McKenzie Healthcare Limited
(trading as McKenzie HealthCare)

A Report by the
Aged Care Commissioner

(Case 24HDC02350)

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

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Complaint and investigation

1. The Health and Disability Commissioner (HDC) received three complaints about the services provided by McKenzie Healthcare Limited (McKenzie Healthcare) to its residents. The following issues were identified for investigation:

- *Whether McKenzie Healthcare Limited provided [Mrs A] with an appropriate standard of care from [Month1] 2020 to [Month15] 2021.*[1]
- *Whether McKenzie Healthcare Limited provided [Mrs E] with an appropriate standard of care in 2022.*
- *Whether McKenzie Healthcare Limited provided [Mrs F] with an appropriate standard of care in 2022.*

2. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

3. The parties directly involved in the investigation were:

Mrs A	Consumer/complainant
Ms B	Complainant/Mrs E's daughter
Mrs C	Complainant/Mrs F's daughter
McKenzie Healthcare Limited	Aged residential care facility

4. Further information was received from:

Health New Zealand|Te Whatu Ora (Health NZ) South Canterbury[2]	National health organisation
Ms D	Mrs E's friend

5. Also mentioned in this report:

Mrs E	Consumer
Mrs F	Consumer

6. In-house clinical advice was obtained from in-house aged care advisor Registered Nurse (RN) Jane Ferreira (Appendices A, B, and C).

[1] Relevant months are referred to as Month1–Month15 to protect privacy.
[2] On 1 July 2022 the Pae Ora (Healthy Futures) Act 2022 came into force, which disestablished all district health boards. Their functions and liabilities were merged into Te Whatu Ora|Health New Zealand (now Health New Zealand|Te Whatu Ora).

Information gathered during investigation

Introduction

7. In 2022 this Office received three complaints about the standard of care provided to consumers at McKenzie Healthcare. All three consumers had high needs and received hospital-level care at the time of the events. The following issues were raised by the complainants:

Complaint 1: Mrs A

8. Mrs A complained about the standard of care provided to her from Month1 to Month15, including the following issues:

- Her lack of personal space for bathing;
- Her lack of care and the dismissive attitude of staff and management at the facility; and
- Her social isolation.

Complaint 2: Mrs E

9. Ms B complained about the standard of care provided to her late mother, Mrs E, in 2022, including the following issue:

- The lack of assistance and care provided to Mrs E when she was isolated during a COVID-19 outbreak, including a lack of support with hydration, nourishment, and hygiene.

Complaint 3: Mrs F

10. Mrs C complained about the standard of care provided to her mother, Mrs F, in 2022, including the following issues:

- The poor call-bell response time; and
- The lack of support for toileting.

McKenzie Healthcare

11. McKenzie Healthcare is an aged residential care facility that provides hospital, rest home, and dementia level of care for up to 85 residents.

12. Between 2021 and 2022 there was a significant turnover of multiple staff at a frontline and management level. This included the turnover of five general managers. The current general manager told HDC that she was asked to step into the role in 2022 after starting as clinical manager three months prior to this, despite having no previous knowledge of New Zealand's aged-care systems and without any formal orientation for the clinical or general manager roles. In addition, the general manager told HDC that there had been no clinical manager prior to or following her appointment, and finding a qualified candidate willing to work in a rural region proved to be difficult, and therefore, as a result, she assumed both roles.

13. At this time, McKenzie Healthcare was operating with six registered nurses and one enrolled nurse. McKenzie Healthcare stated that these staffing shortages, compounded by the COVID-19 outbreak, during which the general manager worked 14-hour days due to staff sickness, presented significant challenges.

14. McKenzie Healthcare told HDC that around this time its computer system was hacked for ransomware, which resulted in data becoming lost. McKenzie Healthcare said that this has limited its ability to provide fulsome information to this Office. McKenzie Healthcare did not specify which information had been collected but subsequently lost, or which information had never been collected.

Consumer 1: Mrs A

Complaint and background

15. Mrs A complained about the standard of care provided to her by McKenzie Healthcare. In particular, she complained about a lack of personal space for bathing, a lack of assistance with hygiene needs, and social isolation.

16. Following her complaint to this Office, Mrs A advised that she no longer wished to be involved in the complaint process, and this Office has been unable to contact her. As this Office received other complaints relating to McKenzie Healthcare that raised concerns about systems issues, an investigation was commenced into the care provided to Mrs A.

17. At the time of the events, Mrs A was 67 years old and resided at McKenzie Healthcare from 28 Month1 to 24 Month15. She had multiple comorbidities, including type two diabetes requiring insulin, an abdominal hernia,[3] and a previous stroke. She was legally blind and had two stomas[4] (from an ileostomy[5] and a urostomy).[6] In addition, Mrs A was prone to recurrent urinary tract infections with extended-spectrum beta-lactamase (ESBL).[7]

Assessments and care planning

18. Mrs A was assessed as requiring hospital-level care and resided in a room where she used shared bathroom and toileting facilities.

19. McKenzie Healthcare did not provide a copy of Mrs A's needs assessment or pre-admission assessments, or evidence of a pre-admission meeting with Mrs A or her orientation to the McKenzie Healthcare facility. Therefore, it is not known what information was provided to Mrs A before or at the time of her admission to McKenzie Healthcare.

20. A long-term care plan (LTCP) dated 29 Month14 states that Mrs A required full assistance with hygiene and toileting. It addressed other needs relevant to Mrs A's health, including

[3] Bulging of the abdominal contents through the muscle or tissue of the abdominal wall.
[4] An opening in the body that allows waste to exit the body.
[5] An opening in the small intestine that allows digested food to pass into a pouch rather than the rectum.
[6] An opening that allows urine to leave the body without the need of a bladder.
[7] A multi-drug-resistant bacteria.

maintaining her safety around her room, but it did not address what risk assessments had been undertaken to allow her to access areas outside her room.

21. McKenzie Healthcare did not provide a copy of Mrs A's interRAI assessments that were completed at pre-admission, on admission, or on a six-monthly basis. However, Mrs A's LTCP referred to outcome scores from interRAI assessments, indicating that an interRAI assessment had been completed at least once prior to Month14.

22. On admission, no nursing assessments were completed for falls risk, pressure injury risk, pain, nutritional needs, low vision, or safety needs. It is also not known what training and support was provided to caregivers prior to Mrs A's admission to ensure that her complex health requirements were met. There is no evidence of shift handover communication or a plan for clinical oversight of a high-risk resident during the settling-in phase. Further, no changes were made to Mrs A's LTCP to accommodate her diagnoses of pyelonephritis[8] and respiratory infection following discharges from hospital in Month5 and Month12, respectively.

23. There was limited evidence of communication to Mrs A's husband, who was her nominated contact and Enduring Power of Attorney (EPOA, not activated). While routine updates of health changes were provided, there is no evidence of involvement during care reviews or the complaints management process.

Stoma management

24. McKenzie Healthcare's Ostomy[9] Management Policy (dated January 2021[10]) states that bladder and bowel function is to be maintained with privacy and dignity, utilising recommended ostomy devices. In addition, the policy states that stoma bags are to be changed when half full to maintain resident comfort.

25. McKenzie Healthcare's Infection Control Policy (dated 15 April 2021) states that consumers with indwelling devices such as ostomy bags are at greater risk for infection. While the policy provides guidelines for nursing care, infection control, hand hygiene, and education for staff and close family, the policy does not discuss informed consent or what education is to be provided to residents, or provide guidance on standard and contact precautions, the use of personal protective equipment (PPE), and waste handling.

26. Mrs A's LTCP states that her stoma bags were to be checked and changed at least twice weekly. The bowel monitoring forms indicate that she was able to empty the stoma bags independently. Mrs A's LTCP detailed the care required to manage her stomas and, likewise, progress notes make regular references to staff caring for her stomas.

[8] A kidney infection.
[9] A surgical procedure that creates an opening in the body for discharge of body wastes.
[10] This policy was first issued in November 2015. The updated date initially stated November 2018, but this was crossed out, with 'January 2021' written over it.

27. Mrs A told HDC that during her admission, she 'had several blow outs of [her] stoma bags and was left in [her] chair or bed covered in faeces', which led to her stoma becoming infected. Mrs A said that as the stoma had become infected, she was prohibited from using the shared toileting facilities. In addition, she stated that her soiled clothes were not removed for extended periods. She said that the lack of attendance from staff led to her decision to discharge herself from McKenzie Healthcare.

28. The clinical notes contain multiple entries of the stoma site leaking[11] and instances of the stoma bag bursting,[12] leading to Mrs A feeling distressed. On multiple occasions, the notes record that Mrs A complained to McKenzie Healthcare staff about a lack of attendance by staff[13] and about a lack of training for caregivers on stoma management.[14] The clinical notes show that on one occasion, staff advised Mrs A that their lack of timely attendance was because they were attending another resident. In addition, Mrs A raised concerns about bathroom sharing[15] with another resident when she would need to empty the stoma bags herself.

29. McKenzie Healthcare advised that as part of orientation training skills, staff are shown by senior healthcare assistants or registered nurses how to manage a stoma, but no formal education is completed. However, its response indicated that more staff training was needed in this respect.

30. Mrs A told HDC that when she made complaints to staff, this was met with disdain, and they did not seem to care about her physical or emotional distress. Progress notes show that while concerns were acknowledged verbally by registered nurses and the clinical coordinator, and an apology was provided, Mrs A's concerns were not registered as a complaint or escalated to a clinical manager, as per McKenzie Healthcare's complaint policy (dated January 2021).[16]

31. The complaint policy states that all complaints are to be registered in the complaints register or documented in the feedback form and submitted to the clinical manager. The complaints will then be investigated and have documented investigation findings with corrective actions. McKenzie Healthcare did not provide evidence of a complaint investigation, corrective actions, or an apology being issued for Mrs A's concerns in this regard.

Infection control

32. On 17 Month3, Mrs A experienced loose bowel motions, and she was placed on contact isolation for suspected gastroenteritis.[17] The isolation ended on 19 Month3. There were two other instances of isolation measures being introduced for Mrs A in Month7 (for a suspected

[11] 20 Month3, 6 Month7, 2 Month10, 29 Month12, 20 Month12, 1 Month13, and 27 Month13.
[12] 3 Month12and 13 Month12.
[13] 13 Month9, 20 Month9, 21 Month9, and 25 Month13.
[14] 20 Month7.
[15] 18 Month2, 8 Month3, and 11 Month9.
[16] This policy was first issued in September 2015. The updated date was initially listed as November 2018, but this was crossed off manually, with 'January 2021' written over it.
[17] An intestinal infection that causes watery diarrhoea.

respiratory infection) and Month9 (for suspected ESBL infection). When isolation measures ended on these occasions, Mrs A was encouraged to socially distance from other residents to avoid transmission of infection.

33. A short-term care plan (STCP) was not commenced for these suspected infections, and the clinical notes show no evidence of specific care information, or what education was provided to Mrs A regarding the isolation measures, infection control, and bathroom use.

34. McKenzie Healthcare stated that no formal training was given to staff around infection control for management of ESBL. McKenzie Healthcare provided a copy of an ESBL leaflet (dated July 2021) that was given to its staff to read as educational material. The leaflet provides an overview of how ESBL infection is caused, how it is treated and prevented, who is at risk, and the isolation measures required to limit its spread. However, the leaflet does not refer to McKenzie Healthcare's infection control policy and process for managing the infection.

Social isolation

35. Mrs A told HDC that it appeared that McKenzie Healthcare was constantly dealing with staff shortages, as visits to her room were sporadic. She added that when her stoma became infected, she was left in 'total isolation'.

36. As noted above, Mrs A stayed in a room with shared bathing facilities. She stated that after her stoma became infected, she was not allowed to use the shared facilities, so she was unable to be showered even after being soiled with faeces due to blow-out of the colostomy bag. She was made to wait until staff were available to shower her and clean up afterwards. This furthered her feelings of social isolation and emotional distress.

37. Mrs A also stated that due to the infection, she was prohibited from joining activities, which meant that she was spending the entire time in her room with minimum connection to others, which included minimum interaction with staff. There is limited comment within the progress notes regarding staff interaction and how Mrs A's social needs were met while she was isolated.

38. As noted above, Mrs A had been initiated on contact precautions on three occasions. Progress notes show that she was dissatisfied with the isolation measures on several occasions.[18] Again, this appears not to have been escalated to the clinical manager for investigation.

Consumer 2: Mrs E

Complaint

39. Ms B complained about the standard of care provided to her late mother, Mrs E, during a COVID-19 outbreak at McKenzie Healthcare from Month1 to Month2 2022.[19] Ms B told HDC

[18] 17–21 Month3, 28 Month7, 11 Month9, and 1 Month11.
[19] Relevant months are referred to as Month1 and Month2 to protect privacy.

that Mrs E passed away after a sustained period of isolation, during which Mrs E received little attention and assistance.

Clinical history

40. Mrs E was admitted to McKenzie Healthcare in 2020 for hospital-level care. At the time of events, Mrs E was 98 years old. She had a history of glaucoma,[20] dementia with marked short-term memory loss, visual impairment, frailty, gluten intolerance, malignant melanoma (cancer), osteoarthritis,[21] and hearing impairment. Clinical records show that she mobilised independently under supervision and required supervision with activities of daily living.

41. The clinical records also show that Mrs E had poor oral intake due to reduced ability to taste or recognise food items, and she had swallowing difficulties. She had a body mass index (BMI) of 14. When she weighed around 33kg with a BMI of 13.2[22] in 2022, Mrs E was started on a nutritional supplement and a puréed/minced diet to support her nutritional intake.

COVID-19 management

42. McKenzie Healthcare's COVID-19 Outbreak Management Plan (undated) states the following:

- Notify the general practitioner (GP) of the outbreak and any unwell residents are to be reviewed;
- Undertake daily outbreak leadership team meetings; and
- Nominate a lead shift person into an infection control coordination role.

43. Mrs E tested positive for COVID-19 infection on 19 Month1. This occurred after two other cases of COVID-19 were detected within the facility, which led to testing of all residents.

44. Infection control measures were introduced following the positive test. McKenzie Healthcare told HDC that these included the following:

- Keeping Mrs E isolated in her private room with airborne precautions;[23]
- Undertaking COVID-19 testing on all McKenzie Healthcare residents and staff every one to two days as per Ministry of Health advice at the time;
- Placing isolation signage and donning and doffing stations for personal protective equipment outside Mrs E's room;

[20] A disease that damages the eye's optic nerve, which leads to vision loss.
[21] A disease that causes degenerative changes to the joints.
[22] A healthy BMI is between 18.5 and 24.9.
[23] Infection control precautions that help to prevent airborne transmission of diseases. These precautions are applied when patients are known or suspected to be infected with infections transmitted by airborne droplets.

- Keeping the room open for sunlight and ventilation;[24]
- Restricting visitors to McKenzie Healthcare or asking visitors to follow airborne precautions when entering restricted areas; and
- Placing air filters in the facility.

45. Progress notes show that Mrs E's son and activated EPOA for personal care and welfare was informed of the positive test on 19 Month1, but informed consent for testing was not sought from Mrs E's son. In addition, the progress notes do not record what education, explanation, and/or advice was provided to Mrs E or her son regarding the Rapid Antigen Test (RAT). In response to the provisional report, McKenzie Healthcare said that Mrs E and her family made informed decisions regarding her care, including declining antibiotics, vaccines (including the COVID-19 vaccine), and anti-viral medications.

46. An STCP[25] was commenced for Mrs E's isolation management. The STCP lists generic guidance relating to infection control and clinical monitoring of COVID-19 infection; however, it does not specifically discuss Mrs E's individual needs.

47. Health NZ's guidance (dated 2022) and South Canterbury aged residential care facility guidance for COVID-19 outbreaks (dated 4 April 2022) state that all COVID-19 positive cases are required to be isolated for at least seven days from the onset of symptoms or from the day of the positive test. Health NZ guidelines state that some cases may need to remain isolated for more than seven days after acute symptoms resolve or if the resident remains infectious, but isolation should not be longer than 10 days. In response to the provisional report, McKenzie Healthcare told HDC that its facility lacked negative pressure rooms or ante-isolation rooms, and had shared Jack-and-Jill bathrooms, which made isolation challenging.

48. Mrs E was isolated for 16 days and remained isolated at the time of her death. No rationale for this extended isolation was documented, and there is no evidence that an assessment was completed at the 7- or 10-day point to assess whether continuing isolation was necessary.

49. Clinical records show that the positive test was documented in the 'Outbreak Log' in the Infection Control Book, and Health NZ's Public Health and Portfolio Manager for Health of Older People was notified of the infection on 19 [Month1]. Email records show regular correspondence between Health NZ and McKenzie Healthcare's general manager[26] concerning the number of residents/staff who had tested positive, the staffing levels, infection control, and the symptoms experienced by residents. However, there is no evidence of input from McKenzie Healthcare's infection control coordinator in the

[24] Ms B disputed this, and states that this did not align with her daughters' or Mrs D's observations and that the room had been semi-dark, with drapes semi-drawn and that Mrs E's room presented with a musty, stale atmosphere.
[25] Undated, with an entry for 'evaluation' dated 1 Month2. However, McKenzie Healthcare told HDC that this STCP was followed during Mrs E's isolation period.
[26] There is evidence of communication on 19, 20, 21, 31 Month1 and 4 Month2.

management of the outbreak or in the care of residents. There is also no evidence of daily outbreak meetings.

50. In response to the provisional report, McKenzie Healthcare told HDC that the general manager sought input from a senior registered nurse, who was also the infection control nurse and had prior outbreak management experience. In addition, the general manager also had previous experience as an infection control chairperson in another country. However, in hindsight, McKenzie Healthcare acknowledged that seeking additional support could have enhanced their management of the outbreak.

51. In relation to communication between McKenzie Healthcare and GP services at the time of the outbreak regarding resident care, there were two emails on 21 Month1 and 4 Month2 to the GP, informing the GP that Mrs E had tested positive for COVID-19 and that she had no symptoms. No other assessment details were included. On 21 Month1 the GP practice advised McKenzie Healthcare that it had not been notified about COVID-19 positive tests, which restricted the practice's capacity to prescribe antivirals and support McKenzie Healthcare's COVID-19 care. The GP practice advised McKenzie Healthcare staff to call the COVID-19 reporting line.

Care provided during isolation

52. McKenzie Healthcare told HDC that other than a low-grade fever of 37.8°C on 29 Month1, Mrs E was asymptomatic for COVID-19 during her isolation.

53. Ms B told HDC that when Mrs E's two granddaughters visited her on 2 Month2, Mrs E was found lying curled up in a soiled bed with matted hair, and dry and scaly skin, and it appeared that she had not been moved for some time. Ms B said that Mrs E appeared to have lost weight, did not have her dentures fitted to allow her to eat, had no straw to allow her to drink fluids, and she had been complaining of hunger. Ms B told HDC that when Mrs E's family challenged staff about their lack of attention to Mrs E, staff responded that it was difficult to continually don their PPE and therefore, frequent visits and checks had been avoided.

54. A further statement was provided by Ms D, Mrs E's friend, who visited her on 3 Month2. Ms D told HDC that Mrs E appeared to be in an uncomfortable position in bed, had 'scabby sores' on her legs, no dentures, and uncombed hair. In addition, Mrs E had been calling out for water, appeared distressed, and did not have access to soft food.

<u>Clinical records for isolation period</u>

55. McKenzie Healthcare told Ms B that during Mrs E's isolation she was checked every half an hour to ensure that she was safe. However, McKenzie Healthcare did not provide a copy of intentional rounding charts (or other documentation) to indicate that this occurred.

56. Mrs E's care plan recorded that she was at risk for pressure injuries and had existing injuries. However, the daily repositioning form recorded only one entry of repositioning on 4 Month2 during her isolation. In addition, clinical records provided by McKenzie Healthcare do not indicate how often skin checks were completed.

57. Mrs E's LTCP recorded that staff were to encourage Mrs E to interact with other residents and attend activities to reduce agitation and sensory isolation. Mrs E's STCP states: '[Mrs E] will need activities in her room to encourage her to stay there [during her isolation].' Progress notes between 19 Month1 and 4 Month2 do not record what activities were offered to Mrs E (except on one occasion).[27] The diversional therapy daily activity record also does not show that Mrs E engaged in any activities from 19 Month1 other than folding clothes, despite the progress notes stating that she was bored and agitated over this period. McKenzie Healthcare told HDC that other than music being turned on and the folding of clothes, no activities were offered to Mrs E. Ms B told HDC that although music was turned on, Mrs E would not have been able to hear this due to her hearing impairment.

58. Mrs E's LTCP records that she was at risk for undernutrition and that she was to 'receive sufficient fluids/hydration', but the LTCP does not quantify the levels of hydration to be provided to her. In addition, Mrs E's dietary assessment records that she needed encouragement with eating and drinking, encouragement with chewing, and verbal cues to chew/swallow. McKenzie Healthcare told HDC that Mrs E repeatedly commented that she could not recognise or taste the food provided and thought that people were trying to poison her, which led to poor oral intake.

59. McKenzie Healthcare said that the general manager frequently encouraged Mrs E to eat and drink, but Mrs E declined. Conversely, Ms B told HDC that when she visited, Mrs E had consumed snacks brought in by the family with enthusiasm. Clinical notes do not record that Mrs E declined to eat and drink, and that encouragement was given to increase her intake. The food and fluid intake records contain only two entries on 1 and 2 Month2, which note that Mrs E had 'poor food and fluid intake'. There is no record of the volume of intake, the content, or any support given. The records do not note that Mrs E complained of hunger.

60. The hygiene records contain daily entries from 19 Month1 to 3 Month2. These show that Mrs E was showered and had moisturiser applied, her dentures were cleaned, her clothes were changed, and her bed linen was changed. Ms B disputed this and told HDC that this did not align with her daughters' or Mrs D's observations when they visited Mrs E.

61. Mrs E's LTCP records that she was to 'have uninterrupted sleep of 8–10 hours at night'. Sleep assessments were recorded from 19 Month1 to 4 Month2. However, documentation appeared to be inconsistent. There were no entries on 21, 22, or 23 Month1, on some nights there was one entry, and on other nights there was more than one entry, and there is no record of how much sleep Mrs E received.

62. Mrs E's STCP states that following a COVID-19 positive test, she needed to have daily temperature recording. The vital signs chart shows that daily temperatures were recorded

[27] On 26 Month2 the general manager recorded that she tried to play music.

from 19 to 28 Month1. Pulse and oxygen saturation monitoring was inconsistent,[28] and from 28 Month1 to 4 Month6 no entries were made.

63. McKenzie Healthcare's Nutrition, Safe Food and Fluid Management Policy (dated January 2021) states that all residents are to be weighed monthly or more frequently, and that this should be recorded in the weight chart. The weight chart shows that no weight recordings were completed during Mrs E's isolation.

64. Mrs E's behaviour management goal states that she 'will not demonstrate behaviours'. The behaviour assessment chart shows only one entry on 30 Month1 2022, which records that Mrs E was agitated and confused, yelling and screaming. There is no record of what interventions were implemented for these concerns. The progress notes record that Mrs E also had behavioural disturbances on 23, 24, 25, 26, and 31 Month1 and 4 Month2.

65. The bowel chart shows inconsistent monitoring of Mrs E's bowel function. There were no entries from 19–23 Month1, 25–31 Month1, and 3–4 Month2.

66. Continence assessments show inconsistent monitoring, with only three entries being documented on 29 Month1, 20 Month1, and 2 Month2.

67. Progress notes between 19 Month1 and 4 Month2 do not record what updates were provided to Mrs E's family regarding her COVID-19 infection.

68. McKenzie Healthcare acknowledged that documentation regarding Mrs E's care could have been better.

End-of-life care

69. From 30 Month1, progress notes indicate that Mrs E's health had been declining. On 30 Month1 McKenzie Healthcare staff recorded that Mrs E needed increased assistance with her cares and that this was 'due to confusion and anxiety related to poor vision and hearing'. On 31 Month1 it was recorded that Mrs E looked very lethargic and dehydrated and needed increased support. On 1 Month2 it was recorded that Mrs E had 'declining health', very little food and fluid intake, and was 'looking pale' and 'gaunt'.

70. On 1 Month2 Mrs E's son was informed of her declining health, and staff asked the GP to prescribe subcutaneous medications.[29] These were prescribed on 2 Month2.

71. Clinical notes do not record whether any discussions about end-of-life/palliative care occurred with family or Mrs E. McKenzie Healthcare provided no evidence of a last-days-of-life care plan.

72. Sadly, Mrs E passed away.

[28] Oxygen saturation was not monitored on 19 or 21 Month1. Pulse was not monitored on 21, 22, 23, 24, and 28 Month1.
[29] Medications injected under the skin.

Review by McKenzie Healthcare

73. When notified by HDC about Ms B's complaint, McKenzie Healthcare completed a review of Mrs E's care and outlined the following findings:

- There were trends of poor communication;
- Formal nutritional records were not implemented or documented, which should have been considered a priority for residents in isolation;
- There was no continuity in daily forms being used for visual checks;
- Documentation on input and output was poor and subjective;
- Vital signs were documented retrospectively onto the weight and vital signs charts;
- There were no records on staff training on fluid and food recording;
- The policy on food and fluid recording was outdated and needed a review;
- There were no activities recorded while Mrs E was in isolation, except for two occasions;
- Registered nurses did not liaise with GPs regarding medication reviews or treatment for COVID-19, as evidenced by the fact that Mrs E continued to receive frusemide[30] (for her congestive heart failure) while dehydrated, and there was a lack of antiviral medication prescription; and
- End-of-life management, including Te Ara Whakapiri care plan,[31] was not implemented.

Consumer 3: Mrs F

Complaint

74. Mrs C complained about the standard of care provided to her mother, Mrs F. Mrs C is particularly concerned that staff took excessive time to answer Mrs F's call bells because of poor staffing and a 'bad work culture'. Mrs C told HDC that the care and welfare of the elderly was at risk due to staff shortages at McKenzie Healthcare.

75. Following the complaint to HDC, on 3 Month5[32] Mrs F transferred to another facility.

Clinical history

76. At the time of events, Mrs F was 79 years old. A needs assessment a month prior to admission stated that Mrs F was transferred from McKenzie Village to McKenzie Healthcare on 28 Month1 for hospital-level care because of a decline in her functional health and inability to manage activities of daily living. Mrs F's admission nursing assessment dated 28 Month1 stated that she had poor mobility and required full assistance with all personal cares, including toileting and continence needs. The assessment also noted Mrs F's stress incontinence, and the need to urinate four to five times overnight.

[30] Medication to increase urinary output.
[31] A national framework that sets out guiding principles for the care of people in their final days of life.
[32] Relevant months are referred to as Month1–Month5 to protect privacy.

77. In addition, the assessment outlined Mrs F's history of chronic kidney disease, congestive heart failure (CHF),[33] and lethargy.

78. McKenzie Healthcare told HDC that Mrs F had low mood and anxiety, and during her admission, she became more reliant on staff. McKenzie Healthcare said that Mrs F had fluctuating mood, and she became tearful and screamed when left alone for more than 10 minutes. McKenzie Healthcare stated that Mrs F frequently told her family that she was not being dealt with, but when asked to elaborate, she said that she was lonely and wanted company, and, on one occasion, McKenzie Healthcare's general manager was in the room when Mrs F was telling the family that she was not being cared for. McKenzie Healthcare said that Mrs F's verbally aggressive behaviour towards healthcare assistants increased, and she threatened them frequently, making complaints of elder abuse against them.

79. McKenzie Healthcare told HDC that due to contradictory communication, unpredictable mood, and aggressive behaviour, staff were anxious about attending to Mrs F alone, potentially delaying call-bell response times.

Call-bell issue

80. Mrs C told HDC that in the first five weeks of Mrs F's admission, on most days it took one to one-and-a-half hours for the call bell to be answered, leading to 'her dignity being taken away'. Mrs C said that Mrs F would ring her when the call bells were not answered, leading to the family having to phone the facility to request that someone answer Mrs F's call bell.

81. McKenzie Healthcare told HDC that its call-bell system is run remotely by a third party. All the call bells within resident rooms and bathrooms are assigned to a pager provided to the caregiver assigned to that room. The pager vibrates when the resident raises the alarm. The caregiver can choose to accept or reject the call. If the call is rejected, it gets escalated to the pager of another staff member, and, if none of the caregivers accept it, it is escalated to the relevant registered nurse. However, once the call is accepted, the bell will still need to be cancelled physically at the call point on the wall of the resident's room/bathroom after attendance.

82. McKenzie Healthcare said that when the call bell is pushed, there is no light above the door of the resident's room, and it is silent. Likewise, there is no centralised main board to let a staff member know that the resident has pushed the call bell.

83. Mrs C told HDC that she raised the issue of call bells not being answered with McKenzie Healthcare. McKenzie Healthcare told HDC that on 8 Month2 a family meeting was held with registered nurses and Mrs F and her family, during which the family disclosed that they were unhappy with how long it took for caregivers to answer Mrs F's call bell. As a result of this complaint, a registered nurse pager was issued to Mrs F to use as a back-up measure when the call bells were not answered. No minutes were provided for this meeting, and there is no evidence of the corrective action plans or investigations undertaken into the complaint.

[33] A condition in which the heart cannot pump blood well enough to meet the body's needs.

84. Following Mrs C's complaint to HDC, McKenzie Healthcare completed a review of Mrs F's call-bell statistics for her entire admission (28 Month1 to 3 Month5).

85. McKenzie Healthcare advised of the following limitations of the review:

- Mrs F was assigned a registered nurse pager on 23 Month2 when this issue was raised, and therefore the data does not include all calls made during that period.
- The statistics include call bells for Mrs F's room, the next room, and the shared bathroom for both rooms, and therefore there is no way to identify which resident had used the bathroom call bell.

86. McKenzie Healthcare acknowledged that extended call-bell response times may have been due to staff attending to other residents. It apologised for this and stated that there was no excuse for not checking on Mrs F.

87. McKenzie Healthcare noted the following contributing factors to the issue:

- Pagers did not escalate to another pager following rejection of a call;
- Five pagers had gone missing, and this affected the way the call bell was escalated to other pagers, as fewer pagers were in action;
- Pagers had been unevenly distributed through its facility;
- Residents were assigned to the wrong pagers, that is, caregivers who were not assigned to care for the residents were being alerted. On these occasions, caregivers rejected calls but did not escalate it to anyone else;
- Pagers were left in nursing stations or staff rooms, rather than being carried around;
- There was a faulty electrical power board, causing issues with pagers not activating, or alarming when a resident had not called; and
- There was a weak Wi-Fi signal at times, which had the potential to drop out the call bells.

88. The call-bell target response times state that emergency calls are to be answered within one minute and assistance calls are to be answered within three minutes. The call-bell statistics provided to HDC show that on more than 40 occasions between 29 Month1 and 8 Month3[34] the response time was more than 30 minutes. In addition, on around four occasions, call bells were rejected more than 10 times for Mrs F's room. On 4 Month2 there were over 40 rejected calls by three caregivers.

[34] The date on which Mrs C raised concerns with HDC.

89. Several documents provided to HDC show evidence of concerns with call-bell systems and pagers, including the following:

- A Health and Safety audit completed in the year identified that 10 pagers were missing from the care home, with only six in use on the day of audit. This was followed up, and eight pagers were found;
- A Health and Safety meeting held on 7 Month1 discussed sensor mats and call bells;
- Caregiver meeting minutes of 31 Month2 refer to missing pagers, and call bells not being answered. The minutes state that McKenzie Healthcare was 'looking at [a] walkie talkie system';
- A resident meeting held on 9 Month3 shows that residents raised concerns about poor response time of call bells;
- The Health and Safety Corrective Action Plan dated 19 Month3 states that 11 out of 52 residents did not know how to use the call bell, following which education was provided to the residents;
- Minutes from the resident meeting held on 9 Month5 describe ongoing problems with call bells left unanswered for up to 20 minutes;
- A corrective action plan dated 22 Month5 noted that 6 out of 10 call-bell alarms did not show on the phone device; and
- Email records on 24 Month5 noted that call bells did not work for six resident rooms.

90. Mrs F's progress notes also document concerns with call-bell systems and call-bell response times on several occasions, including waiting for 1.5 hours on 22 Month2.[35] On several of these occasions, it is recorded that Mrs F had rung her family for support in response to the call bell not working and/or shouting for help.

91. McKenzie Healthcare told HDC that it did not have a call-bell policy. However, it audited call-bell response times as part of its monthly health and safety audit schedule. McKenzie Healthcare stated that its previous maintenance manager completed six-monthly call-bell checks, but it was unable to provide evidence for this.

92. Section 31 of the Health and Disability Services (Safety) Act 2001 requires all certified providers to notify HealthCERT at the Ministry of Health regarding 'any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided', such as issues or outages with call-bell systems.[36] However, there is no evidence that section 31 notifications were sent to HealthCERT during the care provided to Mrs F.

[35] 8 Month2, 18 Month2, 22–23 Month2, 27 Month2, 31 Month2, 3–5 Month3, and 8 Month3.
[36] healthcert-section31-guidelines-Sep24.docx

Continence management and toileting

93. McKenzie Healthcare's Continence Management Policy (dated November 2022) stipulates that the continence needs of residents are to be assessed on admission and then evaluated six monthly, or more frequently as required. Toileting and continence needs are to be recorded on the resident's individual care plan, and if there are any changes in the condition or level of continence, then the issue is to be reported to a registered nurse. Further, the policy stipulates that the privacy and dignity of residents must be respected at all times, and that any incontinence events are to be dealt with promptly.

94. The complaint raised concerns about McKenzie Healthcare's ability to manage Mrs F's continence and toileting needs.

95. Mrs F's admission nursing notes dated 28 Month1 state that she needed to get up four to five times overnight to go to the toilet and required support with mobilising and toileting. Her LTCP also states that she was on frusemide (a diuretic that increases the frequency of urination) to help with fluid retention from CHF.

96. Continence monitoring forms were completed from 4 Month2 to 27 Month4. However, it appears from the documentation that information was recorded inconsistently on the forms. Some days recorded only one episode of urine being passed,[37] while on other days[38] there were no entries. In addition, most entries within the continence assessment form did not record the amount, continence level, or the food/fluid input in relation to the continence episode.

97. Progress notes during Month1 and Month2 2022 describe Mrs F experiencing episodes of urinary urgency with anxiety, pain, and shortness of breath impacting her level of mobility, resulting in an increased dependence on staff assistance with toileting needs. The notes also record that Mrs F was upset after being left on the toilet on 13 Month2.

98. The continence records and progress notes indicate that Mrs F was assisted by staff with toileting as required throughout the day, and between 4–6 times overnight. McKenzie Healthcare's response and file documentation discuss concern about Mrs F's level of fatigue due to disrupted sleep, and the associated impact on her mood, health, and wellbeing.

99. McKenzie Healthcare told HDC that Mrs F was becoming very anxious about toileting, lack of sleep, and how it could be affecting her mood. The progress notes record that an indwelling catheter was inserted on 9 Month3 'with [Mrs F's] consent'. However, the clinical notes do not record the type of catheter inserted, or why it had been inserted, or whether a specialist such as a urologist had been consulted. It was also not recorded what was discussed with Mrs F about this intervention.

[37] 16 Month2, 23 Month2, and 29 Month2.
[38] 20 or 19 Month2, and 15 Month2.

Relevant standards

Health and Disability sector standards 2008

100. From 1 June 2009 to 28 February 2022, care homes were audited against the Health and Disability Service Standards NZS 8134:2008 (NZHDSS 2008). On 28 February 2022 NZHDSS 2008 standards were changed to Ngā Paerewa Health and Disability Services Standard NZS 8134:2021 (NZHDSS 2021). These standards provide guidelines that promote the safe provision of care within residential care facilities. They provide guidelines on several areas of care, including (but not limited to) communication with families and residents, consumer rights, statutory and regulatory obligations, documentation, and the physical environment. More information on these standards can be found in Appendix D of this report.

Aged Residential Care (ARC) contractual obligations

101. The ARC contract[39] with Health NZ lists the following obligations for ARC providers:

- Providers must keep and preserve records and protect the security of them in accordance with statutory obligations;
- Services must be resident-centred, promote residents' independence and their quality of life;
- Providers must involve residents in decisions and encourage involvement of families in the provision of care;
- Providers must provide a caring, comfortable and safe environment that respects residents' privacy and dignity; and
- Providers must make available to prospective residents the services it offers, including resident rights and responsibilities and any other information that is important for residents to receive prior to admission.

Certification and surveillance audits

102. Between 2020 and 2022, the Ministry of Health's certification and surveillance audits recorded several partial attainments.

103. Relevant findings include:

- Partial attainments for:
  - NZHDSS 2008 criteria 1.3.6.1 as not all wounds had individual assessments, plan and evaluations completed;
  - NZHDSS 2008 criteria 1.3.3.4 as there was inconsistent evidence in the progress notes that registered nurses contributed to the evaluation of care provided by caregivers and enrolled nurses;

[39] The ARC contract changes every year. The principles outlined within this section have stayed the same over the years.

- NZHDSS 2008 criteria 1.3.5.2 as care plans did not always reflect the detailed interventions required to support identified issues and to guide staff;
- NZHDSS 2021 criteria 1.8.3 as a complaints register had not been documented for the service under the current agreement and there was no previous complaint documentation evidenced;
- NZHDSS 2021 criteria 2.2.6 as the general manager was unaware of the scope of essential section 31 notification reporting and no notifications were sighted for pressure injuries and registered nurse shortages;
- NZHDSS 2021 criteria 3.2.1 as LTCPs were not documented for residents, care plan and activity plan evaluations did not occur within required timeframes, interRAI assessments had not been completed within 21 days of admission or six monthly, and interRAI assessments did not inform the care plan for one resident.

Responses to provisional report

McKenzie Healthcare

104. McKenzie Healthcare were provided with a copy of the provisional report and given the opportunity to comment. McKenzie Healthcare acknowledged the thoroughness of the investigation and accepted the findings. McKenzie Healthcare stated that it is committed to improving its practices to ensure better care and outcomes for its residents. Other comments have been integrated elsewhere in the report.

Mrs C

105. Mrs C was provided with the relevant parts of the provisional report and given the opportunity to comment. Mrs C thanked HDC for its work and had no further comments.

Ms B

106. Ms B was provided with the relevant parts of the provisional report and given the opportunity to comment. Ms B thanked HDC for its thorough report. Her comments have been integrated throughout this report where relevant.

Mrs A

107. Mrs A did not respond to this Office, and therefore a copy of the provisional report was not provided to her.

Opinion: Introduction

108. In 2022 this Office received three complaints about the standard of care provided to three consumers who were receiving hospital-level care at McKenzie Healthcare. The consumers were vulnerable, with significant comorbidities, and they required daily support from McKenzie Healthcare staff.

109. This report considers whether the care provided to these three residents was of an appropriate standard. I sought responses from McKenzie Healthcare, the complainants, and my aged care nursing advisor, RN Jane Ferreira, to help me determine whether the care was appropriate. After carefully reviewing this information, I consider that McKenzie Healthcare did not provide a reasonable standard of care for the three consumers.

110. In forming this decision, I have taken into account the COVID-19 pandemic, which had a significant impact on the workforce and delivery of coordinated care, particularly in the aged-care sector, and the ransomware attack experienced by McKenzie Healthcare, which affected the provision of information to HDC.

111. I consider that the care provided in each case demonstrated a system-level failure. There was a consistent pattern of poor care for multiple consumers, and inadequate organisational systems to support staff in providing effective care. In my opinion, this resulted from a lack of robust leadership, a lack of strategic direction, and poor clinical oversight. This had a cascading effect on healthcare delivery and resulted in a failure to provide appropriate care and assistance to McKenzie Healthcare staff and residents.

112. On 12 September 2024 I proposed that HDC find McKenzie Healthcare in breach of Rights 4(1)[40] and 4(2)[41] of the Code of Health and Disability Services Consumers' Rights (the Code) for the three consumers. I proposed this option given the departures from accepted standards identified by RN Ferreira and the clear and accepted position that McKenzie Healthcare did not provide a reasonable standard of care. On 4 October 2024 McKenzie Healthcare accepted the proposed Right 4(1) and 4(2) breaches.

113. I discuss the findings for each consumer below.

Opinion: Care provided to Mrs A — breach

Introduction

114. Mrs A was a 67-year-old woman who resided at McKenzie Healthcare from 28 Month1 to 24 Month15. She had multiple comorbidities, including visual impairment and two stomas, for which she required daily assistance. Mrs A complained that there was a lack of attendance by staff, social isolation, and a lack of access to appropriate toileting facilities.

Adequacy of nursing care planning and assessments

115. RN Ferreira advised that the care records indicate that nursing staff were responsive to Mrs A's care requirements and discussed the management of her routine healthcare needs.

[40] The right to have services provided with reasonable care and skill.
[41] The right to services that comply with legal, professional, ethical, and other relevant standards.

However, RN Ferreira noted extensive concerns about various aspects of the care provided to Mrs A.

116. RN Ferreira advised that the lack of pre-admission assessments and pre-admission meeting with Mrs A to discuss her care requirements was not within accepted standards. Similarly, the lack of orientation and provision of information regarding shared facilities following admission to McKenzie Healthcare was not within accepted standards. RN Ferreira advised that admission assessments and orientation would have supported Mrs A to settle into the care home, particularly in terms of understanding the use of shared facilities, including how resident care routines and infection control practices are maintained. Moreover, the ARC agreement stipulates that care providers must discuss the services it offers to prospective residents, while standard 1.3.1 of NZHDSS 2008 stipulates that consumers' entry into services must be facilitated in a competent manner.

117. RN Ferreira also advised that there is no evidence that assessments were completed on admission to identify Mrs A's care and safety needs, such as falls risk, pressure injury risk, pain, or nutritional needs. In my view, as no baseline admission assessments were completed, the training and support provided to caregivers on how to meet Mrs A's care and safety needs was likely to have been limited. This is in conflict with standards 1.3.4 and 1.3.5.2 of NZHDSS 2008, which stipulate the need for gathering information about consumers' needs and support requirements and recording of the necessary intervention within the service delivery plans.

118. RN Ferreira's advice indicated that there was an absence of resident-centered care. In particular, there was a lack of consideration for Mrs A's visual impairment and personal care delivery. I note that this is required by standard 1.3.5 of NZHDSS 2008. RN Ferreira advised that there is limited discussion within Mrs A's clinical notes regarding her care requirements, hazard management, and strategies that were offered to promote her independence. RN Ferreira noted the consideration given to ensure that Mrs A was safe within her room but advised that there was a lack of strategies offered to ensure that Mrs A remained safe and independent in other parts of the care home.

119. RN Ferreira also noted the lack of care planning on several occasions. First, RN Ferreira advised that no changes were made to Mrs A's care plan to accommodate her diagnoses of pyelonephritis and respiratory infection following discharges from hospital in Month5 and Month12, respectively. I consider that as these diagnoses were not accommodated in her care plans, the monitoring and support offered to Mrs A was also likely to have been limited in this respect.

120. Secondly, RN Ferreira advised that no STCP was started regarding infection control measures, personalised care delivery and bathroom use, or evidence of specific care information, when Mrs A was placed on contact isolation on several occasions, which again is in conflict with NZHDSS 2008 standard 1.3.5.

121. RN Ferreira advised that whilst the care met the 'lowest level' of accepted care, the above issues represent moderate deviations from the accepted standards of care. RN Ferreira

noted that the reported workforce difficulties were a mitigating factor. Whilst I recognise that the lowest level of care may have been met, I accept that there was a moderate departure from accepted standards. Several areas of Mrs A's care would have benefited from careful planning and assessment. In my opinion, these were critical components of delivering safe and quality care and ensuring that caregivers were guided in their roles adequately.

Adequacy of infection control policies

122. While RN Ferreira's advice did not indicate any concerns with McKenzie Healthcare's decision to isolate Mrs A, it indicated significant deficits in McKenzie Healthcare's infection control policy.

123. RN Ferreira advised that while the policy discusses hand hygiene, contact isolation, and education for staff and close family, there is no discussion on education for residents or on seeking their consent. In addition, there is minimal guidance on the use of PPE, waste handling, or wider care responsibilities. Further, RN Ferreira advised that the policy contains limited discussion on infection classifications, transmission pathways of infections, PPE use, rationale for care interventions, health education, resident consent, clinical assessment skills and associated responsibilities, risk mitigation strategies to maintain safety needs, support plans to minimise social isolation, site-specific information about shared bathroom use, or communication needs of the resident and their nominated representative.

124. RN Ferreira advised that although a leaflet on managing ESBL infections within the facility was available to guide staff on Mrs A's ESBL infection, this was not integrated with McKenzie Healthcare's internal infection control policy, which would have been within accepted standards.

125. RN Ferreira also noted a lack of policy guidance on shared bathroom use, clinical oversight, delivery of personalised resident care, and safe management during an infection outbreak.

126. RN Ferreira advised that whilst the policies generally met accepted standards, the above issues represent mild departures from the accepted standard of care. I accept this advice. In my opinion, it is insufficient simply to have a policy in place. It is important to ensure that the policy is fit for purpose, as stipulated by NZHDSS 2008 standard 3.3. Policies serve as a framework for consistent decision-making, guiding the care that clinicians provide to residents and ensuring compliance with relevant legal and regulatory requirements.

Dignity and respect

127. Mrs A told HDC that she 'had several blow outs of [her] stoma bags and was left in [her] chair or bed covered in faeces'.

128. The progress notes indicate that on several occasions Mrs A's stoma bags burst and leaked. On one occasion, staff advised Mrs A that their lack of timely attendance was because they were attending another resident. However, the notes do not always document the reasons for the lack of timely attendance on Mrs A.

129. The notes show that Mrs A expressed her distress in relation to using the shared bathroom when needing to empty stoma bags herself. She told HDC that when she was placed in contact isolation, she was restricted from using the shared bathroom. The progress notes indicate that this happened on at least three occasions.

130. RN Ferreira advised that leaving a vulnerable resident distressed and in soiled clothing for any period of time is below the accepted standards of care. McKenzie Healthcare's Privacy and Dignity and Continence Management Policy, the ARC contract, and NZHDSS 2008 Standard 1.1.3 all stipulate that privacy and dignity must be maintained for residents at all times.

131. The lack of internal guidelines relating to health education and seeking consent (discussed above) indicates that limited health education was provided to Mrs A.

132. RN Ferreira advised that the lack of respectful care along with communication and the lack of consent represents a moderate to severe deviation from the accepted standards of care. I accept this advice.

133. In my opinion, the care provided to Mrs A was unacceptable. This is because Mrs A's stoma bag became full to the point of bursting, there was a delay in attending to Mrs A, and her concerns relating to sharing of the bathroom facilities were not addressed adequately. I am also critical that Mrs A was not provided with access to a toileting facility while being isolated. While I accept that this was to prevent infection transmission to other residents, Mrs A still had the right to access a toileting facility, which represents a significant failure to provide basic, dignified care.

Complaint management

134. Mrs A complained to HDC about a lack of staff attendance, stoma management, and social isolation while contact isolation measures were in place. The progress notes show that on several occasions Mrs A expressed dissatisfaction with the infection control measures, social isolation, stoma management, and the lack of access to a bathroom. While these concerns were acknowledged by nursing staff, the issues were not registered on the complaint register, as required by McKenzie Healthcare's complaints management policy and standard 1.1.13 of NZHDSS 2008.

135. RN Ferreira advised that there is no evidence that these concerns were resolved through agreed interventions with Mrs A, or that the concerns were escalated to senior clinical staff such as the clinical manager, as required by the complaints policy, or that the concerns were discussed during registered nurse meetings, or that an apology was given to Mrs A. RN Ferreira said that given Mrs A's complex health needs and repeated expressions of care concerns, a meeting with the clinical manager and/or a clinical lead would have been appropriate.

136. RN Ferreira advised that the above issues were a moderate to significant departure from the accepted standards of care. I accept this advice. Mrs A raised her concerns repeatedly, and although McKenzie Healthcare staff acknowledged Mrs A's concerns, the issues were

not managed actively or resolved to an acceptable level, which did not comply with McKenzie Healthcare's internal complaints management policy. In my opinion, the level of communication provided to Mrs A and her husband about complaint concerns was minimal, and she would have benefitted from more direct engagement, such as a meeting with the clinical manager to discuss and agree to solutions.

Conclusion

137. In summary, there were several departures from accepted standards in Mrs A's care, of which I am critical. I find that McKenzie Healthcare breached Right 4(1) of the Code for the following reasons:

- The failure to provide an adequate standard of nursing care, including the failure to complete preadmission assessments and baseline nursing assessments, the failure to provide resident-centered care, which led to a loss of dignity, the failure to provide orientation to Mrs A, and the failure to complete care planning following hospital discharge and when Mrs A was placed in contact isolation; and
- The inadequate infection control policy in place to guide staff.

138. In addition, I find that McKenzie Healthcare breached Right 4(2) of the Code for the following reasons:

- The failure to follow standards 1.3.1, 1.3.4, 1.3.5, 3.3, 1.1.3, and 1.1.13 of NZHDSS 2008;
- The failure to follow the ARC agreement; and
- The failure to follow McKenzie Healthcare's Privacy and Dignity, Continence Management, and Complaint Management policies.

Opinion: Care provided to Mrs E — breach

Introduction

139. Mrs E was a 98-year-old woman who resided at McKenzie Healthcare from 2020 to 2022. She had several chronic conditions, including dementia, low vision, and hearing impairment, for which she needed daily support. In addition, Mrs E was at risk of undernutrition and dehydration, which required close monitoring. This section discusses the care provided to Mrs E while she was placed in contact isolation for COVID-19 from Month1 to Month2 2022.

140. I express my sincere condolences to Ms B and her whānau for Mrs E's passing.

Lack of adherence to outbreak management plan

141. RN Ferreira advised that McKenzie Healthcare's COVID-19 outbreak management plan aligned with public health guidelines. It appears that many aspects of the plan were followed, such as the implementation of infection control measures to meet contact and

droplet precautions, timely event escalation to public health and the portfolio manager for older people's health at Health NZ, and regular communication with public health and the portfolio manager on positive COVID-19 cases within the facility. However, RN Ferreira advised that other aspects of the plan were not followed.

142. RN Ferreira noted that daily care-home outbreak meetings were not completed, and there is no evidence of an infection control specialist at McKenzie Healthcare to guide resident care clinically in terms of isolation timeframes and attend outbreak meetings. RN Ferreira also advised that there was limited communication with primary-care services to seek specific guidance regarding resident care, and there was no evaluation of the outbreak once infection had resolved.

143. RN Ferreira said that it is unclear whether an operations manager from McKenzie Healthcare was involved in the organisational reporting responsibilities, such as notifying HealthCERT, or attending external meetings to support the care-home clinical team, given the staffing challenges, which would be considered accepted practice in the circumstances.

144. In response to the provisional report, McKenzie Healthcare told HDC that its general manager had infection control experience and had also consulted a senior nurse with infection control experience, although there is no documentation of this consultation.

145. I acknowledge McKenzie Healthcare's statement to HDC but ultimately accept RN Ferreira's advice. While there is evidence of emails between McKenzie Healthcare's clinical lead and Health NZ's portfolio manager, I am concerned that there is no evidence of daily outbreak meetings, minimal evidence of involvement of an infection control specialist, or an evaluation after the outbreak ended, as required under the outbreak management plan. Further, communication with primary-care services appears to have been minimal, as indicated by an absence of GP assessments within Mrs E's notes and email correspondence from the GP practice on 21 Month1, which indicated that the practice was not being notified of COVID-19 cases. McKenzie Healthcare acknowledged that it would have benefited from further support during the pandemic.

Extended isolation

146. Health NZ's outbreak management guidelines at the time state that some cases needed to remain isolated for more than seven days after acute symptoms resolved, or if the resident remained infectious, but isolation was not to be longer than 10 days. Mrs E was isolated for 16 days, with no documented assessments to explain this.

147. RN Ferreira advised that accepted practice would include consideration of GP assessment, ongoing transmission risk for infection, indications for further testing, impact on wellness and wellbeing, and establishment of an agreed review date of isolation measures and resident needs in partnership with Mrs E and her family.

148. RN Ferreira advised that the outbreak management plan and STCP were not updated to reflect the rationale for Mrs E's extended isolation, including any specific considerations for care during this time. In addition, there is no evidence of interaction with the IPC team for

clinical guidance regarding Mrs E's status and ongoing care requirements at the end of the seven- and ten-day period.

149. I agree that there is no evidence that McKenzie Healthcare reassessed Mrs E's status and ongoing care requirements, and I am concerned that Mrs E continued to be isolated for an extended period with no apparent rationale. This implies that resident-centred care was not provided, as stipulated by the ARC agreement and NZHDSS 2021 standard 2.3. Socialisation was a recognised need for Mrs E, as reflected in her LTCP. Social isolation is known to have a detrimental impact on older people's wellbeing, such as increasing the risk for physical and cognitive decline and significantly diminishing older people's quality of life. Therefore, it is essential that care-home leaders carefully assess the need for isolation.

Care planning, risk assessments, and monitoring during isolation

150. RN Ferreira noted several concerns in relation to care planning and its implementation during Mrs E's isolation. RN Ferreira advised that the care record provides limited evidence of clinical leadership and care oversight, or of nursing assessment, care planning, and care delivery during this timeframe.

151. While a generic STCP was implemented to manage Mrs E's COVID-19 illness, RN Ferreira noted several gaps in terms of nursing assessment, monitoring, and care escalation. In particular, the STCP did not comment on Mrs E's individual care and safety needs, or use of personalised strategies to support Mrs E, as required by NZHDSS 2021 standard 2.3. Further, during her isolation, no nursing risk assessments were completed for her falls risk, nutritional needs, personal care requirements, consideration of triggers to mood and behaviours, signs of boredom or loneliness, or her wider care and safety needs.

152. RN Ferreira advised that the clinical file contains no documented evidence of a GP assessment, a request by nurses for review of Mrs E's prescribed medications, or consideration of suitability for antiviral medications.

153. In terms of monitoring, there is also no evidence of nutritional records, intentional rounding, fluid balance charts, evidence of increased frequency of weight recording given Mrs E's high-risk factors for weight loss, or consideration of dehydration considering Mrs E's frusemide prescription. The absence of review of Mrs A's prescription is also highlighted in McKenzie Healthcare's internal review.

154. Mrs E's STCP stated that her vital signs were to be monitored four times a day while in isolation. Although this happened daily between 19 and 28 Month1, no assessments were completed between 28 Month1 and 4 Month2despite Mrs E's extended isolation period and clinical decline. Therefore, Mrs E's STCP was not followed, and it appears that the care provided to Mrs E at the time of the events was not evaluated, as required by NZHDSS 2021 standard 3.2.4, which stipulates that consumers are to receive care that is consistent with their needs and goals.

155. Over the isolation period, Mrs E was noted to be refusing meals and having episodes of thirst and one episode of nausea, although the refusal of food is disputed by Ms B. The STCP stated to encourage oral fluids and to introduce a lighter, alternative diet if menu items were refused. However, RN Ferreira advised that there is no evidence of assessment by staff, and a lack of exploration of strategies to manage these issues. As noted above, there is no evidence of nutritional records, a fluid balance chart, or weight recordings during this time. This is in conflict with NZHDSS 2021 standard 3.2.4, which stipulates the need for timely risk assessments when there are changes in resident health.

156. RN Ferreira also noted that while there were bowel record entries of Mrs E's self-reported bowel results on 16 and 24 Month1, there were no further entries for the next 10 days, which presents clinical and care concerns. She also noted that it is unclear whether Mrs E was able to provide a reliable account of bowel patterns given her history of cognitive impairment, and whether further enquiry or nursing assessment occurred, which would be accepted practice.

157. The progress notes report changes to Mrs E's mood and behaviour during the isolation period, with increased persistence in calling out to staff. There is no evidence that pain assessments were completed, or monitoring forms or bowel records reviewed to consider contributing factors to the displayed behaviour. RN Ferreira noted that Mrs E received quetiapine on 24, 25, and 26 Month1 for agitation, but the rationale and evaluation of effectiveness is unclear in the nursing notes.

158. A behaviour monitoring form commenced on 30 Month1, following an incident in which Mrs E began to hit a healthcare assistant and to yell during the care. RN Ferreira advised that it is unclear whether an incident report was completed or whether further enquiry occurred at this time, which would be accepted practice. She noted that there is no evidence of assessment by a registered nurse to consider wider contributing factors to displays of agitation or distress, given Mrs E's medical history, and no review of care and safety needs, particularly falls risk and the associated side effects of the additional medication.

159. I accept this advice. In my opinion, there was minimal consideration of Mrs E's individual needs during isolation. Mrs E was a vulnerable consumer with cognitive impairment and disabilities that affected her vision and hearing. Under these circumstances, extra care was necessary to ensure that Mrs E's safety and personal needs were protected during isolation through careful planning, assessment, and monitoring. I am critical that this did not occur.

Recognition of clinical decline and escalation

160. RN Ferreira advised that Mrs E's clinical records demonstrate clinical decline from 30 Month1 and in Month2. This is indicated by Mrs E's reduced oral intake, dehydration, episodes of confusion, decline in mobility with Mrs E needing assistance from two people, and concerns about her continence. RN Ferreira advised that staff did not recognise these signs in a timely manner or escalate this to senior staff members, such as a clinical manager or GP, to guide ongoing clinical care requirements and provide monitoring.

161. I accept this advice. I agree that Mrs E demonstrated many signs of deteriorating health, as indicated by my advisor and by the observations noted by Mrs E's whānau. As these symptoms were not recognised by staff in a timely manner, they were not escalated to senior staff. This is evidenced by McKenzie Healthcare's statement to HDC that Mrs E had been well during her isolation (except for a fever), and the absence of risk assessments and evidence of communication with a GP.

Lack of activities during isolation

162. RN Ferreira advised that social connections, access to activities, and contact with family are essential elements to support a resident's quality of life. However, apart from the folding of clothes, no other activities or opportunities to socially connect with her family were provided to Mrs E during her time in isolation. McKenzie Healthcare told HDC that other than music being turned on and the folding of clothes, no activities were offered to Mrs E.

163. In my opinion, although Mrs E was limited by contact isolation, it is unacceptable that she was left without access to recreational activities. As stated by Ms B, music was not an effective measure given Mrs E's hearing impairment. Mrs E's STCP reflected the need for social engagement to reduce her risks during isolation. Activities and diversional therapy can provide many benefits, including relief of stress and boredom, and improvement in self-confidence and memory, particularly in older people living with dementia. Moreover, a lack of access to meaningful activities is in conflict with NZHDSS 2021 standard 3.3.1. Therefore, I am critical that this was not done.

End-of-life care

164. As discussed above, Mrs E showed several signs of clinical deterioration over Month1 and Month2. While a registered nurse informed Mrs E's EPOA that she had deteriorated, and subcutaneous medications were prescribed by the GP for comfort on 2 Month2 (which also indicates that Mrs E was reaching the end of her life), there is no other evidence of end-of-life care planning before she passed away. RN Ferreira advised that essential care needs over this period, such as pain, pressure risks, skin and oral care, medication management, and delivery of holistic care were not met. In addition, these care needs were not communicated to the rest of the care team. RN Ferreira noted that there is no evidence that the existing advance care plan was used to inform last-days-of-life care planning.

165. I agree that there was insufficient end-of-life care planning, as also indicated by McKenzie Healthcare's internal review of Mrs E's care, and I am critical of this. Mrs E should have received these essential care needs to ensure that she was comfortable and supported during her last days.

Communication with family

166. RN Ferreira's advice was critical about the communication practices at McKenzie Healthcare.

167. RN Ferreira advised that while there is evidence that Mrs E's EPOA was informed of her positive test, there is no further communication relating to her COVID-19 illness, particularly in terms of further testing and health education. RN Ferreira noted that timely

communication with residents and their families is an essential part of outbreak management, as it provides an opportunity to share vital information, provide reassurance, and answer questions.

168. RN Ferreira advised that there was also limited communication with Mrs E's EPOA regarding Mrs E's end-of-life needs. While the EPOA was informed of Mrs E's declining health, it appears that no further communication or updates were given around the changes to her health and her end-of-life care.

169. In response to the provisional report, McKenzie Healthcare stated that Mrs E and her family made informed decisions about her care, including declining antibiotics, vaccines (including the COVID-19 vaccine), and anti-viral medications.

170. I acknowledge McKenzie Healthcare's response but ultimately accept RN Ferreira's advice. In my opinion, the quality and frequency of communication with Mrs E's EPOA was minimal, as evidenced by a lack of documentation regarding these matters. Engaging whānau in decision-making about care planning is crucial in providing high-quality care to individuals in need and is stipulated by the ARC agreement and NZDSS 2021 standards 1.7.4, 1.7.2, and 2.3.12. Regular communication with families fosters understanding, empathy, and trust between care providers and the whanāu, and I am critical that this did not occur.

Documentation standards

171. RN Ferreira noted several areas of concern relating to documentation.

172. First, as discussed above, Mrs E's STCP did not incorporate her individual care and safety needs, and there was an absence of documentation relating to nursing risk assessments and monitoring information during Mrs E's contact isolation. Further, there were many inconsistencies in documentation relating to her sleep records, vital signs monitoring, including temperature monitoring, behavioural assessments, bowel charting, and continence assessments. McKenzie Healthcare acknowledged that documentation regarding Mrs E's care could have been better.

173. The many examples of poor documentation reflect poorly on the system at McKenzie Healthcare. Clinical records reflect a clinician's reasoning and are an important source of information regarding the patient's care. Documentation is also a key component of ensuring continuity of care, and in ensuring that the next clinician can understand the rationale behind previous clinical decisions. Clinical documentation is therefore a cornerstone of good care, and a core requirement of NZHDSS 2021. In addition, poor clinical notes hamper later enquiry into what happened — thereby compromising the opportunity to address issues raised by or on behalf of a consumer, as well as quality improvement measures that may flow from such enquiry.

Conclusion

174. RN Ferreira advised that the above failures represent a moderate to significant departure from the accepted standards of care. I accept this advice. In my opinion, the care provided

to Mrs E was substandard. There were several significant departures of which I am critical. I find that McKenzie Healthcare breached Right 4(1) of the Code for the following reasons:

- The failure to update Mrs E's STCP to reflect the rationale for her extended isolation;
- Inadequate care planning, risk assessment, and monitoring;
- The failure to recognise and escalate Mrs E's clinical decline; and
- The failure to provide an adequate standard of communication to Mrs E and her whānau.

175. In addition, I find McKenzie Healthcare in breach of Right 4(2) of the Code for the following reasons:

- A lack of adherence to McKenzie Healthcare's COVID-19 outbreak management plan;
- The failure to adhere to NZHDSS 2021 standards 2.3, 3.2.4, 3.3.1, 1.7.4, 1.7.2, and 2.3.12; and
- The failure to adhere to the ARC agreement.

Opinion: Care provided to Mrs F — breach

Introduction

176. Mrs F was 79 years old and lived at McKenzie Healthcare between Month1 and Month5 2022. Mrs F had limited mobility and required a high level of assistance to support her with activities of daily living. Mrs C has expressed concern about the standard of care provided to Mrs F in relation to delayed call-bell responses and delayed delivery of care from McKenzie Healthcare staff.

177. RN Ferreira advised that the daily nursing care provided to Mrs F was appropriate in the circumstances, and that there is evidence of observations being taken regularly, concerns being escalated to the GP, and collaborative healthcare management. However, RN Ferreira identified many aspects of Mrs F's care that did not meet the accepted standards of care. I discuss these below.

Delayed call-bell response times

178. Mrs C told HDC that staff took an unacceptable amount of time to answer Mrs F's call bells, to the point that Mrs F would call her family, and her family had to call reception to ask that her call bells be answered.

179. The call-bell target response time for non-emergency bells is three minutes, and for emergency bells one minute, as indicated by the call-bell statistics report. However, call-bell statistics provided to HDC (for Mrs F's room, a neighbouring room, and a shared en suite bathroom) show that between Month1 and Month3, on more than 40 occasions the call-bell

response time was more than 30 minutes for both rooms. While the call-bell statistics report cannot confirm how many calls were related to Mrs F's room, the volume of missed calls indicates that it is more likely than not that some of the extended calls came from Mrs F's room. In addition, on several occasions caregivers appear to have been rejecting call bells.

180. McKenzie Healthcare found several other issues within its call-bell system that affected the call-bell response time, including a lack of pagers, pagers being distributed unevenly, residents being assigned to the wrong pagers, pagers not being carried by staff, a faulty electrical board, weak Wi-Fi, staff behaviour, the absence of a light above the door of the resident's room, and the lack of sound when the call bell was pushed. There is evidence that the issue of call bells not being answered had been raised by residents and staff persistently. In addition, I note that there is no call-bell policy to provide guidance to staff, including the expected timeframes for responding to calls.

181. RN Ferreira advised that the care provided to Mrs F represented a significant departure from the accepted standards of care. RN Ferreira highlighted that residents rely on call bells to communicate with staff, and Mrs F was kept waiting longer than necessary. RN Ferreira noted that staff require policy information to guide their practice, and education to provide skills to keep residents safe. I note that this aspect of care did not meet the ARC agreement or standard 4.1.2 of NZHDSS 2021. In addition, despite there being health and safety concerns, no section 31 notifications to HealthCERT were completed.

182. It appears that McKenzie Healthcare recognised these concerns and implemented several corrective actions, such as escalating the issue to the call-bell company and instating interim safeguarding measures such as providing a nurse pager to Mrs F. I also acknowledge McKenzie Healthcare's response that staff were anxious about responding to Mrs F due to behavioural concerns.

183. However, the evidence shows that these issues were longstanding, and the safeguarding measures implemented by McKenzie Healthcare did not prevent the degree of harm experienced by Mrs F. As RN Ferreira's advice indicates, it also appears that a number of critical safeguarding measures, such as intentional rounding and visual checks, were not implemented.

Continence management

184. Mrs F's admission nursing assessment states that she had stress incontinence and needed to urinate four to five times overnight.

185. On 9 Month3 an indwelling catheter was inserted. However, RN Ferreira advised that the rationale for this is unclear, as Mrs F's clinical records show no evidence of urinary retention or of Mrs F being unwell. It appears that the insertion of an indwelling catheter was not done in consultation with the clinical manager, GP, or another health professional such as a urologist or a gerontology nurse specialist. In addition, there is no evidence that Mrs F's prescribed medications were reviewed, or non-pharmacological strategies considered to manage her incontinence. RN Ferreira advised that an indwelling catheter should be

considered only when non-invasive methods have been unsuccessful, and it appears that potential non-invasive measures had not been explored.

186. RN Ferreira advised that any change in resident care interventions should be reflected in the care plan, as is also indicated by NZHDSS 2021 standard 3.2.4. However, Mrs F's clinical records do not show evidence of a nursing assessment, specific interventions, care evaluation, or what ongoing care was necessary following the catheter insertion. In addition, RN Ferreira noted that McKenzie Healthcare did not document the catheter type, balloon size, drainage systems, frequency of product changes, safe positioning and use of securing devices, discussion of informed consent, health education to Mrs F, infection control strategies, fluid intake and output, personal hygiene needs, bowel management, and skin care.

187. RN Ferreira noted deficiencies within McKenzie Healthcare's Continence Management Policy. She advised that while the policy refers to storage and emptying of urinary drainage bags, there is no discussion of catheter management, care planning for a resident with a urinary device, reference to infection control policy, discussion of education, staff training, or clinical competencies and professional development opportunities, and nor does the policy outline any associated nursing responsibilities, which presents an improvement opportunity for McKenzie Healthcare. The policy conflicts with NZHDSS 2021 standard 5.3.2, which stipulates that policies must be evidence-based. In addition, while there is evidence of training in the management of urinary catheters having been delivered, it is not known whether the staff involved in Mrs F's care attended this training or were assessed as being clinically competent in providing care for her, owing to the absence of training records.

188. RN Ferreira advised that the above issues represent a moderate to significant departure from accepted standards of care. I agree that there is a lack of evidence supporting Mrs F's IDC insertion, and a lack of policy guidance and training provided to support staff. It concerns me that this intervention appears to have been undertaken for Mrs F with limited assessment, discussion, and planning for ongoing care.

Complaint management

189. Progress notes show that Mrs F and her family raised several concerns about the call-bell response time. While this was acknowledged and responded to by way of a meeting, RN Ferreira advised that there are no meeting minutes or corrective actions of an agreed approach to improve the issues. In addition, I note that the complaint was not registered in McKenzie Healthcare's complaints register, as is required by its internal policy.

190. I note that McKenzie Healthcare has acknowledged this oversight and provided a rationale for the use of verbal interactions rather than written feedback as per its policy, and it has apologised for not meeting resident expectations. Nevertheless, I consider that McKenzie Healthcare's complaints management did not meet NZHDSS 2021 standard 1.8.3. This appears to have been reflected in the Ministry of Health's audit of the facility in 2022, which found a partial attainment regarding NZHDSS 2021 criteria 1.8.3.

191. RN Ferreira advised that there are opportunities for improvement in complaints management processes and documentation standards to reflect interaction with family and support effective consumer-focused care. I accept this advice. In my opinion, effective complaints management is essential for enhancing the quality of care, as complaints provide an opportunity to identify where care may have fallen short and to drive meaningful change.

Documentation

192. I have noted several areas of concern relating to the documentation of Mrs F's care.

193. As noted above, there were many omissions regarding documentation of the catheter insertion. RN Ferreira advised that there were also delays in completing admission nursing assessments and care plans, and inconsistencies in documentation such as monitoring forms and related nursing analysis. She noted that there is no family/whānau contact record to reflect the frequency of interactions between the parties involved, which is part of service provider responsibilities and accepted documentation standards. In addition, I have noted that the documentation within the continence monitoring forms was inconsistent, with most entries not providing detailed information on the amount of urine, continence level, or food/fluid input as indicated by the continence assessment headings.

194. RN Ferreira advised that these documentation concerns represent mild departures from the accepted standards of care. I accept this advice. As discussed previously, clinical documentation is a cornerstone of good care, and a core requirement of NZHDSS 2021.

Conclusion

195. There were several departures from accepted standards in Mrs F's care, of which I am critical. I find that McKenzie Healthcare breached Right 4(1) of the Code for the following reasons:

- The failure to manage Mrs F's continence needs adequately;
- The failure to have an internal call-bell policy/procedure to guide staff actions; and
- The failure to protect Mrs F's safety, by not answering call bells in a timely manner.

196. In addition, I find McKenzie Healthcare in breach of Right 4(2) of the Code for the following reasons:

- The failure to adhere to the ARC agreement;
- The failure to adhere to NZHDSS 2021 standards 4.1.2, 3.2.4, 5.3.2, and 1.8.3;
- The failure to adhere to McKenzie Healthcare's complaints management policy; and
- The failure to complete section 31 notifications to HealthCERT when there were health and safety risks, as required by the Health and Disability Services (Safety) Act 2001.

Changes made

197. McKenzie Healthcare told HDC that it made the following changes in response to the above complaints:

- The staff roster management now has oversight from the general manager.
- It has recruited seven additional registered nurses and three New Zealand-trained enrolled nurses. It said that the staffing turnover has now stabilised.
- 12-hour shifts have been established to support continuity of care.
- It has developed a new call-bell monitoring policy to ensure timely response, with daily audits of response times and rejected calls.
- The faulty electrical board has been replaced.
- A new IT professional has been employed with a focus on software, security, and Wi-Fi systems.
- It has completed one-on-one training on documentation. Since 2023 it has actively been working to improve nursing documentation and assessments. McKenzie Healthcare stated that while progress has been made, there is still considerable work to be done, and it is committed to enhancing its documentation to ensure clarity, accuracy, and thorough reflection of the care provided.
- It has added an ongoing quality improvement measure with the auditing of five resident files per month.
- It is developing standards of care for caregivers, which will provide standards on clinical deterioration, timely communication, basic nutrition, dehydration, head-to-toe assessment, and the screening and monitoring of residents.
- It is creating a checklist/flowchart for early detection of dehydration.
- It will ensure the organisation of activities for residents in isolation, and that this is recorded moving forward.
- It will formulate a quality and clinical risk management committee — the newly appointed quality and governance manager will be accountable for this committee.
- There is an ongoing recruitment programme to address staffing gaps.
- A wound nurse portfolio has been assigned to a registered nurse.
- It has introduced values that it expects all staff to portray to residents and other staff — partnership, respect, integrity/inclusion, dignity and excellence.
- Its staff have completed HDC's online modules.
- It has reviewed its internal policies to ensure compliance with the NZHDSS 2021 standards and has updated its practices to comply with the ARC agreement.
- It has strengthened its complaints management processes to ensure that concerns are addressed effectively.

- It has made it a priority to fully understand and comply with Section 31 notifications to HealthCERT, and it has implemented SAC 1 and SAC 2 reporting as required by the Health and Disability Services (Safety) Act 2001.
- It has implemented the ISBAR framework[42] to improve communication within clinical and allied health teams.
- It has completed training on the STOP and WATCH tool[43] to enhance early identification of clinical deterioration.
- It is addressing some concerns with its electronic resident notes system to improve the ease of use, readability, and accuracy and to increase efficiency.

Recommendations

198. I acknowledge the significant changes made by McKenzie Healthcare since the introduction of its new general manager. In addition, I recommend that McKenzie Healthcare:

a) Provide a written apology to Mrs A, Ms B, and Mrs F and her whānau for the breaches of the Code identified in this report. The apologies are to be sent to HDC, for forwarding to Ms B, Mrs F, and Mrs A, within three weeks of the date of this report.

b) Provide an update on the changes made to improve its systems and processes, within an evaluated corrective action plan as part of quality improvement practice, as recommended by RN Ferreira. A copy of the corrective action plan should be provided to HDC within six months of the date of this report.

c) Complete education on communication with and about older people and their whānau, including strategies for ensuring that changes in resident needs are documented safely and communicated appropriately to minimise the risk of similar occurrences in the future, as recommended by RN Ferreira. Evidence of this education material and staff attendance records are to be provided to HDC within six months of the date of this report.

d) Complete education on caring for people living with dementia mate wareware, including around person-first care, recognition of change or decline, use of the STOP and WATCH tool,[44] and related responsibilities in care and communication. Evidence of this education material and staff attendance records are to be provided to HDC within six months of the date of this report.

e) Discuss with the nursing team the importance of accurately recording all concerns raised by the family in the resident's clinical record, as recommended by RN Ferreira,

[42] Communication tools | Te Tāhū Hauora Health Quality & Safety Commission.
[43] The Stop and Watch early warning tool helps care staff to identify and report specific issues. More details can be found at: Acute deterioration | Te tipuheke tārū (Frailty care guides 2023) | Te Tāhū Hauora Health Quality & Safety Commission.

and ensure that family/whānau contact record templates are placed on each resident's clinical record. Confirmation that this recommendation has been completed is to be provided to HDC within six months of the date of this report.

f) Provide copies of certification of completion in relation to HDC's online modules for all current staff, within six months of the date of this report.

g) Complete an audit of all call-bell response times over a three-month period and report back on the audit findings where call bells have lasted over target timeframes, including reasons for delayed attendance and how the issues have been reviewed and improved. Evidence of the audit findings and corrective findings are to be provided to HDC within 12 months of the date of this report.

h) Provide a copy of McKenzie Healthcare's new call-bell policy, within three months of the date of this report.

i) Provide evidence of the standards of care it has developed for its caregivers and evidence of the training provided to caregivers, within 12 months of the date of this report.

j) Consider seeking support from South Canterbury ARC health experts to strengthen its clinical practice standards, to inform individualised assessment, planning, and delivery of safe resident care, as per RN Ferreira's advice. As part of this consultation, McKenzie Healthcare is to seek guidance on infection control and prevention, recognising clinical decline, end-of-life care, complaints management, statutory responsibilities, continence management, activity provision, meeting social needs of residents, and documentation standards. An update on this recommendation is to be provided to HDC within three months of the date of this report.

Follow-up actions

199. A copy of this report with details identifying the parties removed, except the clinical advisor on this case, McKenzie Healthcare Limited, and Health NZ South Canterbury, will be sent to HealthCERT at the Ministry of Health and Health NZ South Canterbury and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from aged care advisor RN Jane Ferreira relating to Mrs A's care:

> '1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by McKenzie Healthcare. 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**
> Consumer complaint letter received 28 February 2022.
>
> Provider response letter dated 6 May 2022.
>
> Letter of apology from McKenzie Healthcare to [Mrs A] dated 9 May 2022.
>
> Clinical records including activity documentation, a nursing care plan, continence assessments, wound care management plans, incident and infection records, and nursing progress notes within the electronic care record 2020–2021.
>
> Organisational policies including Complaint Management, Infection Prevention and Control, Wound Management, Ostomy Care, Privacy and Dignity.
>
> Additional evidence received 24 February 2023 including medical records, care monitoring forms, transfer documentation, IPC policy QAN18, education records.
>
> **3. Complaint**
> [Mrs A] has expressed concern regarding the standard of care she received while resident at McKenzie Care Home between [Month1] and [Month15]. Her concerns relate to communication, infection control processes, social isolation and delayed delivery of care.
>
> **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:
>
> — Infection prevention and control (IPC) practices and care strategies to support [Mrs A's] health and wellbeing.
> — Communication between the provider and [Mrs A], and actions taken to resolve [Mrs A's] concerns directly.

Background

[Mrs A] was admitted to the care home at hospital level care on 28 [Month1], and discharged home on 24 [Month15]. Prior to admission [Mrs A] was supported at home by her husband and community care services.

[Mrs A's] medical history is complex with multiple comorbidities, including cardiovascular and respiratory disease, Type 2 Diabetes, stroke/CVA, seizures, osteoarthritis, chronic pain, abdominal hernias, an ileostomy, and urostomy due to a total cystectomy. Clinical information refers to recurrent urinary infections, identified ESBL, and multiple drug allergies.

[Mrs A] has low vision and is legally blind, requiring close support from staff with activities of daily living. According to nursing information [Mrs A] was admitted into a single bedroom with shared bathroom facilities. She mobilised with a low walking frame between her bedroom and the care home lounge and dining areas with minimal assistance. She was able to voice her own needs, with the care plan stating Enduring Power of Attorney (EPOA) was in place, but not activated (not sighted), listing her husband as her nominated contact.

a) Whether in the circumstances the nursing care was appropriate.

The Admission and Discharge report shows [Mrs A] had three short-stay admissions to the care home in … 2020, prior to permanent admission at hospital level care in [Month1]. There is no available evidence of any preadmission information, such as hospital discharge summaries, a needs assessment, or minutes of a pre-admission meeting with [Mrs A] to discuss her care requirements, which would be accepted practice given her complex health needs. There is no evidence of orientation provided to [Mrs A] to support her settling-in phase as a new resident to the care home, nor evidence of completed admission nursing assessments to identify her care and safety needs, such as falls risk, pressure injury risk, pain or nutritional needs. There is limited discussion in clinical records of communication and care requirements given her low vision, hazard management or strategies offered to promote her independence which would be accepted practice.

It is unclear what information, training and support was provided to the care home staff prior to [Mrs A's] admission to ensure her complex health requirements, care and safety needs were able to be met and maintained. There is no evidence submitted of shift handover communication or a plan for clinical oversight of a high-risk resident during the settling-in phase. Admitting residents to permanent care on a background of short stay admissions can potentially influence accurate nursing assessment and ongoing care due to the risk of familiarity or normalisation of resident status by the care team.

There is no evidence of any interRAI assessments completed during [Mrs A's] stay at the care home. The submitted long term care plan dated 29 [Month14] provides discussion of interRAI assessment outcome scores and indicates agreed interventions for [Mrs A's] identified needs. The care plan appears to address personal care and hygiene

requirements in a personalised way. It provides guidance for specific interventions relating to ostomy care, monitoring and reporting, including criteria for escalation of care concerns. Bowel monitoring forms indicate [Mrs A] was able to participate in her care and empty the ostomy bags independently.

The electronic care record reflects that nurses were responsive to [Mrs A's] care requirements with daily entries from registered nurses (RNs) discussing the management of her routine healthcare needs. Vital signs, blood sugar monitoring, weight recordings and other observations were taken regularly, and communicated via email or phone call to the General Practitioner (GP). Qualified staff have provided some robust statements regarding resident assessment, interventions and escalation of concern. There is evidence of regular assessment by the GP and involvement of acute care services where indicated. The care record reflects that additional guidance was sought from allied health colleagues, such as the Diabetes Nurse Specialist and Stoma Nurse, to inform collaborative care delivery which is accepted practice.

The nursing care plan states that [Mrs A] was prone to recurrent urinary infections with Extended Spectrum Beta Lactamase (ESBL), a multidrug resistant organism, identified in urine samples. The organisation's Infection Control policy (QAN 18), states that people with indwelling devices, such as [Mrs A's] ostomy sites, are at greater risk of infection. The policy provides guidance for nursing care, referring to contact isolation, hand hygiene, and education for staff and close family. There is no discussion of health education provided to the resident in the policy nor discussion of care consent which presents an improvement opportunity. The policy refers to the use of standard and contact precautions however there is minimal guidance provided about what this means when caring for [Mrs A], with limited discussion about the use of personal protective equipment (PPE), waste handling or wider care responsibilities. The provider has submitted evidence of an information leaflet on ESBL from an international health trust that was given to staff to read, however this does not appear to be referenced within the organisation's IPC policy which would be accepted practice.

It is unclear from the care record if [Mrs A] received any information at the time of her admission regarding shared bathroom facilities, how resident care routines would be arranged to accommodate individual needs, or health education regarding IPC practices in a shared space. On 8 [Month3] [Mrs A] raised concerns about bathroom sharing with the Clinical Coordinator. Nursing documentation reflects that [Mrs A] was advised to use the middle bathroom in another community when her bathroom was occupied. According to a physiotherapy assessment [Mrs A] experienced shortness of breath on exertion, pain and peripheral oedema amongst her other health concerns. Nursing documentation also indicated that [Mrs A] relied on a familiar environment and position of furniture to support her safety needs. It is unclear if any additional risk assessments were completed by qualified staff at this time to ensure she remained safe when accessing a different part of the care home.

On 17 [Month3] [Mrs A] experienced an episode of loose stools. Progress notes refer to commencing precautionary isolation measures, which is an accepted intervention for suspected symptoms of gastroenteritis and in line with the organisation's Infection Prevention and Control policy.

An RN entry in the care record states "*Carers to check and empty bag so doesn't have to go to the toilet".* There is no evidence of documentation in the care record that health education was provided to [Mrs A] at this time, or what alternatives were available to her to meet her personal hygiene needs. There is no evidence that a short-term care plan was commenced with a specific plan regarding IPC measures and personalised care delivery, including bathroom use, which would be accepted practice. RN entries 18–20 [Month3] state that [Mrs A] was distressed about the IPC measures, social isolation and lack of access to a bathroom. She met with the clinical coordinator on 21 [Month3] to raise her concerns, however there is no evidence of meeting minutes, an apology or change to any agreed care interventions.

According to the nursing progress notes [Mrs A] experienced two further episodes of ill health which required her to isolate in her bedroom prior to hospital transfer. Progress note entries reflect care oversight by the clinical manager and care delivery by care staff, however there is no evidence of specific care information entered in the electronic record as outlined in the IPC policy, which would be accepted practice. It is also unclear what nursing assessment occurred on [Mrs A's] return to the care home following hospital admissions in [Month5] for pyelonephritis, and [Month12] for a respiratory infection, or if changes were made to her plan of care.

There are multiple progress note entries that discuss episodes of leaking from [Mrs A's] ostomy, changes in skin integrity, timeliness of care delivery and associated resident distress during her stay to the care home; "*Unhappy stoma bag always bursting making her excoriation on stoma more painful".* [Mrs A] has described being left in soiled clothing awaiting care following these events.

The organisation's Ostomy Management policy (3.2.14a) outlines its purpose:

"To minimise the risk of infection, monitor ostomy function, identify and treat ostomy deterioration as quickly as possible, and to ensure client comfort". The organisation's Privacy and Dignity policy (1.13) states that *"privacy and dignity will be observed at all times …, and individuals given respect"*.

The Ostomy Management policy, Procedure (1) refers to "*emptying the ostomy product when half-full for comfort"*, noting that individualised frequency of changes will be reflected in the resident's care plan. [Mrs A's] care plan states staff are to check if the ostomy bags are full, and twice weekly changes in stoma products. There are no RN clinical review meeting minutes included where weekly resident concerns are raised, however there is evidence that the RN team informed the GP of changes in health status and [Mrs A] was referred to the Stoma Nurse Specialist for expert advice which is

accepted practice. It is unclear if her nutritional requirements were regularly reviewed within the six-monthly resident review process as nursing assessments and care plan evaluation was not part of the evidence bundle. According to clinical records a referral for dietician input was only actioned at [Mrs A's] request in [Month14].

There is no discussion within these policies regarding care partnership, explanation of personalised health interventions, the involvement of a support person or discussion of resident choice and consent. There is evidence within staff entries acknowledging and apologising for the delay in care, citing challenges with staffing and competing priorities. It is unclear if [Mrs A's] concerns were escalated to senior staff for investigation and recorded within incident and complaint management processes which would be accepted practice.

While the care record reflects regular RN involvement in [Mrs A's] care there is minimal evidence provided of care staff support in the submitted documentation, which limits comment about staff interaction, personal care delivery or the application of infection control practices. There are incomplete clinical records in the evidence bundle and the provider response has highlighted issues with staff turnover as a contributing factor to sourcing the requested clinical documentation.

From the evidence reviewed to respond to this question it appears that the nursing care provided to [Mrs A] met the minimum standard of accepted practice in the circumstances and would be viewed similarly by my peers. I consider there are moderate departures from accepted practice standards, with identified opportunities for improvement regarding appropriate, clinically safe resident admissions, nursing assessment, personalised care, communication and documentation standards.

b) Whether the communication with [Mrs A] and her family was appropriate.
The Ngā Paerewa Health and Disability Service Standards (HDSS) and Age-Related Residential Care (ARRC) Services Agreements require service providers to acknowledge and involve the consumer and their nominated representatives in all aspects of care. This includes notifying the nominated person of any change in the resident's health condition or of any adverse event. On review of the submitted clinical evidence there appears to be collaboration between [Mrs A], her husband and a range of health professionals during her stay at the care home. There is no specific record submitted to evidence Family/Whānau interaction, however there is evidence within progress note statements and adverse event forms that [Mrs A's] husband was updated by an RN following an incident or when there was a change in her health status.

As outlined in the contractual requirements, new residents and their nominated representative are invited to meet with the clinical team to review the admission nursing assessments, proposed care plan, and discuss wishes for future care as part of the therapeutic relationship. This process is repeated at six-monthly intervals, or more frequently as clinically indicated. A health management assessment dated 31 [Month11] shows the last case conference (resident review meeting) was held

2 [Month8]. The clinical coordinator has referred to speaking with [Mrs A] regarding InterRAI assessment findings and a telephone conversation with her husband, which indicates partnership in care. It is unclear if [Mrs A] signed her care plan to acknowledge her agreement or if meeting minutes were taken and shared with [Mr and Mrs A] which would be accepted practice.

[Mrs A] has raised concerns with care delivery, communication, IPC practices and feelings of social isolation. There is no evidence of a complaint record submitted by the provider, nor evidence provided that [Mrs A's] specific concerns were addressed or resolved. Given [Mrs A's] complex healthcare needs and expressions of care concerns, a meeting with the care home manager and clinical leads would be deemed appropriate as part of service provider responsibilities to healthcare consumers. The provider response has identified opportunities for improvement related to staffing, workplace culture and organisational values but there is no additional evidence supplied, such as a corrective action plan, to support this.

As outlined in the care record, [Mrs A] reported the delayed assistance left her feeling distressed and frustrated. She expressed concern regarding the lack of empathy, dignity and respect. It is unclear if there were competing priorities at the time, however leaving a vulnerable resident distressed and in soiled clothing for any period of time is below acceptable standards of care. As cited in the organisation's Privacy and Dignity policy (1.13) "*privacy and dignity will be observed at all times …, and individuals given respect*".

The organisation's Complaint Policy (1.5), updated January 2021 acknowledges the rights of the consumer to make a complaint, noting concerns can be shared verbally, in person, by phone or in writing, and outlines the organisation's process of open disclosure by providing full and frank information to the consumer. The policy acknowledges HDSS contractual responsibilities and references the Code of Health and Disability Services Consumers' Rights 1996. Point (1.0) of the policy outlines the procedure for receiving and responding to a complaint. The Complaints Flowchart provides guidance steps to frame investigation response documentation, however there is no evidence presented of any actions taken in an attempt to resolve [Mrs A's] concerns directly.

From the evidence reviewed to respond to this question it appears that communication with [Mrs A] was below the standard of accepted practice in the circumstances. There appear to be moderate to significant deviations noted regarding informed consent, respectful care and effective communication, which would be viewed similarly by my peers.

c) Whether the provider's outbreak management procedure is adequate and in line with best Infection Prevention and Control (IPC) practice or not. Is there sufficient information to guide staff (related to specific outbreaks) and does this entail communication with families/EPOA?

The organisation's Infection Control Management Policy (QAN18) updated January 2021 outlines service provider responsibilities to safe health practice and IPC management. The Outbreak Management Procedure policy provides discussion about the care and management of suspected resident and staff cases, with information to guide staff about the different types of outbreaks, identification of symptoms, care and reporting responsibilities. The policy includes a flow sheet to guide decision-making with appropriate templates to record resident or staff cases, and action plans.

It is unclear if the submitted IPC policy is part of a wider suite of documents. There is limited discussion of infection classifications, IPC criteria, transmission pathways, hand hygiene, PPE use and rationale for care interventions, health education, resident consent, clinical assessment skills and associated responsibilities. There is no discussion regarding risk-mitigation strategies to maintain safety needs, or support plans to minimise the impacts of social isolation.

The policy discusses gastrointestinal infections and states that for a suspected outbreak of Norovirus that "*residents will isolate … in their own room (as well as able)*". The policy states "*If toilet is shared minimise exposure to other residents by additional cleaning of toilet and high-touch areas with bleach, and reinforce hand washing with soap and water*". It is unclear if the organisation has a site-specific policy regarding shared bathroom use, clinical oversight, delivery of personalised resident care and safe management during an outbreak.

The policy does not provide specific guidance about communicating with the resident and their nominated representative, stating *"Relatives informed if appropriate".* Timely communication with residents and their nominated representatives is an essential part of outbreak management and provides an opportunity to share vital information, provide reassurance and answer questions in a meaningful way.

From the evidence reviewed to respond to this question, it appears the organisation's Outbreak Management Procedure policy meets the minimum standard of accepted practice. There are mild to moderate departures in process noted, and it would be viewed similarly by my peers. There are opportunities to review IPC policies, systems, processes and documentation standards to ensure staff are well informed, and consumer care and safety needs are maintained in a culturally safe way.

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.

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

Request for additional advice: 23 January 2025

Thank you for the opportunity to review my initial advice and provide additional comment. I have been asked to consider the following questions and clarify what the level of departure is.

1. Please could you clarify whether the care provided to the consumer met accepted standards and if not, why not.
2. Please could you clarify whether the standards regarding her care was appropriate or not.

a) Whether in the circumstances the nursing care was appropriate.
From the information reviewed and discussion points I consider the care provided to the consumer was of the lowest level of accepted practice in the circumstances. While the submitted clinical information indicated that the care home had systems and processes in place, it appears that the application of policy guidance was not consistently followed. There are concerning deviations in clinical oversight and responsibilities to nursing assessment, care planning, and personalised care delivery to a resident with complex needs. Given the reported workforce difficulties and associated challenges experienced by the provider at the time, I considered this a relevant factor and concluded moderate departures.

- Departure from accepted practice: Moderate

b) Whether the provider's outbreak management procedure is adequate and in line with best Infection Prevention and Control (IPC) practice or not. Is there sufficient information to guide staff (related to specific outbreaks) and does this entail communication with families/EPOA?
It appears that the organisation's Outbreak Management Procedure policy generally met the required standards at the time of [Mrs A's] admission. I note there was no site-specific information available about shared bathroom use, particularly management of resident needs during an outbreak. A comment was made to strengthen guiding documents about communication responsibilities, management of social isolation and delivery of culturally safe care. As outlined in my review's discussion points, I consider there to be mild departures related to adherence to clinical standards in the circumstances and this would be viewed similarly by my peers.

- Departure from accepted practice: Mild

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

Appendix B: In-house clinical advice to Commissioner

The following in-house clinical advice was obtained from aged care advisor RN Jane Ferreira relating to Mrs E's care:

> '1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by McKenzie Healthcare. 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**
> Consumer communication dated 9 December 2022
>
> Provider response letter dated 20 February 2023
>
> Clinical documentation including nursing assessments, care plans, progress notes, monitoring forms, medication and wound care records
>
> Organisational policies relating to administration of medications, confidentiality, communication, induction and orientation, nutritional requirements, staff education, resources and related training records
>
> COVID-19 documentation and public health guidance
>
> Additional documentation received 17 March 2023 including medication records and communication information
>
> **3. Complaint**
> [Mrs E's] daughter has expressed concern regarding the clinical care provided to her mother during a COVID-19 outbreak at the care home in [Month1], and related communication with family/whānau.
>
> **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 management of [Mrs E's] care during her COVID-19 isolation period
>
> — documentation of clinical information and clinical service delivery
>
> — the extended isolation period and impact to overall health and wellbeing
>
> — if the complaint response and corrective actions have addressed all issues
>
> — any further information relevant to this complaint

Background

[Mrs E] was admitted to the care home [in] 2020, at hospital level care following a decline in health. Prior to admission she lived independently in a retirement village unit. Her medical history included hyponatraemia, malignant melanoma, dementia, inflammatory bowel syndrome, transient ischaemic attacks, osteoarthritis, restless leg syndrome, glaucoma with low vision, hearing impairment. According to file information [Mrs E] mobilised independently with a walking frame and required moderate supervision from the care team with activities of daily living. She was described as frail with a history of poor oral intake, a reduced ability to taste or recognise food items and swallowing difficulties. Nursing documentation indicates [Mrs E] regularly mobilised about the care home, participated in activity sessions and liked to help with tasks such as folding washing. [Mrs E] tested positive for COVID-19 on 19 [Month1] and passed away [in] 2022.

I extend my condolences to [Mrs E's] family at this time.

a) Do you consider the management of [Mrs E] during her isolation period for COVID-19 to be in line with public health guidelines and expected nursing practice during the period [Month1–Month2]?

According to file evidence, isolation measures were introduced for [Mrs E] on 19 [Month1] following a positive result received from a Rapid Antigen Test (RAT) obtained during routine resident screening for COVID-19. As outlined in Te Whatu Ora|Health New Zealand's guidance for Aged Resident Care (ARC) facilities during COVID-19 outbreaks, COVID-19 positive cases are required to be isolated for at least seven days from the onset of symptoms, or from the day of a positive test result (Te Whatu Ora, 2022). This health information is also referenced in the Management of a COVID-19 Outbreak in South Canterbury Aged Residential Care (ARC) Facilities health district document dated 4 April 2022. The South Canterbury ARC document provides clear guidance for service providers regarding outbreak management following case identification including decision steps for event escalation, communication, clinical support, documentation and reporting responsibilities within the national COVID-19 framework.

There is evidence within communication records of timely event escalation by the care home clinical lead to public health and the portfolio manager for health of older people, in line with the national pandemic response plan. The South Canterbury ARC document refers to establishing outbreak management meetings between public health, infection prevention and control (IPC) specialists and affected care homes to discuss a wide range of agenda items, in addition to resident and staff case numbers. The provider has submitted evidence of regular email communication between the care home clinical lead and portfolio manager regarding case numbers, but there is no evidence of IPC specialist input to clinically guide resident care, particularly isolation timeframes, or attendance at the ARC outbreak meetings as recommended in health guidance documents for service providers.

There is limited evidence of communication with General Practitioner (GP) services at the time of the outbreak to seek specific guidance regarding resident care. There appears to be communication delays between the care home and the GP practice, with an email on 21 [Month1] querying the coordination of alerts received via the Ministry of Health COVID-19 reporting system and the impact of delayed reporting on medical support. It is unclear if an operations manager from McKenzie Healthcare was involved with organisational reporting responsibilities as outlined in the ARC document, such as notifying HealthCERT, or attending external meetings to support the care home clinical team given staffing challenges which would be considered accepted practice in the circumstances.

The care home has provided evidence of a COVID-19 outbreak management plan template with timeframes and action points to guide staff practice which appears to align to public health guidance for ARC facilities. It is unclear if this document was implemented at the time of the outbreak in [Month1]. There is no further evidence of daily care home meetings as outlined in the outbreak management plan, status review or evaluation at the closure of the event which would be accepted practice to align with the ARC guidelines.

The provider has discussed implementing IPC measures including the use of personal protective equipment (PPE) to meet the requirements for contact and droplet precautions. There is supporting evidence of an outbreak checklist with photographic evidence of room signage and PPE donning and doffing stations. The provider has submitted evidence of delivery of staff education and training, including IPC measures and the correct use of PPE, which was acknowledged by the portfolio manager. There is evidence of communication with residents and families about restricted visiting including requirements for visitor RAT tests, as outlined in public health guidance documents, with evidence of a site-specific visitor's waiver for McKenzie Healthcare.

Timely communication with residents and their nominated representatives is an essential part of outbreak management and provides an opportunity to share vital information, provide reassurance and answer questions in a meaningful way. The Organisation's Communication Policy, April 2022, states that "any contact with relatives regarding resident's wellbeing will be reported and documented on LeeCare" (the electronic care record). The care record reflects that [Mrs E's] EPOA was updated about the positive RAT test on 19 [Month1], however it is unclear if health education was provided to [Mrs E] and her EPOA regarding RAT testing, and if informed consent was obtained prior to testing, which would be accepted practice. There is limited evidence of communication with [Mrs E's] EPOA during the outbreak from point of notification on 19 [Month1] until a qualified nurse entry on 1 [Month2] regarding [Mrs E's] health decline. While a generic short-term care plan (STCP) was implemented for [Mrs E] with outbreak care instructions, there are identified gaps in nursing assessment, monitoring and contemporaneous reporting, communication and care escalation.

The STCP (17) states to refer to the GP if the resident has significantly deteriorated for a future management plan. It appears qualified staff did not recognise signs of resident decline in a timely way and seek further support. Other than email communication on 1 [Month2], there is no evidence of a GP assessment or medication review since [Mrs E's] last GP visit on ... It is unclear if the duty nurse escalated care concerns regarding [Mrs E's] frail presentation to a senior registered nurse (RN) for support before contacting the GP on 1 [Month2]. There is no evidence that nursing assessments were completed to inform clinical decision-making which would be accepted practice at this time.

I note [Mrs E's] EPOA was informed on 1 [Month2] that she was unwell however there is no evidence that health concerns were communicated to the care team or that coordinated end of life care planning was commenced, which would be accepted practice in the circumstances. The consumer communication has expressed concern regarding [Mrs E's] frail presentation and alleged poor care identified during their visit to the care home. The clinical record reflects signs of increasing frailty and dependency but does not provide evidence that essential care needs were met during [Mrs E's] last days of life, particularly evidence of pain, pressure risk or skin assessment, oral care, medication management or delivery of meaningful holistic care in line with accepted practice standards.

From the evidence reviewed to answer this question it appears the operational responsibilities to external reporting were met and maintained; however there are identified deviations from safe clinical practice regarding qualified nurse leadership, timely nursing assessment and care planning, recognition of and acting on acute decline, and related care, communication and documentation responsibilities.

Departure from accepted practice: Moderate to significant

b) Do you consider the documentation of clinical information across all aspects of the clinical service delivery during her COVID-19 illness through to her passing, to be in line with accepted practice

The external COVID-19 notification form sent to South Canterbury ARC team states that [Mrs E] recorded a positive RAT result on 19 [Month1]. Her GP and family were informed. She was accommodated in a single room with her own bathroom, noting the door was closed per IPC measures, and a PPE station including bins and posters was in place, which is in line with accepted practice at the time. A COVID-19 short-term care plan (STCP) was commenced by the care home at the same time. The document provides generic care guidance with prompts to aid decision-making but does not specifically discuss individual care and safety needs, particularly the use of call bells as a safety aid and communication tool during the isolation period. The STCP and care record provides limited evidence of personalised strategies to holistically support [Mrs E] at this time. There is no evidence that nursing risk assessments were completed to manage her needs while in isolation such as falls risk given low vision, nutritional needs, personal care requirements, consideration of triggers to mood and behaviour

events, signs of boredom or loneliness, or wider care and safety needs. Sleep records provide evidence of routine safety checks and care interventions overnight but there is no evidence of regular safety checks (intentional rounding) provided across the AM and PM shifts which would be accepted practice for a vulnerable resident.

The electronic care record provides limited evidence of clinical leadership and care oversight, nursing assessment, care planning and care delivery during the timeframe in question. The "interventions" column of the STCP lists a wide range of steps for consideration by qualified and care staff however it appears these were not consistently implemented for [Mrs E]. The STCP refers to COVID-19 monitoring and recording of vital signs up to four times daily as clinically indicated. It appears this occurred daily between 19 and 28 [Month1], however there is no evidence of further assessment between 28 [Month1] and [Month2], despite discussion of extended isolation and apparent clinical decline.

Progress note entries 19–30 [Month1] describe [Mrs E] as independent with personal care requirements. Comments refer to reduced oral intake, an episode of nausea, seeking behaviours and confusion. Entries on the Hygiene record indicate [Mrs E's] needs changed from 31 [Month1], requiring increased assistance from two staff with comments referring to reduced mobility and continence concerns. InterRAI assessments and care plans report that [Mrs E] had a BMI of 13.8 and weight of 34.5kg, last recorded 10 [Month1]. Care documentation states that due to low vision [Mrs E] required assistance with meal set up, explanation of menu items and supervision with eating and drinking. Records reflect difficulty with taste and swallowing food. She was offered a minced, moist diet per nutritional assessment … and received a prescribed regular nutritional supplement. The STCP states to encourage oral fluids, >1000mls/24hr period, and to introduce a lighter, alternative diet if menu items are refused. There is no evidence that nutritional records, a fluid balance chart or increased frequency of weight recordings were implemented given her high risk factors, or consideration of dehydration risk with prescribed diuretics. Progress notes report meal refusal and episodes of thirst but there is no evidence of assessment by qualified staff. It is unclear if ice blocks or other easily tolerated nutritional solutions were offered at this time given [Mrs E's] known small appetite and taste difficulties. Bowel records indicate [Mrs E] self-reported bowel results to the RN, with entries recorded on 16 [Month1] and 24 [Month1] 2022. There is no further entry on the bowel record for the next ten days which presents clinical and care concerns. It is unclear if [Mrs E] was able to provide a reliable account of bowel patterns given her history of cognitive impairment, and if further enquiry or nursing assessment occurred which would be accepted practice. It is unclear if nursing staff recognised signs such as nausea, reduced appetite, thirst, drowsiness or mood changes indicated clinical concern.

The care record indicates [Mrs E] experienced short-term memory loss related to her cognitive impairment and was known to frequently seek staff assistance for different activities or companionship. Progress note entries report changes to mood and behaviour during the isolation period with increased persistence in calling out to staff.

While care entries report offering laundry to fold to reduce boredom, there is no evidence that pain assessments were completed, monitoring forms or bowel records reviewed to consider contributing factors to the displayed behaviour.

Medication administration records reflect that [Mrs E] received PRN Quetiapine on the PM shift of 24, 25 and 26 [Month1] for agitation but rationale and evaluation of effectiveness is unclear in nursing notes. A behaviour monitoring form was commenced on 30 [Month1] following an interaction while carers were assisting [Mrs E] with personal requirements, however it is unclear if an incident report was completed or further enquiry occurred at this time which would be accepted practice. There is no evidence of RN assessment to consider wider contributing factors to displays of agitation or distress given [Mrs E's] medical history of hyponatraemia, bowel concerns, osteoarthritis and undernutrition, and no review of care and safety needs, particularly falls risk and the associated side effects of the additional medication.

Medical records show [Mrs E] was seen twice by her GP … prior to contracting COVID-19. The COVID-19 notification form, 19 [Month1], states the GP was informed following [Mrs E's] positive RAT test, but there does not appear to be documented evidence of a GP assessment, a request by nurses for review of prescribed medications, or consideration of suitability for antiviral medications within the clinical file at the time. The notification form states that [Mrs E] had declined vaccination (Flu and COVID-19), and that her advance care plan indicated she was not for resuscitation, hospitalisation, or antibiotic therapy, which is also reflected in interRAI information. There is no evidence that the advance care plan was used to inform last days of life care planning.

The COVID-19 STCP refers to informing the GP of clinical concerns. A progress note entry on 31 [Month1] by the RN states "[Mrs E] is very lethargic and looks dehydrated."

Staff were reminded to offer fluids however it is unclear why a fluid balance chart was not commenced and GP contacted for clinical guidance given the identified concern.

An entry 1 [Month2] states that [Mrs E] was "in isolation due to COVID-19 — declining in health … looking very gaunt and pale". Notes state the GP was informed via email and anticipatory medications requested by the duty nurse. There is limited evidence that pain assessments or additional nursing measures were commenced or data gathered to inform the GP at this time. It is unclear if nurses across the next shift attempted to follow up on the escalated care concerns or request a telephone, virtual or care home consultation which would be accepted practice. It is also unclear what after-hours support was in place by the GP practice, or local health services.

The care record on 2 [Month2] shows a Medi-Map system link flagging "Patient Chart Changed, PRN started. Refer to Medi-Map for further details". There is no evidence of a supporting entry in medical notes by the GP with instructions to guide [Mrs E's] ongoing clinical care requirements, and no evidence of RN involvement in nursing documentation regarding the medication changes and ongoing care needs, which

would be accepted practice at this time. While the STCP was updated 1 [Month2] to reflect decline, there is no evidence that care planning was commenced for last days of life. End of life care planning is considered a responsibility of the clinical team and an important part of the therapeutic relationship, and communication and support for family/whānau is important during the end of life phase. The Frailty Care Guides provide guidance about accepted practice standards to support clinical judgement and inform staff practice (HQSC, 2019). End of life care pathways, such as "Te Ara Whakapiri", are a recommended approach to support last days of life (HQSC, 2019; MoH, 2017).

It is unclear if [Mrs E's] EPOA was regularly updated of the changes to her health status by the clinical manager or RN at this time, as outlined in the Organisation's Communication Policy. 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.

Medication administration records reviewed between … [Month1] and [Month2] 2022 show that [Mrs E] received all regular medicines as prescribed, however PRN records show that [Mrs E] only received one dose of prescribed pain relief (Paracetamol) during this timeframe, on ... It appears the requested additional medications prescribed … were not administered during [Mrs E's] last days of life, and it is unclear from the care record what nursing assessments, clinical discussions or rationale for care delivery occurred at this time.

From the evidence reviewed to respond to this question I consider there are moderate to significant departures from accepted practice standards regarding the management and documentation of [Mrs E's] clinical care, and this would be viewed similarly by my peers.

Departure from accepted practice: Moderate to significant

c) Do you consider [Mrs E] to have had an extended isolation period that contributed to the decline in her overall health and wellbeing preceding her passing?
COVID-19 health guidance for service providers states that "decisions regarding isolation need to balance with residents' wellbeing and managing the risk of transmission … While isolation must be within the facility, positive cases do not necessarily need to be confined to their rooms … Some cases may continue to have symptoms and remain infectious beyond Day Seven — recommended to remain isolated for a further 24hrs after acute symptoms resolve, but not longer than ten days (unless significantly immunocompromised)." (Te Whatu Ora, 2022)

As discussed in question (A), there were regular opportunities to collaborate with and seek support from regional health experts and IPC specialists through daily outbreak meetings facilitated by public health. There is evidence that the care home provided

regular updates to the portfolio manager of case numbers, with communication reporting that [Mrs E] was their last remaining positive case, however there is no evidence of interaction with the IPC team for clinical guidance regarding [Mrs E's] status and ongoing care requirements at the end of the seven and ten day period. It is unclear why the outbreak management plan and STCP was not updated to reflect the rationale for her extended isolation, including any specific considerations for care during this time. Accepted practice would be to consider GP assessment, ongoing transmission risk, indications for further testing, impacts to wellness and wellbeing, and establish an agreed review date of isolation measures and resident needs, in partnership with the consumer and their nominated representative.

The COVID-19 notification form sent 19 [Month1] comments that [Mrs E] experienced low vision, was confused and trying to leave her room. The IPC record #837961 notes "surveillance RAT positive, no symptoms, Isolation. Will need activities in her room to encourage her to stay there." Other than folding washing, there is no discussion of activities offered to [Mrs E] during her time in isolation, with no reported interventions noted in diversional therapy (DT) records since 14 [Month1]. Social connections, access to activities and contact with family/whānau are essential elements to support resident quality of life, as outlined in service provider contractual requirements (Ministry of Health, 2022). It is unclear if [Mrs E] was assisted to communicate with her family via telephone or digital platform, or if other strategies were considered to support her to stay connected while isolated.

From the evidence reviewed to respond to this question I consider the care provided to [Mrs E] to be below the minimum standard of accepted practice at this time. It appears the care home team did not recognise signs of decline and act in a timely way during the extended isolation period. There are identified concerns with clinical oversight, communication, management, delivery and documentation of care which would be viewed similarly by my peers.

Departure from accepted practice: Moderate to significant.

d) Do you consider the response to the complaint has addressed all issues, and do the corrective actions identified by the facility fall in line with expected practice moving forward?

The provider response has highlighted challenges with the COVID-19 pandemic and related workforce issues which may have impacted the delivery of coordinated resident care at the time. The response letter has acknowledged concerns with documentation standards and discussed strategies toward improvement, with supporting evidence of education and skills workshops for the care team. As outlined in the Health Quality and Safety Commission's Frailty Care Guides, recognition of decline, both gradual and acute, and acting on this is an essential part of the nursing role. Partnered with this is the importance of communication and collaboration with care partners, which includes the consumer and their nominated representative, and understanding the role of family/whānau in care (HQSC, 2019).

The response letter includes an apology, acknowledges the areas of concern and includes a list of recommendations to improve service delivery based on their case review. As a practice point, to provide reassurance of improvement outcomes the identified areas for strengthening would benefit from framing in an evaluated corrective action plan, with measurable timeframes and auditable, evidence-based results aligned to quality improvement methodology. A key recommendation from this review would be to request submission of the completed plan by an agreed date.

An additional area for improvement relates to caring for people living with dementia mate wareware. I note that [Mrs E's] InterRAI assessment comments refer to expressions of distress and occasional altercations with care home staff or residents. Nursing records indicate a pattern of seeking behaviours requiring regular redirection and support from the care team. Frequency of input can potentially influence care team responses, which increases the risk that resident actions become normalised over time, and key signs of change are missed. This presents an education opportunity for the care home team about person-first care, recognition of change or decline, use of the STOP and WATCH and ISBAR tools, and related responsibilities to care and communication.

The provider has completed a case review, identified areas for improvement and commenced corrective actions which is in line with accepted health management and quality improvement practice. I note the organisation intends to appoint a Quality and Governance manager to support operational and clinical responsibilities, and form a Quality and Clinical Risk Management team to inform the provider's list of improvement recommendations and guide development areas. Additional focus is required on clinical leadership, including direction and delegation skills, nursing assessment, care planning and care evaluation, and related nursing responsibilities.

From the evidence reviewed to respond to this question it appears the provider has considered areas for development, identified relevant actions and is in the process of introducing approaches to quality improvement. To ensure this occurs in a robust manner I recommend the provider seek support from South Canterbury ARC health experts to strengthen clinical practice standards, to inform individualised assessment, planning and delivery of safe resident care.

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/

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Request for additional advice: 27 January 2025

Thank you for the opportunity to review my initial advice and provide additional comment. I have been asked to consider the following questions and clarify what the level of departure is.

1. Please could you clarify whether the care provided to the consumer met accepted standards and if not, why not.
2. Please could you clarify whether the standards regarding her care was appropriate or not.

Do you consider [Mrs E] to have had an extended isolation period that contributed to the decline in her overall health and wellbeing preceding her passing?

I consider the care provided to the consumer does not meet accepted standards in the circumstances. Guiding documents discussed criteria for isolation periods and health review. As identified in discussion points, no clinical rationale was provided for the extended care period with no evidence of an active support plan in place. I consider there to be serious concerns with clinical oversight, resident assessment, care and communication in the circumstances.

- Departure from accepted practice: Serious.

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

Appendix C: In-house clinical advice to Commissioner

The following clinical advice was obtained from RN Jane Ferreira relating to [Mrs F's] care:

'Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by McKenzie Healthcare. 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.

Documents reviewed
Consumer letter of concern dated 8 September 2022

Provider response dated 19 November 2022

Provider letter of apology to [Mrs C] dated 17 November 2022

Clinical documentation including nursing assessments and care plan, personal care records, monitoring forms, progress notes, activity records, wound management forms, call bell monitoring reports, incident and infection records

Organisational policies: Resident Rights' Complaint management, Continence management

Call bell management documentation, audit reports, corrective action plans

Meeting minutes: residents, qualified staff, care staff meetings

Additional evidence received 3 March 2023 including call bell audits and email communications

Complaint
[Mrs F's] daughter and EPOA (not activated) [Mrs C] has expressed concern about the care of her mother during her four-month admission to the care home. Her concerns relate to call bell response times, delayed delivery of care and poor communication.

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:

— Call bell management, oversight and management of clinical care

Background
[Mrs F] was admitted to the care home at hospital level care on 28 [Month1] due to increasing frailty and related healthcare needs. Prior to admission she lived in the retirement village with her husband and received regular carer support. Her medical

history includes congestive heart failure, chronic obstructive pulmonary disease (COPD), atrial fibrillation, hypertension, lumbar radiculopathy, dyslipidaemia, osteoarthritis, peripheral oedema, continence concerns, anxiety and depression.

According to nursing information [Mrs F] had limited mobility and required a high level of assistance to meet her personal care needs. During her time at the care home [Mrs F] and her family reported concerns with call bell response times and the impact upon delivery of personal care. Due to unresolved concerns [Mrs F] transferred to another care home on 3 [Month5].

1) Do you consider call bell response times for [Mrs F's] shared room, to be in line with acceptable practice? Please provide rationale with relevance to policy and procedure, staffing and target parameters.
[Mrs F] was admitted to [a room] that shared a bathroom with another room. The organisation's Health and Safety policy states that on admission residents will receive orientation to their new environment and use of the call bell system.

A review of submitted call bell data between 28 [Month1] and 19 [Month5] shows a total of (1,813) call activations to Room … and (969) to Room ... The auxiliary alarm located in the shared bathroom was activated (116) times during this period, however as outlined in the provider response it is difficult to determine which resident was using the bathroom at the time. The report shows there were (100) emergency activations recorded for Room … during [Mrs F's] admission. Target response times state: Emergency calls (1 minute); Assistance calls (3 minutes). The report shows that response times extended out to more than 20 minutes on several occasions, and as long as 45 minutes to 1.29.13 for both rooms, which is below accepted health and safety standards. There are further accounts of unanswered bells lasting as long as several hours, however the provider response infers that residents were in another part of the care home at this time. It is unclear what other safeguarding measures the care team used in addition to call bell alerts, such as intentional rounding, to visually check residents, or process within shift routines to monitor environmental safety.

A Health and Safety audit completed … identified that multiple pagers were missing from the care home, with only six in use on the day of audit. A corrective action plan was commenced with a goal for staff to locate the missing pagers by month end. Evaluation on 2 [Month2] shows that 8 pagers were located giving a total of 14 devices, but it is unclear what steps were introduced by management to maintain safe device use across shifts. It is also unclear what measures were introduced to ensure staff responded appropriately to call bell alerts or what leadership strategies were considered to ensure resident safety was maintained across each shift.

According to communication between a technology provider and the care home, there appears to be a long-standing issue with the organisation's call bell system. A report dated 1 November 2018 acknowledged a range of problems with the nurse call system stating "it will sometimes fail to respond to a resident call". The report refers to delays

in bed and chair exit mats or door sensors to register resident activity, raising the risk of resident harm, with comments of pager wear and tear. A proposed solution refers to a system upgrade to integrate with the electronic care management system. Provider information states a modern call bell system was installed in August 2019.

File documentation refers to an ongoing system issue requiring "rebooting of sensor mats and bells". A Health and Safety meeting held 7 [Month1] discussed the replacement of sensor mats and call bells. It is unclear if concerns were escalated to senior managers or organisational leaders for further action at this time.

The consumer letter has discussed delays in staff responding to call bells, delays in resident care delivery, and associated dissatisfaction and distress. Minutes from a resident meeting held 9 [Month3] also reflect concern raised by other care home residents, discussing poor response times to answering call bells, and request that managers invest in more pagers, as only 12 were in use. Minutes from the resident meeting held 9 [Month5] describe ongoing problems with call bells left unanswered for up to 20 minutes. Residents ask that they at least be acknowledged so they are aware of wait times, with reassurance that help will come soon.

Email communication 24 [Month5] between the care home and the provider identified "a number of modules offline", requiring tech support to remedy.

A resident at a meeting [the following month] stated that he'd "given up" using his nurse call bell system as it did not work.

An older call bell exception report dated 12 March 2019 shows delayed response times in excess of 20 minutes to Rooms …, with evidence of call rejection on pager history. Call bell data reviewed across [Mrs F's] admission in 2022 shows that (1308) calls to … were rejected from five different pagers during her stay, which appears to indicate a long-standing systems and practice concern. Given the known issues with the call bell system, it is unclear if [Mrs F] was offered a different room closer to the nurses station so her needs could be responded to more promptly.

There is no evidence of an organisational call bell policy included in the evidence bundle, and provider communication has confirmed there is no such policy in use.

Policies are implemented to provide guidance to staff regarding actions and expectations for care and service delivery. It would be expected that a call bell policy provide guidance to staff regarding service responsibilities, such as expected timeframes for responding to calls, pager use and the call escalation process, management of call bell outages, maintenance concerns, reporting of faults and how to respond to health and safety issues or clinical events. Staff orientation, health and safety training and ongoing education requirements are also indicated for inclusion.

It would be expected practice that a call bell policy is aligned to incident management processes and reflect responsibilities to external reporting requirements. Section 31 of

the Health and Disability Services (Safety) Act 2001 requires all certified providers to notify HealthCert regarding "any incident or situation that puts at risk (or potentially could put at risk) the health or safety of the people for whom the service is being provided", such as issues or outages with call bell systems.

From the evidence reviewed to respond to this question it appears the care provided to [Mrs F] was below the accepted standard of practice in the circumstances.

Residents rely on call bells to communicate with staff. The call bell reports and information in resident meeting minutes indicate that residents were kept waiting longer than necessary which is below expected standards of care. Staff also require policy information to guide their practice and education to provide skills to keep residents safe. Given the ongoing concerns with the call bell system and lack of a call bell policy or supporting guidelines to ensure resident health and safety needs are met and maintained I consider this to be a significant departure from accepted practice standards and this would be viewed similarly by my peers.

2) Please comment on reports from the family of their need to communicate with care home staff via phone calls to alert their mother's needs. Is this in line with acceptable nursing practice?

Residents have the right to be informed, to feel safe and supported and receive services of an appropriate standard. Residents, family/whānau or nominated representatives are encouraged to communicate with their service provider as part of the therapeutic relationship, and as outlined in contractual requirements. The Age-Related Residential Care Services Agreement; D3.1 (h) states service providers will acknowledge, value and encourage the involvement of families/whānau in the provision of care. Ngā Paerewa Health and Disability Service Standards (HDSS), A2.3 (2iii) state service providers will ensure residents and their whānau are empowered to make decisions about their own care and provide support in order to achieve their goals.

As outlined in clinical file documentation [Mrs F] required the assistance of a call bell to communicate with staff. [Mrs F's] nursing care plan outlined the preferred location and positioning of her call bell, and monitoring records discuss overnight safety checks. Her medical history notes urinary urgency and due to mobility issues she required regular support from staff to meet toileting requirements by day and night. Nursing progress notes discuss assisted toileting and accounts of resident interaction. The nursing care plan and progress note entries show [Mrs F's] family were very supportive and she spoke with them regularly on her mobile phone. The nursing care plan and diversional therapy activity records reflect the valued relationship with family/whānau, and discuss [Mrs F's] social and recreational interests, which aligns to D16.5 (ciii) of the ARRC agreement.

It appears meetings were held in response to concerns raised with call bell reaction times, communication and involvement in resident activities, however there is no evidence of meeting minutes outlining corrective actions or an agreed approach to

improvement at this time. There is also no evidence of a family/whānau contact record to reflect the frequency of interactions between the parties involved, which is part of service provider responsibilities and accepted documentation standards.

The organisation's complaint management policy provides a flowsheet to guide actions regarding communication, investigation and resolution. The provider response has acknowledged this oversight, provided rationale for the use of verbal interactions rather than written feedback per policy at the time, and apologised.

From the evidence reviewed to respond to this question it appears the communication between the care home and [Mrs F's] family met the minimum standard of accepted practice in the circumstances. There are opportunities for improvement with complaint management processes and documentation standards to reflect interaction with family/whānau to support effective consumer-focussed care delivery.

3) Do you consider [Mrs F's] continence management, from admission to discharge, was in line with acceptable nursing practice relating to all aspects of clinical assessment, care planning and care delivery requirements?

The organisation's Continence Management policy (3.2.4) states that a resident's continence history will be obtained using InterRAI, a clinical assessment tool, and LeeCare, an electronic care record, and that resident toileting requirements will be recorded in an individual care plan. The policy states that continence needs will be assessed on admission and evaluated six monthly, or more frequently as required, as part of the resident review process, which is in line with the aged residential care contractual responsibilities for service providers.

The pre-admission needs assessment and admission nursing assessment reflects that [Mrs F] experienced continence concerns with urinary frequency related to the effects of prescribed medications and associated health needs. Progress note entries during [Month1] and [Month2] 2022 describe [Mrs F] experiencing episodes of urinary urgency with anxiety, pain and shortness of breath impacting her level of mobility, resulting in an increased dependence on staff assistance with toileting needs. Continence records and progress note entries indicate [Mrs F] was assisted by staff with toileting as required through the day, and between 4–6 times overnight. The provider response and file documentation has discussed concern with [Mrs F's] level of fatigue due to disrupted sleep, and the associated impact to her mood, health and wellbeing.

An RN progress note entry on 9 [Month3] states that "*an indwelling urinary catheter (IDC) was inserted with [Mrs F's] consent"*. The rationale for this intervention is unclear as there does not appear to be evidence of consultation with the clinical manager, general practitioner (GP), or another health professional.

The Continence Management policy states "*if bladder training is required, add to LTCP after consultation with an appropriate health professional*."

Continence records and progress note entries discuss toileting patterns in preceding days with no obvious indication that [Mrs F] was unwell or experiencing signs of urinary retention, requiring intervention. The Frailty Care Guides discuss strategies for supporting people with stress, urge or functional incontinence, which may include a review of medications, toileting patterns, or referral for a bladder scan or consultation with specialist health professionals. There does not appear to be a referral made for a Urology assessment, input sought from a continence or gerontology nurse specialist, review of prescribed medications or consideration of non-pharmacological strategies to support [Mrs F's] continence needs, which would be accepted approaches to practice. Given the policy guidance, it is unclear why a health professional was not involved in [Mrs F's] clinical assessment or care decisions at this time.

According to accepted practise standards, decisions to catheterise are made in partnership with the consumer and are only considered when all other non-invasive methods have been unsuccessful. There is no discussion within progress notes of health education provided to [Mrs F], or involvement of a nominated representative, as part of informed consent. There does not appear to be an entry within progress notes by the clinical manager or a senior registered nurse, or a documented discussion within clinical care meeting minutes, regarding the indications for catheterisation or a proposed plan of ongoing care.

Any change in resident care interventions are required to be reflected in the resident's care plan, and communicated effectively to the care team to ensure consistency in care delivery across shifts. Progress notes do not discuss nursing assessment, specific care interventions, equipment use, outcome, or a proposed plan of ongoing care which would be the accepted standard of nursing practice. [Mrs F's] care plan does not provide care evaluation, with rationale to discuss when and why an IDC was introduced. There is no goal for care stated nor guidance provided regarding specific interventions for ongoing care which is an accepted part of the nursing process.

Details such as catheter type, balloon size, drainage systems and frequency of product changes, safe positioning and use of securing devices are important aspects of care delivery. Other points for consideration would include discussion of informed consent, health education or infection prevention and control strategies, monitoring of fluid intake and output, bowel management, personal hygiene needs, skin care, infection risk and specific delivery of catheter care.

The Continence Management policy provides reference to the storage and emptying of urinary drainage bags, but no discussion of catheter management, care planning for a resident with a urinary device, or outline of associated nursing responsibilities which presents an improvement opportunity. It would also be usual practice to provide reference to the organisation's infection prevention and control policy, and provide discussion of education, staff training, clinical competencies and professional development opportunities for further learning. While provider education records evidence delivery of scheduled training sessions, it is unclear if the staff involved with

caring for [Mrs F] at the time had attended specific training on urinary catheterisation and been assessed as clinically competent to provide care for a catheterised resident, which is the accepted practise standard.

From the evidence reviewed to respond to this question it appears the management of [Mrs F's] continence needs was below the standard of accepted practice and would be viewed similarly by my peers. There are moderate to significant departures from accepted practice related to clinical assessment, informed consent, care, Communication and documentation standards, with areas for improvement identified in policy development, staff education and training.

4) Do you consider the overall nursing care provided to [Mrs F] for the duration of her admission to be in line with expected nursing practice, and aligned to MOH requirements for a hospital level care provider? Please provide comment related to clinical assessment, care planning, staffing and care delivery.
On review of the clinical documentation including the interRAI nursing assessment, care plan, observation charts and progress notes I consider the daily nursing care provided was appropriate in the circumstances. There is evidence that vital signs and other observations were taken regularly and concerns escalated to the GP. There is evidence of referral to a counsellor and to mental health services for assessment and clinical support, evidencing collaborative healthcare management.

There is room for improvement relating to clinical management, leadership and oversight of resident care. There are identified delays in meeting contractual timeframes with admission nursing assessments and care plans, and inconsistencies in documentation standards, such as monitoring forms and related nursing analysis. While interRAI assessment comments are reflected in care planning, there are no goals for care noted which form an important part of the nursing process to guide delivery of consumer-focussed care. As discussed in question three, there is minimal guidance regarding the management, monitoring and care requirements for a resident with an indwelling urinary catheter, nor evidence of evaluation of care.

It is unclear if an initial meeting was held with [Mrs F] and her family as part of the resident review process, and contractual responsibilities, during the settling-in phase. This meeting provides an opportunity to review the proposed care plan, and allow the consumer and service provider to discuss any queries or identified points of concern in the early part of the new admission relationship.

The provider response has highlighted challenges with the COVID-19 pandemic, staff turnover and related workforce issues which may have impacted the delivery of coordinated resident care at the time. I note involvement by the local DHB hospital regarding safe rostering with support in place to reopen part of the care home and assist with new resident admissions.

From the evidence reviewed to respond to this question I consider the care provided to [Mrs F] met the minimum standard of accepted practice. There are mild departures from accepted standards which have been acknowledged by the provider, however these appear low risk given the competing priorities and circumstances at the time. There are opportunities for ongoing improvement relating to clinical leadership, nursing responsibilities and documentation standards.

5) With consideration to response documentation provided by McKenzie Healthcare in regard to call bell monitoring records for [Mrs F's room]; internal auditing schedules; call bell maintenance records; and the more recent review of systemic processes, do you consider McKenzie Healthcare has effectively identified deficits in their call bell monitoring system and implemented appropriate corrective actions, sufficient to ensure ongoing safe service delivery for consumers at this facility?
The organisation's certification audit completed January 2021 indicates that organisational and clinical governance systems and processes were in place at the time of audit, and met agreed criteria under the Health and Disability Service Standards. The report indicates the presence of a complaint register, appropriate actions followed complaints or adverse events, with evidence of audit and maintenance records. There were no findings related to the call bell system.

The organisation's Audit and Survey Policy outlines objectives and steps to meet quality processes. The policy discusses quality indicators and the application of trend analysis to determine rates of achievement or areas for improvement. It is unclear if the clinical governance team had explored a relationship between call bell response times, falls rates, infection data, or other indicators of unmet resident needs, within monthly benchmarking at the time. There was no evidence of quality meeting minutes or thematic analysis provided within the evidence bundle which may have informed further comment here. The provider response and supporting additional communication received 3 March 2023 has outlined operational challenges 2021–2022 related to workforce turnover, a ransomware breach impacting IT systems and information access, and the associated disruption of the COVID-19 pandemic.

From the evidence reviewed to respond to this question it appears there has been considerable effort and improvement in the provider's systems and processes. The current manager has provided evidence of regular audits of the call bell system with robust analysis and discussion of corrective strategies to support ongoing improvement. There is evidence of engagement with residents, seeking their involvement with care home improvement opportunities. There is evidence of engagement with external agencies to review Wi-Fi connectivity, call escalation, service and system improvements, and discussion of policy development to support staff training. Based on learning and feedback the provider has discussed opportunities to introduce leadership training, education on workplace culture, and develop a primary nurse model to improve care oversight and teamwork. As a recommendation, it would be good to sight these improvements within an evaluated corrective action plan as part of quality improvement practice.

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/

Request for additional advice: 27 January 2025

Thank you for the opportunity to review my initial advice and provide additional comment. I have been asked to consider the following questions and clarify what the level of departure is.

1. Please could you clarify whether the care provided to the consumer met accepted standards and if not, why not.
2. Please could you clarify whether the standards regarding her care was appropriate or not.

Please comment on reports from the family of their need to communicate with care home staff via phone calls to alert their mother's needs. Is this in line with acceptable nursing practice?

On review of the supplied information, I consider there to be deviations in communication pathways, complaint management processes and documentation standards. There is a lack of record keeping to reflect engagement with consumers and their representatives, agreed actions and evaluation of outcomes in the circumstances and this would be viewed similarly by my peers.

- Departure from accepted practice. Mild to moderate.

Do you consider the overall nursing care provided to [Mrs F] for the duration of her admission to be in line with expected nursing practice, and aligned to MOH requirements for a hospital level care provider? Please provide comment related to clinical assessment, care planning, staffing and care delivery.

From the information reviewed and identified discussion points I consider the daily care provided to [Mrs F] was adequate in the circumstances. Although systems and

processes were in place, it appears that the application of policy guidance did not consistently occur (refer question 3), which increased the risk of compromised care and documentation delays. Given the reported workforce difficulties and associated challenges experienced by the provider at the time, I consider these to be mild to moderate deviations, and this would be viewed similarly by my peers.

- Departure from accepted practice: Mild to moderate.

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

Appendix D: Relevant standards

Health and Disability sector standards 2008

The Health and Disability sector standards 2008 (NZHDSS 2008) states the following:

> '1.1.10 Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent …
>
> 1.1.13 The right of the consumer to make a complaint is understood, respected, and upheld …
>
> 1.1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy and independence …
>
> 1.1.8 Consumers receive services of an appropriate standard …
>
> 1.1.9 Service providers communicate effectively with consumers and provide an environment conducive to effective communication …
>
> 1.2.8. Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers …
>
> 1.3.1 Consumers' entry into services is facilitated in a competent, equitable, timely and respectful manner, when their need for services has been identified …
>
> 1.3.4 Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner …
>
> 1.3.5. Consumers' service delivery plans are consumer focused, integrated and promote continuity of service delivery …
>
> 1.3.6.1. The provision of services and/or interventions are consistent with, and contribute to, meeting the consumers' assessed needs, and desired outcomes …
>
> 1.3.3.4. The service is coordinated in a manner that promotes continuity in service delivery and promotes a team approach where appropriate …
>
> 1.3.5.2 Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process …
>
> 1.4.3 … Consumers are provided with adequate toilet/shower/bathing facilities …
>
> 1.4.5 Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity and dining needs …
>
> 3.3 Documented policies and procedures for the prevention and control of the infection reflect current accepted good practice and relevant legislative requirements …'

Ngā Paerewa Health and Disability Services Standard 2021

The Ngā Paerewa Health and Disability Services Standards 2021 (NZHDSS 2021) states the following:

> '1.4.1 I shall be asked, and shall have opportunities to share, what is important to me …
>
> 1.4.3 My services shall be provided in a manner that respects my dignity, privacy, confidentiality, and preferred level of interdependence …
>
> 1.6.3 My service provider shall practise open communication with me …
>
> 1.6.4 I shall be provided with the time I need for discussions and decisions to take place …
>
> 1.7.2 I shall be empowered to actively participate in decision making …
>
> 1.7.4 My whānau shall be included in decision making with my consent and shall be enabled to do so through access to quality information, advice, and resources …
>
> 1.8.3 My complaint shall be addressed and resolved in accordance with the Code of Health and Disability Services Consumers' Rights …
>
> 2.3 Service providers ensure day-to-day operations is managed to deliver effective person-centered and whānau-centred services …
>
> 2.3.12 Service providers demonstrate whānau and community [participation], where relevant, in the planning, implementation, monitoring, and evaluation of service delivery …
>
> 2.2.6 Service providers shall understand and comply with statutory and regulatory obligations in relation to essential notification reporting …
>
> 3.1.1 During the initial engagement prior to service entry, service providers should ensure there are documented entry criteria that are clearly communicated to people, whānau, and, where appropriate, local communities and referral agencies …
>
> 3.2.1 Service providers shall engage with people receiving services to assess and develop their individual care or support plan in a timely manner. Whānau shall be involved when the person receiving services requests this …
>
> 3.2.4 In implementing care or support plans, service providers shall demonstrate [t]hat the provision of service is consistent with, and contributes to, meeting the person's assessed needs, goals, and aspirations … That needs and risk assessments are an ongoing process and that any changes are documented …

3.2.5 Planned review of a person's care or support plan shall be undertaken at defined intervals in collaboration with the person and whānau, together with wider service providers;

3.3.1 Meaningful activities shall be planned and facilitated to develop and enhance people's strengths, skills, resources, and interests, and shall be responsive to their identity;

3.6.4 A documented transition, transfer, or discharge plan, including current needs and risk mitigation, shall be developed in collaboration with the person and whānau and the accepting service provider …

4.1.2. The physical environment, internal and external, shall be safe and accessible, minimise risk of harm, and promote safe mobility and independence …

4.1.4. There shall be adequate numbers of toilet, showers, and bathing facilities that are accessible, conveniently located, and in close proximity to each service area to meet the needs of people receiving services …

5.2.1. There is an [infection prevention (IP)] role, or IP personnel, as is appropriate for the size and the setting of the service provider …

5.3.2. Service providers shall have policies and guidelines in place, appropriate to the size, scope, and complexity of the service, which will comply with evidence-informed practice.'