequate standard of care whilst in Lonsdale. They also queried why he was not showered for six months and why he was confined to his bed because of a broken hoist.

5. I extend my sincere condolences to Mr B's family and friends for their very sad loss.

Lonsdale's response

6. Mr A, General Manager, told HDC that initially Mr B was admitted to Lonsdale for respite care after having resided at a motel and having received services four times daily. However, later this was extended for a 12-month period. Mr A explained that Mr B never showered when residing at Lonsdale as Mr B did not consent to this and preferred to be washed daily, despite attempts by staff to encourage him to allow them to shower him.

7. Mr A said that up until 27 March 2022, Mr B 'was regularly transferred out of bed on request — usually to smoke. Initially, (from 13 to 17 December) this was by way of a "steddy eddy" transfer device.' However, on 17 December 2021, Mr B had an accident with the device, and it was determined that the 'steddy' was no longer safe for him and that 'hoisting would be required. As [Mr B] was able to bear weight through his legs, the standing hoist was an appropriate choice.' On 26 March 2021, Mr B experienced violent swaying and involuntary body movements, which made it difficult for staff to transfer him safely. Because smoking was important to Mr B and Lonsdale believed it was important for Mr B's mental health, on occasion staff persisted in utilising the hoist to get him out of his room when it was deemed safe for him and the staff involved. Mr A stated that at no point was a standing hoist unavailable, and the only reason it was not used was because of safety concerns.

[1] Hereafter referred to as Lonsdale.

8. Regarding the choking incident, Mr A noted that there had been a previous event when Mr B had choked, and a plan was made for Mr B to sit upright when eating to mitigate the risk of choking. However, Mr A stated:

> 'It is a fair question if more should have been done to recognise and mitigate the risk of choking, in particular by referring [Mr B] for specialist assessment. It's one we have asked ourselves.'

Resolution proposal

9. On 8 May 2025, I notified Lonsdale of HDC's investigation of this matter. I proposed that HDC find Lonsdale in breach of Right 4(1) of the Code[2] of Health and Disability Services Consumers' Rights (the Code) based on a review of the complaint and the Lonsdale response. Clinical advice regarding the care Lonsdale provided to Mr B was received from RN Jane Ferreira and was enclosed with the notification. RN Ferreira's advice supported my reasoning for proposing this finding.

10. On 8 May, Mr A agreed to the proposed finding of a breach of the Code.

Responses to provisional decision

11. Lonsdale and Ms B [Mr B's mother and complainant] were given an opportunity to respond to the provisional decision.

12. Lonsdale responded that it had no further comments to make, except that it had identified a title that needed to be corrected. The correction has been incorporated into the final decision.

13. Ms B responded that they regretted placing Mr B in the care of Lonsdale.

Decision

Lonsdale Total Care Centre — breach

14. Lonsdale has a duty of care to ensure that its vulnerable residents are receiving an adequate standard of care and support in line with their individual needs whilst meeting contractual obligations and adhering to the Code.

Expert advice regarding standard of care provided to Mr B

15. RN Ferreira stated:

> 'In summary, it appears that nursing information did not identify that Mr B was at risk of airway obstruction, choking and aspirating due to his progressive disease process and associated frailty. As outlined in the provider's response, staff had highlighted the possibility that a choking event could happen, however the care plan provides no discussion of risk factors, safety considerations or a plan to guide first-responder actions.'

[2] Every consumer has the right to have services provided with reasonable care and skill.

16. I accept RN Ferreira's advice and am critical that Mr B's risk of airway obstruction, choking, and aspiration was not identified earlier and made part of a more comprehensive care plan, as a discussion of risk factors and safety considerations would have highlighted the risks and associated preventions.

17. RN Ferreira advised:

> 'It appears that the care team knew Mr B well and were responsive to his needs; however, I consider the lack of personalised care guidance to have potentially created increased risk, particularly for those who were not familiar with Mr B's care requirements.'

18. I accept RN Ferreira's advice. Although some of the care team appeared to know Mr B well, I am concerned about the lack of written information accessible to carers who did not know Mr B well. In addition, I acknowledge RN Ferreira's comment that there was no specific guidance about how to manage Mr B's smoking habit safely or consideration of activities that could have reduced the risk of loneliness.

19. RN Ferreira stated:

> 'From the evidence reviewed to respond to this question and raised discussion points, I consider there to be moderate departures in responsibilities to nursing assessment, care plan development, open communication, care review processes and documentation standards, which would be viewed similarly by my peers.
>
> Departure from accepted practice: **Moderate**
>
> While the daily care record and progress notes evidence care occurring, it appears that the care plan was not updated to reflect his changing needs and revised interventions.'

20. I accept RN Ferreira's advice and am critical that at the time of events there were moderate deficits in the care provided to Mr B, including nursing assessments, care plans and reviews, open communication, and documentation standards. Although a long-term care plan was implemented on 30 March 2022, this was much overdue, and the plan lacked comprehensive nursing input and other details. This was a missed opportunity to provide a more comprehensive assessment, which would have better informed the care provided to Mr B.

Conclusion

21. In my opinion, taking into account Lonsdale's response and RN Ferreira's advice, Lonsdale Total Care Centre breached Right 4(1) of the Code, which states that 'every consumer has the right to have services provided with reasonable care and skill'. I find that Lonsdale did not provide services to Mr B with reasonable care and skill.

22. I note that Lonsdale has accepted this finding.

Showering and broken hoist — other comment

23. In response to Ms B's query why Mr B was not showered for six months and was confined to his bed due to a broken hoist, Lonsdale said that Mr B did not consent to being showered, but he was washed daily. Lonsdale advised that Mr B's movements made it unsafe to utilise the hoist on most occasions, not because a hoist was broken. It is my view that Lonsdale has provided a plausible explanation of why these issues occurred, and I acknowledge that the staff were respecting Mr B's wishes.

Changes made as a result of this event

24. Mr A told HDC that numerous changes occurred at Lonsdale specifically related to nursing practices, such as:

- Care planning — Processes on admission have been upgraded to include more comprehensive documentation and individualised intervention.
- Progressive stay — Within three weeks of initial assessment, the care plans and other documentation are re-evaluated and expanded to include a more comprehensive assessment and necessary amendments noted.
- Digital versions of policies and guidance documents — These are now available to all staff, including individuals' care plans and a digital noticeboard where pertinent new resident information remains in place for up to 10 days.
- Documentation quality control — Care plans and files are being internally reviewed using a newly developed audit tool, on a two-monthly basis.
- Identifying and assessing risk — Lonsdale is now working with a different GP provider who has twice-weekly clinics with a regular Lonsdale nurse practitioner (NP). If outside the clinics, the NP reports any urgent changes directly to the GP. This has led to a closer relationship between the GP and nurse.
- Follow-up due to residents' change in presentation — More vigilant attention by all staff is now required for residents with potentially serious presentations, which has led to more timely referrals and follow-ups.
- Open communication — Any communication is now detailed in the notes. All incidents and care plan reviews are routinely followed up by communication with the family.
- Concerns from family — Any concerns raised by the family are now followed up with communication and, if applicable, meetings with the family.

RN Ferreira's response to changes made as a result of the event

25. RN Ferreira was asked to comment on whether the changes made at Lonsdale were adequate. RN Ferreira advised:

> 'I have reviewed the attachments against my initial advice, and it appears that the changes made are both responsive and appropriate. I would like to acknowledge the provider's commitment to resident safety and quality improvement and the changes made in response to learnings from this complaint. It shows that considerable time has been invested in reflection, strengthening skills, roles, and resident care systems.'

Recommendations

26. I consider that comprehensive changes have already been developed and implemented at Lonsdale as a consequence of the events, including wider system changes such as nursing responsibilities and processes, as discussed above. I note that Lonsdale has provided an appropriate apology for the deficits identified in this report, which will be shared with Mr B's family.

27. I commend Lonsdale for having provided an apology to Mr B's family and for the prompt commitment to improve safety and quality for its residents. Accordingly, I will not request a further apology from Lonsdale or make any further recommendations to improve safety and quality of care.

Follow-up actions

28. A copy of this report with details identifying the parties removed, except Lonsdale Total Care Centre and the advisor on this case, will be sent to the Health New Zealand | Te Whatu Ora - Commissioning Agency and HealthCERT and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Ms Carolyn Cooper
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from RN Jane Ferreira, Nurse Advisor:

'**CLINICAL ADVICE — AGED CARE**

CONSUMER	**:**	Mr [B]
PROVIDER	**:**	Lonsdale Care Home
FILE NUMBER	**:**	C22HDC02367
DATE	**:**	20 March 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 Lonsdale Care Home. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. Documents reviewed

- Letter of complaint received 23 September 2022
- Provider responses dated 25 November 2022, 30 June 2023, 10 August 2023
- Clinical records, including admission information, initial nursing assessment, care plan, progress notes, medications, health records, communication records, incident reports, and external reporting records
- Organisational policies and information, including complaint management, nutrition and hydration resources, maintenance records, corrective actions, meeting minutes, training records
- Additional evidence: cultural safety, nutrition and hydration, moving and handling, nursing assessments and care plans, admission, emergencies, continence assessments and management, medication management, falls management, incident reporting and management

3. Complaint

Ms [B] has expressed concern about the care provided to her son [Mr B] during an extended respite admission at Lonsdale Care Home. Her concerns relate to personal care delivery, nutritional needs, and management of choking events.

<u>Background</u>

Mr [B], aged 28 years, was admitted to the care home on 13 December 2021 for a respite stay at hospital-level care, funded by Mana Whaikaha/Disability Support Services. He was well known to local health services and closely supported by his family/whānau. Mr [B]'s medical history included a severe CNS demyelinating syndrome, likely multiple sclerosis, with tremors and muscle spasms, asthma, anxiety, and depression. Records show that Mr [B] was living with low vision and limited mobility (bed/chair bound) and was highly dependent on carer assistance to meet all activities

of daily living, including eating, drinking, and personal care requirements. He communicated well and was able to make his needs known.

On […] May 2022, Mr [B] experienced a sudden choking event during an assisted meal. Despite first aid measures and paramedic support, he sadly passed away during the event. I extend my sincere condolences to his family/whānau and friends at this time.

4. Review of clinical records

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

In particular, comment on:

a) **The identification and management of Mr [B]'s nutritional needs, including choke risk, and if the plan of care was appropriate in the circumstances**.

The Age-Related Residential Care (ARRC) Service Agreement and Ngā Paerewa Health and Disability Service Standards (HDSS) require service providers to ensure that appropriate policies and processes are in place to support a resident's care and safety needs. The provider has submitted copies of the organisation's policies, procedures, and resources, which provide guidance about meeting an older person's needs and related care requirements in the ARC setting.

In this case, Mr [B] was a young man living with disability who had been admitted to the care home for a respite stay. From the information supplied, it is unclear what preadmission clinical information was available to the care home team to inform his admission assessments and plan of care. Progress note entries in the electronic care record 14 December 2021 introduced Mr [B] and outlined the admission process. An initial care assessment tool outlined his identified abilities and required support, noting that Mr [B] required assistance to feed himself. Cultural needs describe his food choice as a normal diet.

The tool identified that Mr [B] had a nasal discharge with chest expectoration, noting a liquid cough syrup was charted but no further discussion was provided about impacts to his health and wellbeing, with no evidence that a short-term care plan was commenced to outline care requirements at this time.

While nursing assessments were not included in the supplied evidence, the admission progress note entry reported that baseline observations, falls and pressure injury risk assessments were completed. The Registered Nurse (RN) entry stated that Mr [B] could communicate effectively and was orientated to time, place, and person. His mobility and personal care requirements were discussed, noting that he required assistance to reposition and meet all activities of daily living. The initial assessment identified that Mr [B] was sight impaired but no further information was provided about how to support him as he settled into a new environment. While the tool outlined essential care needs,

there is no guidance about how to safely manage his smoking habit or consideration of activities/interests to reduce the risk of loneliness at this time.

It appears that a formal care plan was not implemented for Mr [B]'s planned stay until March 2022, which is concerning. Records state that Mr [B] was initially admitted for a "*trial period of residential service for support with all aspects of day-to-day care"* (6 December 2021–10 April 2022). This was revised by the funder on 14 March 2022 to extend the hospital-level care service by twelve months until 12 March 2023. It is unclear whether a resident review meeting was held in partnership with Mr [B] and his nominated representative, the funder, and care home leaders during this time to determine goals for care and an ongoing support plan. Records show that a long-term care plan (LTCP) was implemented on 30 March 2022, but there is no evidence supplied of any nursing assessments that were completed to inform the new care plan. It appears that an InterRAI clinical assessment was not completed given the change in status to inform appropriate service delivery or whether clarification was sought regarding the assessment process, which would be considered accepted practice. It is unclear whether Mr [B] had an advance care plan with goals for care in place. His cultural requirements or lifestyle wishes were not discussed, which would be recommended considering his progressive health pathway.

The organisation has referred to the Te Tāhū Hauora Health Quality & Safety Commission Frailty Care Guides 'Nutrition and Hydration' resource, which provides information about dietary requirements to inform nursing assessments, resident care plans, and related interventions (HQSC, 2019; HQSC, 2023). Given the lack of assessment data, it is difficult to provide comment about identified risk areas to inform the LTCP. Mr [B]'s LTCP discussed care interventions to be provided across the three shifts. Nutritional needs state that he required a normal diet, required full assistance with feeding, and to monitor food and fluid intake. No personalised guidance was provided about food preferences, item recognition given low vision, safe feeding strategies, weight management, or associated risk factors to malnutrition, dehydration, or choking. It is unclear whether Mr [B] had been seen by a dietitian or speech language therapist given his progressive health concerns to inform safe care needs at this time.

Records reflect that Mr [B] was able to communicate his needs and provide consent to care interventions. Progress note entries across Mr [B]'s stay regularly report episodes of meal, medication, and care refusal, and staff concern with bowel management. While the daily care record and progress notes evidence care occurring, it appears that the care plan was not updated to reflect his changing needs and revised interventions. The provider has acknowledged that documentation standards are a development area and advised that a new electronic record has been implemented, in partnership with new clinical and operational policies (June 2022).

Records show that Mr [B] was regularly seen by a general practitioner (GP) during his admission, with clinical notes reflecting referral to external health professionals for further involvement in his care. It appears the GP had been informed that Mr [B] was declining planned care; however, RN entries in the care record provide minimal discussion of GP visits and any related clinical instructions. RN entries raise concern with

meal refusal; however, it appears from the provider response that associated risk was not identified, therefore implementation of nutritional monitoring was not considered clinically indicated by the RN team. The HQSC resource recommends monitoring of food and fluid intake to inform evidence-based care decisions, such as signs of health concern, commencement of a nutritional supplement, or referral for specialist assessment.

File information reports that on 7 March 2022, Mr [B]'s mother expressed concern that his speech was becoming worse and requested he receive a soft diet. It is disappointing to note that her concerns and feedback were not considered by the RN team, which would be considered culturally appropriate. It appears that no further nursing assessment occurred at this time. Records state that Mr [B] enjoyed meals brought in by his family, and the provider has advised they were supportive of this given Mr [B]'s level of health and wellbeing. It appears from the response that the care team knew Mr [B] well and attempted to facilitate his wishes with kindness to support his quality of life.

The care record on 4 May 2022 states that Mr [B] was "*coughing with observed swallowing difficulties"*. The provider has advised that he had a strong cough reflex and was able to clear his throat. However, the care plan provides no discussion about Mr [B]'s coughing ability or related signs of concern with coughing, such as identification of choking or aspiration. The RN entry provides no evidence of nursing assessment, noting to "*keep monitoring him while feeding him"*. It is unclear how this information was communicated across the care team and what specific monitoring the RN required. It appears that an incident report was not completed as first aid was not required, although it would be considered accepted practice to ensure that potential risk was escalated to clinical leaders for follow-up and care review in the circumstances. It appears that a safe swallow assessment, dietary review, or care plan update was not completed.

The care record shows that on 7 May 2022, Mr [B]'s mother informed the RN that Mr [B] had choked when she was assisting him with his meal. The RN entry stated that Mr [B] reported to the RN that he "*did not choke with food but lozenges got stuck"*. There appears to be no evidence of nursing assessment, care review, or consideration of risk-minimisation factors in response to the reported event. Given this was the second reported episode of safe swallow concerns in three days, it would be considered accepted practice for nurses to ensure that safety needs were maintained. Part of clinical risk and incident management processes would be completion of an incident report given Mr [B]'s mother had escalated concerns, even if the RN considered the event to be low risk. This may have prompted a care review by the manager and RN team with GP notification for further assistance.

Respected health resources describe choking events as potentially life-threatening emergencies, therefore direct-care teams are required to be appropriately trained in first aid, follow organisational policies, and receive regular education about recognising and responding to acute change (Ausmed 2024; HQSC, 2023). Nursing records show that the duty team on […] May 2022 were responsive to the sudden change in Mr [B]'s

status with actions in keeping with expected approaches to clinical emergencies. The provider has submitted evidence of incident investigation with a detailed corrective action plan developed in response to learnings from this event, which appears appropriate in the circumstances.

In summary, it appears that nursing information did not identify that Mr [B] was at risk of airway obstruction, choking, and aspirating due to his progressive disease process and associated frailty. As outlined in the provider's response, staff had highlighted the possibility that a choking event could happen; however, the care plan provides no discussion of risk factors, safety considerations, or a plan to guide first-responder actions. It appears that the care team knew Mr [B] well and were responsive to his needs; however, I consider the lack of personalised care guidance to have potentially created increased risk, particularly for those who were not familiar with Mr [B]'s care requirements.

From the evidence reviewed to respond to this question and raised discussion points, I consider there to be moderate departures in responsibilities to nursing assessment, care plan development, open communication, care review processes, and documentation standards, which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

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.

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

References

AUSMED. (2024). Choking First Aid in Residential Aged Care
https://www.ausmed.co.nz/learn/articles/choking-aged-care

Health Quality and Safety Commission. (2019; 2023). Frailty Care Guides.
http://www.hqsc.govt.nz/'

Appendix B: Changes made at Lonsdale Total Care Centre since events

Care planning

1. Processes on admission have been upgraded. The Initial Care Plan prepared by the admitting RN within 24 hours of admission in collaboration the resident and their whānau/support person is a more comprehensive document and records targeted, individualised interventions in a wholistic manner.

2. Within three weeks of the initial assessment and care plan, a more comprehensive plan is developed, building on the initial plan with new information and the benefit of experience of the resident in this environment. Focused evaluations of the effectiveness of interventions are recorded in the care plan and any necessary amendments made.

Digital versions of policies and guidance documents

3. All clinical staff and management have access to current, digital versions of all the facility policies and guidance documents online. This includes each individual resident's care plan. Staff are trained, encouraged, and reminded to access these before working with a resident or when a change is made to the care plan. When changes are made to care plans, this is flagged on our digital noticeboard. The Noticeboard is an alert to staff to check the relevant resident's care plan as a change has been made. These notices remain in place for seven to ten days, so all staff have an opportunity to be informed. Most staff access all of the information on mobile devices. Everyone is familiar with the technology and the procedure, and this prevents knowledge gaps with care plans.

Documentation Quality Control

4. Lonsdale documentation is governed by our Clinical Documentation and Report Writing Policy (revised May 2024). A copy can be provided on request. Care plans and resident files are reviewed two monthly by the Clinical Lead and the General Manager as part of our Internal Auditing System. I have attached a copy of the 2025 Audit Schedule. The last such audit was conducted on 19 March 2025. In addition, the Clinical Lead uses a care plan audit tool we have developed to assess the completeness and quality of each individual RN's care planning at least annually**.** This is used to provide feedback to the RN in an effort to improve the quality of work for each individual nurse.

Identifying and assessing risk

5. A change of GP provider in early 2024 has led to a closer relationship with a regular Nurse Practitioner at our twice weekly clinics. Between clinics, RNs report any changes in presentation for each resident via an ISBAR. If the RN making the assessment or noting a change in presentation considers that medical advice or action is required urgently (i.e. not requiring hospitalization but needing attention before the next scheduled NP clinic), the ISBAR is sent to our provider for action. For all other matters, the ISBARS are reviewed by the Clinical Lead and presented to the NP at the next clinic. This ensures that no significant change in a resident's condition is missed in that multiple senior staff are made aware of any changes in presentation. This avoids what could be an important detail being lost in the documentation or verbal handovers and not actioned appropriately.

Follow-up due to resident change in presentation

6. Since Mr [B]'s death, our staff are more vigilant in following up potentially serious presentations (e.g. any report of choking). Referrals are made in a timely manner to allied health professionals (e.g. dietician, speech-language therapist) for further assessment. In particular, perceived need for changes in diet are scrutinized by the Clinical Lead and RN team. This process resulted in the two attached referrals from November 2024 seeking swallowing assessments. The assessments were made and the care plans amended to reflect the advice given.

Open Communication

7. There have been lapses in the past with staff not communicating effectively with residents and their whānau or of failing to document these interactions. It is now an established practice that when communication is made with families, the nature and content of the interaction is detailed in the notes headed 'Family Communication'. At a minimum, this occurs after any adverse event (falls, etc.), before and after the resident is seen by the Nurse Practitioner and when the care plan is being reviewed. Between 1 and 28 May 2025, there are 61 episodes so recorded in the residents' notes on a wide variety of topics.

Concerns from family

8. In addition to this, where either our staff or EPOA whānau have any ongoing concerns about their loved one's condition or care, this is addressed proactively by inviting them in for a meeting with the relevant staff. This can include our Nurse Practitioner, the General and/or Clinical Manager and anyone else who may be relevant. We have found that 'front footing' potential issues is beneficial.