HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Inadequate home support services provided to older person

1. This report concerns the standard of care provided to Mrs A by Lavender Blue Nursing and Home Care Agency Limited (Lavender Blue), a homecare nursing agency, in 2022. On 7 April 2025, a Commissioner-initiated investigation was commenced after it was discovered that Mrs A had presented to her general practitioner (GP) with an advanced pressure area[1] on her left hip and declining mobility that was neither monitored nor treated by Lavender Blue staff.

Information gathered

2. Mrs A, aged 94 years at the time, lived at home with her husband and daughter. Her clinical history included dementia, congestive heart failure,[2] impaired glucose tolerance[3] and bronchiectasis,[4] resulting in shortness of breath. Mrs A also had a high risk of falling because of her unsteady balance.

3. Mrs A started receiving support services from Lavender Blue in 2018 and was assessed as requiring level 2 support.[5] Lavender Blue said Mrs A was initially assessed as needing twice-daily support. However, in 2022, when Mrs A moved in with her daughter, she received support services around three times a week for a total of around three to four hours for showering and dressing. Mrs A's service delivery plan (dated 15 February 2021 and developed by a registered nurse) stated that she required prompting, guidance, and supervision to complete her personal care, dressing, and grooming tasks.

4. The service delivery plan also stated that, in addition to providing support with showering and dressing, support workers were responsible for reporting signs of increasing confusion, declining function, and incidents of falls or near misses to the clinical support services team.[6] Further, the support worker was responsible for performing a skin check at each visit and reporting any signs of reddening, bruising, blisters, or darkening of the skin to Mrs A, her daughter, and the clinical support services team. Lavender Blue confirmed to the Health and Disability Commissioner (HDC) that the support worker's role involved reporting any concerns such as decline in skin condition to the clinical support services team.

5. Mrs A's service user agreement (dated 28 August 2019) stated that Lavender Blue would provide suitably trained and experienced staff to deliver services to her. Lavender Blue told HDC that only one support worker had provided care to Mrs A in 2022 and that this worker had met all of Lavender Blue's internal training requirements. The training material provided to HDC included guidance on implementation of the service delivery plan, providing

[1] A preventable harm caused by localised damage to the skin.
[2] A condition in which the heart cannot pump blood efficiently enough to meet the body's needs.
[3] Also known as prediabetes.
[4] A lung condition where the airways get damaged and widen.
[5] Requires moderate support with activities of daily living.
[6] The clinical support services team consisted of three registered nurses, two enrolled nurses, and one nursing manager.

personal cares such as showering and dressing, providing skin care to clients, and identification of pressure injuries. The orientation manual states that support workers are required to immediately report any signs of pressure areas to the clinical support services team to ensure remedial measures can be implemented to reduce discomfort and prevent further deterioration. Mrs A's support worker completed her orientation in 2014, nearly eight years before these events. Lavender Blue said the support worker received further training in 2019 that was based on the content in the orientation handbook. Other than this, no further education was provided to her about skin care and managing pressure injuries.

6. The training material did not include information on pressure injury classification, the process for completing skin checks, identifying signs of declining health, the escalation process for support workers, or documentation requirements. Lavender Blue said it reviews support workers on the job annually but did not state what this review consists of, and training records showed no evidence of annual reviews completed for Mrs A's support worker after 2017. In response to the provisional report, Lavender Blue said the support worker was reviewed on 13 November 2019 and 14 January 2021.

7. Mrs A's clinical notes provide no evidence that the support worker completed any skin checks or any concerns relating to pressure areas. The support worker said she did check Mrs A's skin at the time of supporting her and noticed no red or broken areas before 19 September 2022. However, the support worker said that, on 19 September 2022, she did 'notice an area on the side at the top of [Mrs A's] thigh that was red and raw'. The support worker informed Mrs A's daughter but not the clinical support services team; she assumed this was unnecessary because Mrs A's daughter was taking her to the GP (and subsequently the hospital). The support worker said she would have informed the clinical support services team if Mrs A had returned home. The concerns relating to Mrs A's skin were not documented. Lavender Blue told HDC that an internal note[7] recorded that the support worker had informed a member of the clinical support services team that Mrs A had gone to the GP and then the hospital. The clinical support services team member could not recall the reason for this.

8. The support worker also said that she noticed Mrs A was less mobile than usual on 19 August 2022. This meant that hygiene care such as washing needed to be performed with Mrs A seated on a chair rather than in the shower. This occurred for the next six consecutive visits (19 August until 15 September 2022) but was neither documented in the clinical notes nor reported to the clinical support services team. As a result, no remedial measures were implemented to monitor Mrs A's declining mobility. Lavender Blue also said that the family had not alerted the support worker to the seriousness of Mrs A's decline and that the support worker was unable to complete a skin assessment over this period because it was difficult to assess Mrs A on the chair. Lavender Blue said that, had they been made aware of the decline, they would have contacted the GP for Mrs A's needs to be reassessed.

9. Lavender Blue initially said that the clinical support services team reviews clients annually and that all reviews for Mrs A's care were up to date at the time of these events. Clinical records show that a registered nurse completed an annual review on 2 September 2022,

[7] This note was not provided to HDC.

which was seven months late as the previous review had been completed on 15 February 2021. Lavender Blue later acknowledged this delay of seven months and said it was due to the backlog of reviews arising from the COVID-19 pandemic and because staff were prioritising consumers with higher needs.

10. The documentation in the annual review was minimal; no concerns were documented other than a mention of Mrs A having fallen in the previous 12 months. No incident form was completed for the fall. In response to this, Lavender Blue told HDC that this was because the fall was not reported until several months after the event and that Mrs A's daughter decided that it did not require a medical assessment. In addition, Lavender Blue said that it was not actually a fall, but rather a 'slip' from the toilet seat.[8] However, the 2023 Health Quality & Safety Commission Te Tāhū Hauora Frailty Care Guides include a 'slip' in their definition of a fall.[9]

11. The annual review noted that Mrs A was transferring (moving from one position or surface to another) independently and that she and her daughter were happy with the level of support provided by Lavender Blue. The annual review did not reflect the changes in Mrs A's skin condition and mobility as observed by the support worker.[10] There also appeared to be no consultation with Mrs A's support worker nor a physical examination of Mrs A. No changes were made to the service delivery plan. Lavender Blue said it would have expected Mrs A's husband and daughter, as her natural supports, to have noticed Mrs A's declining health and that the family did not alert Lavender Blue staff to any decline during the annual review. In response to the provisional report, Lavender Blue said that, when Mrs A moved in with her daughter, the daughter cancelled all care except for showers three times a week as she was going to provide other support. Lavender Blue said this significantly reduced the time its staff spent with Mrs A and therefore also the support worker's ability to recognise the decline in her health.

12. On 23 September 2022, Mrs A presented to her GP at her local medical centre, who noted and photographed a large, advanced pressure injury on her left hip; the GP gave this photograph to HDC. In addition, the GP noted that Mrs A had declined significantly, that family were unable to get her out of a chair by themselves, and that she had no mobility aids at home. Mrs A was subsequently referred to hospital for treatment of the pressure injury.

Responses to provisional report

13. Mrs A's daughter was provided with the 'information gathered' section of the provisional report for comment. She said the family was happy with the service provided by Lavender Blue and found them responsive to their needs. In addition, she said the pressure injury was addressed by the support worker as soon as they became aware of it.

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[8] Mrs A's daughter told Lavender Blue that this was not a fall, but rather a slip from the toilet seat, which she had only mentioned during the annual review as a 'passing comment'.

[9] Falls | Ngā hinga (Frailty care guides 2023) | Health Quality & Safety Commission Te Tāhū Hauora

[10] Other than the annual review and providing a required point of contact for the support worker, it is unclear how the support worker and the clinical support services team interacted.

14. Lavender Blue was provided with a full copy of the provisional report for comment. Its comments have been incorporated into this report where relevant.

Independent clinical advice

15. Independent clinical advice was provided by Maria Escarlan, nurse practitioner (**Appendix A**). Ms Escarlan noted the following departures from accepted standards of care:

- Standard of personal care, including skin care between 19 August and 15 September 2022 – severe departure;
- Adequacy of training and education provided to support workers – severe departure;
- Adequacy of nursing oversight provided to support workers – moderate departure;
- Standard of nursing care – severe departure.

Decision: Lavender Blue – breach

16. Lavender Blue's responsibility to provide care in accordance with the Code of Health and Disability Services Consumers' Rights (the Code) included ensuring that its staff were suitably trained, as stipulated in the service user agreement. In my opinion, Lavender Blue failed to adequately equip Mrs A's support worker with the knowledge necessary to recognise early signs of pressure injury development and declining health and when to escalate such concerns. I agree with Ms Escarlan that the pressure area was most likely present earlier than 19 September 2022, as evidenced by the photographs of Mrs A's wound. The lack of training provided to the support worker, in conjunction with the lack of nursing oversight, resulted in the delayed recognition of Mrs A's pressure area and declining health. I am critical of this.

17. I am also concerned about Lavender Blue's reliance on Mrs A's family members to report signs of decline. In my opinion, it was the responsibility of Lavender Blue staff, as healthcare providers, to complete an independent and thorough assessment at the time of providing care and during annual reviews to ensure that Mrs A's needs were being met. I am critical that this did not occur on 2 September 2022 or earlier given that the annual review should have occurred in February 2022. In my view, obtaining the perspective of family members is only one factor in determining whether Mrs A was adequately supported, and I am concerned at the level of reliance placed on her family to report changes in her health. In my opinion, Mrs A's nurse should have completed an independent and fulsome assessment at the time of the annual review, including performing a physical examination, and I am concerned that this did not occur.

18. As a healthcare provider, Lavender Blue was responsible for providing services to Mrs A in accordance with the Code. Having reviewed all the information in this case, and for the reasons set out in the preceding two paragraphs, I consider that Lavender Blue breached Right 4(1) of the Code, which states that every consumer has the right to receive services with reasonable care and skill.

Recommendations and follow-up actions

19. In light of the findings, I recommend that Lavender Blue:

a. Provide a formal written apology to Mrs A's family for its breach of the Code. The apology is to be sent to HDC for forwarding to Mrs A's family within three weeks of the date of this report.

b. Review the current education and training being provided to support workers on the below topics to ensure it aligns with accepted practice:

i. Pressure injury management and undertaking skin assessments;

ii. Signs of acute health decline;

iii. The process for escalating care to the clinical support services team; and

iv. Documentation requirements.

As part of this review, Lavender Blue should consider introducing annual refresher courses to support workers and consider engaging an independent clinician with experience working within community settings. Lavender Blue is to provide evidence of this review, along with any corrective actions to be implemented, within 12 months of the date of this report.

c. Develop an information leaflet about the prevention and care of pressure injuries for distribution to families and natural supports. Provide a copy of this information leaflet to HDC within three months of the date of this report.

d. Review its process for undertaking annual reviews of the service delivery plans, including the frequency of these reviews. Provide evidence of this review, along with any corrective actions to be implemented, within six months of the date of this report.

20. A copy of this report with details identifying the parties removed, except Ms Escarlan and Lavender Blue Nursing and Home Care Agency Limited, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: Independent clinical advice to the Commissioner

The following independent advice was obtained from Maria Escarlan, Nurse Practitioner.

Complaint:	**Lavender Blue Nursing and Home Care Agency/Mrs [A]**
Our ref:	**23HDC00015**
Independent advisor:	**Ms Maria Escarlan**

I have been asked to provide clinical advice to HDC on case number **23HDC00015**. I have read and agree to follow HDC's Guidelines for Independent Advisors.

I am not aware of any personal or professional conflicts of interest with any of the parties involved in this complaint.

I am aware that my report should use simple and clear language and explain complex or technical medical terms.

Qualifications, training and experience relevant to the area of expertise involved:	I am currently registered as a nurse practitioner in older people's health. I have a subspecialty in wound care. I have a total of 18 years' nursing experience. Between 2013 and 2020, I was managing aged residential care (ARC) facilities providing rest home-level care, hospital-level care, dementia care, and psychogeriatric care. Then I got employed in the hospital in 2020 in a clinical nursing specialist nursing role to provide clinical support to ARC facilities across Taranaki, including (but not limited to) wound care management. This role includes provision of expert clinical advice and management of patients with complex wounds across aged residential services, provision of training and education to upskill RNs, and liaison between secondary experts, i.e., wound CNS, vascular service, and foot podiatry service, to support best practice and improve patient outcomes. I also provide guidance and support in community care nursing together with the multidisciplinary team. In 2022, I registered as a nurse practitioner and have continued working in a clinical support role and providing more advanced practice in the scope of a nurse practitioner. My professional qualifications include registration as a registered nurse in the Philippines, a general and obstetric registered nurse in New Zealand (NZ), and a nurse practitioner in NZ. My academic qualifications include a Bachelor of Science in Nursing (Philippines), a Competency Assessment Programme (NZ), a Certificate (Nursing-Gerontology), a Postgraduate Diploma (Nursing-Clinical), a Master of Health Sciences (Nursing-Clinical), a Postgraduate Certificate of Proficiency in Therapeutics: Knowledge

	and Integration, and a Postgraduate Certificate of Proficiency in Nurse Practitioner Prescribing Practicum.
Documents provided by HDC:	1. Lavender Blue Nursing and Home Care Agency's responses dated 26 June 2023, 23 March 2025, 14 April 2025, and 1 August 2025. 2. Clinical records from Lavender Blue Nursing and Home Care Agency covering the period 2 August 2017 to 5 September 2022. 3. Service User Agreement 4. Copy of [Mrs A]'s goals 5. New Employee Orientation Handbook 6. Orientation Assessment Form for Support Worker [Ms B] 7. Authority Form from Support Links 8. Clinical records from [Mrs A's general practitioner] dated 23 September 2022
Referral instructions from HDC:	**Lavender Blue Nursing and Home Care Agency** 1. Whether the standard of personal cares, including skin care, provided to [Mrs A] was adequate. 2. Whether the training and education provided to support workers was adequate in this instance. 3. Whether there was adequate nursing oversight of the support workers. 4. Whether the standard of nursing care provided to [Mrs A] was adequate. 5. Any other matters you consider warrant comment.

Factual summary of clinical care provided complaint

Brief summary of clinical events:	Mrs [A] received support services for personal care three times a week from Lavender Blue Nursing and Home Care Agency (Lavender Blue) between August 2017 and September 2022. On 23 September 2022, [Mrs A] presented to her general practitioner at […], who noted a large pressure injury on her left hip. This did not appear to be escalated by the support worker at Lavender Blue. [Mrs A]'s medical history includes dementia, impaired glucose tolerance, atrial fibrillation, CHF, bronchiectasis, and hypertension. Lavender Blue's primary support worker for [Mrs A] was Ms [B]. There was no support service provision between 15 and 17 August 2022 due to [Mrs A]'s COVID infection.

	On 19 August 2022, [Ms B] noted [Mrs A] to be less mobile. Personal hygiene cares, such as washing [Mrs A]'s hair, were performed while [Mrs A] was on the chair. This has occurred for the next six consecutive visits, from 19 August until 15 September 2022. There is no evidence on the clinical notes of provision of skin assessment and cares. An abnormality on [Mrs A]'s skin was first noticed by [Ms B] on 19 September, which prompted a GP review, but this was not escalated to Lavender Blue's clinical team. This was also not documented on the clinical notes. On 2 September 2022, an annual review of the Support Level Assessment for [Mrs A] was conducted by [Ms C], RN. This was reflected in the clinical note's documentation on 5 September 2022. However, [Mrs A]'s skin condition, transfer and mobility assessment did not reflect what was reported by [Ms B] above. [Ms C] noted that [Mrs A] was independently mobilising and transferring. The pressure injury was also not detected and documented, which would likely have already been present during that time.

Question 1: Whether the standard of personal cares, including skin care, provided to [Mrs A] was adequate.	
List any sources of information reviewed other than the documents provided by HDC:	Guiding Principles for Pressure Injury Prevention and Management in New Zealand https://www.acc.co.nz/assets/provider/pressure-injury-prevention-acc7758.pdf
Advisor's opinion:	In my opinion, the standard of personal care, including skin care, provided to [Mrs A] between 19 August and 15 September 2022 was inadequate and did not meet the standard practice. Pressure injuries are a major cause of preventable harm for patients using healthcare services. I believe the gaps are: 1. [Ms B] failed to recognise the early signs of [Mrs A]'s risk of developing/developed pressure injury. Immobility is a major risk factor for developing pressure injury.

	2. There is no sufficient evidence that an appropriate and thorough skin assessment and care was delivered by Ms [B]. 3. [Ms B] was providing personal care on the chair in six consecutive visits, which could have raised a red flag that [Mrs A]'s condition declined or was not improving. 4. Failure to escalate the change in [Mrs A]'s condition to the RN/clinical team.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Skin assessment is an integral part in personal hygiene cares. Early identification, staging, and management of pressure injuries are essential parts of the provision of care as a healthcare provider. Prevention includes comprehensive assessment and minimising potential development of pressure injuries through monitoring, nursing intervention, assessment and risk identification. Where patient condition is compromised, such as immobility in [Mrs A]'s case, and pressure injury cannot be prevented, further injury is minimised, and recovery is aided through appropriate evidence-based interventions such as repositioning, off-loading the area, utilising pressure-relieving cushions and other equipment. Any acute change in patient's baseline is usually escalated to the clinical team. Sources as above.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Severe departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Consulted the peers who are currently working in community nursing in New Zealand. They believe that the care provided was poor and unacceptable.

Please outline any factors that may limit your assessment of the events.	N/A
Recommendations for improvement that may help to prevent a similar occurrence in future.	My recommendations for improvement: 1. Escalation plan for the support workers on what to look out for when the client in the community has an acute change in status. 2. Education on pressure injuries for support workers, with refresher courses. 3. Pressure injury information leaflets available for the family members. 4. Documentation on the clinical notes of personal cares, including skin care.

Question 2: Whether the training and education provided to support workers was adequate in this instance.	
List any sources of information reviewed other than the documents provided by HDC:	QRG-abridged-25Feb2025.pdf https://static1.squarespace.com/static/6479484083027f25a6246fcb/t/67bd4fbfd6865e7a07acc9e8/1740459974549/QRG-abridged-25Feb2025.pdf Guiding Principles for Pressure Injury Prevention and Management in New Zealand pressure-injury-prevention-acc7758.pdf https://www.acc.co.nz/assets/provider/pressure-injury-prevention-acc7758.pdf
Advisor's opinion:	In my opinion, the training and education provided to support workers by Lavender Blue was not adequate in this instance and has not met the standard of care. Providing skin care, including "pressure area", is reflected in the Lavender Blue Nursing and Home Care Agency Limited New Employee Orientation Handbook; however, the depth of information is not up to date and not enough. There is no evidence of annual refresher courses/training for the support workers.
What was the standard of care/accepted practice at the	Health professionals, including support workers and carers, have access to education and educational resources based on current evidence that enables them

time of events? Please refer to relevant standards/material.	to provide culturally appropriate care that prevents and manages pressure injuries. Every person who is at risk of developing a pressure injury, and those who care for them, have access to information on how to recognise the risks, undertake preventive and management measures and access support to reduce the occurrence of pressure injuries. Care is planned in collaboration with people and their families/whānau or other carers, and they have the opportunity to ask questions about pressure injuries and their prevention and management. Sources as above.
Was there a departure from the standard of care or accepted practice? • No departure; • Mild departure; • Moderate departure; or • Severe departure.	Severe departure
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	This is viewed by my peers as poor and has not meet standard of care.
Please outline any factors that may limit your assessment of the events.	N/A
Recommendations for improvement that may help to prevent a similar occurrence in future.	My recommendations for improvement: 1. The organisation should provide in-depth education on skin assessment and pressure injury identification and prevention. 2. The organisation should maintain systems for recording education and training and identify and meet educational and training needs of the support workers. 3. Staff to ensure their current knowledge of, and skills in delivering, care to people who are at risk of developing pressure injuries are up to date. This care includes assessing, identifying, preventing

	and managing pressure injuries. Staff are supported in identifying their education and training needs and keep records of their professional development. 4. Information leaflets on pressure injury risk factors, prevention and early identification, to whom and when to report any concerns, and the treatment options and support available for people at risk. 5. An assessment of the supports required for self-management or home-carer management as appropriate.

Question 3: Whether there was adequate nursing oversight of the support workers.	
List any sources of information reviewed other than the documents provided by HDC:	National Framework for Home and Community Support Services (HCSS) https://www.health.govt.nz/system/files/2020-06/national_framework_for_home_and_community_support_services_29sept2020.pdf
Advisor's opinion:	In my opinion, there was inadequate nursing oversight of the support workers. There was no recorded evidence that the RN and the support worker communicated and integrated their assessments and care to reflect [Mrs A]'s current needs at that time. The gap showed on [Ms C]'s annual review conducted on 2 September 2022. [Ms C]'s assessment of [Mrs A] remained unchanged despite the acute decline of [Mrs A]'s condition. There was no evidence that the primary support worker's input was included during the review.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	Registered health professionals such as RNs are part of the team and can provide assessments and oversight to the non-regulated team. Roles and duties may include delegating and supervising non-regulated staff; conducting comprehensive assessments; writing and reviewing support plans; managing care support; analysing goal activity; and helping to integrate services across primary, secondary and community care.
Was there a departure from the standard of care or accepted practice?	Moderate departure

• No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Inadequate and has not met standard of care.
Please outline any factors that may limit your assessment of the events.	N/A
Recommendations for improvement that may help to prevent a similar occurrence in future.	My recommendations for improvement: Review of the organisation's policy on needs assessment. For timely clinical assessment, including where there is a change in condition, the support worker should be included during the goal setting and reviews of the client. Using their clinical judgement and the results of the risk assessments, healthcare professionals work with people, carers and families/whānau or other carers to develop a care plan.

Question 4: Whether the standard of nursing care provided to [Mrs A] was adequate.	
List any sources of information reviewed other than the documents provided by HDC:	National Framework for Home and Community Support Services (HCSS) https://www.health.govt.nz/system/files/2020-06/national_framework_for_home_and_community_support_services_29sept2020.pdf interRAI New Zealand https://www.interrai.co.nz/
Advisor's opinion:	In my opinion, the standard of nursing care provided to [Mrs A] was inadequate. The reasons for this were: 1. [Ms C] (RN) failed to recognise the presence of a pressure injury when the annual assessment was conducted on 2 Sep 2022. It appeared that the RN did not do a physical examination during this review. 2. The timeframe in between the nursing reviews on [Mrs A]. The documentation provided showed that [Mrs A]'s recent reviews were on 15 Feb 2021 and 2 Sep 2022. There was a 19-month gap in between, which I believe is a significant gap that likely contributed to failing to recognise the early decline or gradual change of the client's condition. 3. The nursing documentation on the clinical records was not comprehensive and lacked vital information on [Mrs A]'s needs for the support worker to follow through.
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	1. A nursing assessment typically involves a comprehensive assessment of the client's health. 2. At least an annual review or six-monthly for clients with high and complex needs. 3. Accurate documentation of findings is crucial for ongoing patient care and communication among healthcare providers. 4. interRAI assessments are currently not required in the community nursing sector. Sources above.
Was there a departure from the standard of care or accepted practice?	Severe departure

• No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	Inadequate and has not met standard of care.
Please outline any factors that may limit your assessment of the events.	N/A
Recommendations for improvement that may help to prevent a similar occurrence in future.	My recommendations for improvement: • Utilisation of interRAI Home Care assessment by the RNs: an in-depth assessment focused on supporting a person at home. It is comprehensive and takes an overall view so that all health professionals involved in your care have a picture of your situation. All of this can help clinicians, providers, clients and families to make informed decisions about the care they need. • Education on nursing assessment and care planning.

Question 5: Any other matters you consider warrant comment.	
List any sources of information reviewed other than the documents provided by HDC:	N/A
Advisor's opinion:	
What was the standard of care/accepted practice at the time of events? Please refer to relevant standards/material.	
Was there a departure from the standard of care or accepted practice?	

• No departure; • Mild departure; • Moderate departure; or • Severe departure.	
How would the care provided be viewed by your peers? Please reference the views of any peers who were consulted.	
Please outline any factors that may limit your assessment of the events.	
Recommendations for improvement that may help to prevent a similar occurrence in future.	

By signing this report, I agree to HDC correcting any formatting, spelling, or grammar issues on the proviso that the substance of the report and any quoted material remains unchanged.
Signature: 
Name: Maria Escarlan
Date of Advice: 30 August 2025

Further comments provided by Ms Escarlan on 15 September 2025:

> I have read and reviewed the response provided by Lavender Blue.
>
> a. My advice remains the same. No changes.
> b. No further comments to make.
>
> Thank you very much.
>
> Kind regards,
> Maria Escarlan