Decision 24HDC00630
27 August 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

# Failure to provide appropriate treatment to vulnerable resident

## Introduction

1. First, I acknowledge the distress endured by Mr A and his family and the ongoing impact these incidents have had on them.

## Complaint background

2. On 3 March 2024, this Office received a complaint from Mrs B about the care provided to her father, Mr A (77 years old at the time of events) at Fullerton Investments Limited (trading as Manor Park Private Hospital) located in Lower Hutt, Wellington. Mrs B's mother, Mrs A, has an activated Enduring Power of Attorney (EPOA)[1] for Mr A's care and welfare. She asked Mrs B to make the complaint on her behalf.

3. Mrs B's main concerns relate to the unstageable[2] pressure injuries[3] on both Mr A's heels, about which the family were not informed; that his EPOA was not informed of Mr A's fall on Day3 Month3 2023; and that Mr A appeared malnourished and had lost 12kg within a couple of months.

4. Mr A was admitted to a dementia level of care at Manor Park Hospital on 30 Month1 2023. Prior to this, he had resided at a rest-home level of care, but due to increasing presentations of stress and distress he was reassessed as needing psychogeriatric level of care.[4] His medical background included Alzheimer's[5] with behavioural and psychological symptoms of dementia, hypertension,[6] and chronic kidney disease.

5. Mrs B stated that 'due to concerns over his care' at Manor Park Hospital, Mr A was transferred to another care home on Day2 Month5 2024.

[1] A legal document in which a person (the donor — Mr A) appoints another person (the attorney — Mrs A) to make decisions on the donor's behalf if the donor becomes incompetent.
[2] A pressure injury is graded from 1 to 5 to specify the level of tissue damage the person has experienced. For example, a grade/stage 1 pressure injury could be described as redness of the skin and a closed wound, whereas a grade/stage 4 pressure injury is an open wound that extends to the muscle, tendon or bone. When a pressure injury is noted to be 'unstageable', this is because slough, or dead tissue, is covering the wound bed and hinders a clear assessment of the wound's depth and complicates the determination of the appropriate treatment needed.
[3] An injury to the skin and underlying tissue resulting from prolonged pressure on the skin.
[4] The four 'levels of care' in New Zealand are rest home, hospital level, rest home dementia, and psychogeriatric specialist hospital care (or D6).
[5] A type of dementia that affects memory, thinking, and behaviour.
[6] High blood pressure.

**Outcome sought**

6. Mrs B told HDC:

> '[W]e want to ensure that Manor Park is providing the correct care to their patients. That anyone currently there, or who will be admitted are not put through the same neglect that our Dad was. No one deserves to be treated like this.'

**Scope of investigation**

7. The following issue arising from the complaint was investigated by HDC:

- *Whether Fullerton Investments Limited (trading as Manor Park Private Hospital) provided Mr A with an appropriate standard of care between Month3 2023 and Month4 2024 (inclusive).*

**HDC investigation findings**

8. HDC gathered information from Manor Park Private Hospital, including clinical records, guidelines, and organisational policies. On review of this information, the following conclusions were reached.

*Management of Mr A's pressure injuries*

- From Day1 Month3 2023, Mr A appeared to deteriorate, with a poor appetite, poor oral intake, and declining mobility, eventually requiring assistance from two people to meet his everyday needs. There is no evidence that his pressure-injury risk factors relating to his deterioration were considered at this time.
- From Day6 Month3 2023, it was documented that Mr A's right heel was 'quite red with nil evidence of blood'. However, there is no evidence of a skin integrity assessment being conducted and no evidence of regular monitoring of his reddened heel or escalation to the clinical manager or wider care team.
- Mr A's bilateral heel pressure injuries were identified on Day8 Month3 2023 and noted in his progress notes as 'a pressure injury starting'. However, no photographs of his heels were taken, no specialist advice, such as from a wound-care specialist, was sought, there is no evidence of wound staging, and his wound-care goals were not discussed.
- There is no evidence of nursing oversight of managing Mr A's pain related to his bilateral heel pressure injuries or consideration of Mr A's nutritional needs to support wound healing.
- There is no evidence that a repositioning chart was commenced to record whether Mr A was receiving regular turns to ensure that he would not develop further pressure injuries on his body.
- There is no evidence of communication with Mr A's EPOA or his family regarding the identified pressure injuries.
- There is no evidence that a short-term care plan was commenced to guide staff on how to manage Mr A's pressure injuries, or that any monitoring records were implemented.

- It is noted in Mr A's progress notes that his sacral area was red because he had been sitting up all day, but there is no evidence of a reassessment of his skin or pressure injury risk, or of changes being made to his mobility plan.
- The wound records appear to indicate inconsistencies in delivery of wound care.
- There is no evidence that an incident report was completed regarding Mr A's pressure injuries, and no evidence of an event analysis investigation completed by care-home leaders.

*Management of Mr A's nutritional needs and weight monitoring*

- Although progress notes document Mr A's decline in eating and drinking, there is no evidence that a short-term care plan was commenced to guide staff on managing his food and fluid intake or that any food and fluid monitoring charts were commenced.
- Mr A's notes indicate that he lost 13.6kg between Month3 2023 and Month4 2024; however, there is no evidence that Mr A's weight was recorded regularly (such as weekly) or that his weight loss was escalated to care-home leaders.

*Management of Mr A following his fall on Day3 Month3 2023*

- Progress notes on Day3 Month3 2023 record that Mr A had an unwitnessed fall and was found on the floor of his room around 5.30pm.
- There is no evidence that Mr A's EPOA was informed of his fall.
- There is no evidence that a pain assessment was conducted following his fall.
- Following his fall, neurological observations were performed inconsistently.
- There is no evidence that a review of this event was conducted or corrective actions implemented by care-home leaders.
- From Day5 Month3 2023, Mr A presented with poor mobility, pain while weight bearing, and general unwellness. While the GP was informed at the time, there is no evidence that Mr A's care plan was updated to reflect his functional decline.

**In-house advice**

9. In-house aged-care advice was sought from registered nurse (RN) Jane Ferreira (Appendix A), who identified the following departures from the accepted standard of care provided by Manor Park Private Hospital to Mr A:

- Management of Mr A's pressure injuries — **Moderate to serious departure**
- Management of Mr A's nutritional needs and weight monitoring — **Moderate to serious departure**
- Management of Mr A following his fall on Day3 Month3 2023 — **Moderate departure**

**Response to provisional opinion**

*Mrs B*

10. Mrs B was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

11. Mr A's wife, Mrs A, told HDC:

> 'I was given no other option but to send my husband to Manor Park. I am sickened and distressed by the whole experience. I paid for his care and they didn't look after him. It is a hospital and they are supposed to look after people … I am very disappointed and hurt.'

12. Mrs B told HDC:

> 'This report shows that [Manor Park] have failed to uphold that contract by not providing basic necessities for a patient of his level of care … The phrase "There is no evidence" is continuously repeated throughout the report which shows a severe disregard for documentation requirements [and] [t]he responses from Manor Park … show a failure to take responsibility for their actions.'

13. Mrs B also stated: 'I have noted that there is no mention that Manor Park failed to notify the Ministry of Health to advise of his pressure injuries. This was highlighted to us straight away by [another care facility] as a legal obligation.'

*Manor Park Private Hospital*

14. Manor Park Private Hospital was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

15. Manor Park noted its 'sincere apologies to Mr A's family for the failure to provide services to Mr A with reasonable care and skill'. Manor Park said that it remains 'committed to implementing further training and learnings from this complaint'.

16. Manor Park was provided with a copy of RN Ferreira's advice. Manor Park told HDC: '[W]e accept that there was poor documentation of care provided.' Manor Park noted the following:

- In terms of managing Mr A's pressure injuries, 'there are identified concerns with nursing assessment, timely delivery of wound care, evaluation processes, communication and documentation standards'.
- In terms of managing Mr A's weight loss, '[registered nurses'] progress notes provide no discussion of weight recordings, identified discrepancies, nursing actions (such as reweighing, checking scale calibration) or clinical escalation'.
- In terms of Mr A's fall, 'there are apparent opportunities for improvement in clinical oversight and documentation standards regarding the quality and consistency of care information'.

**Decision — breach**

17. The issue in this matter is whether Manor Park Private Hospital provided Mr A with an appropriate standard of care between Month3 2023 and Month4 2024 (inclusive). RN Ferreira identified issues in three areas of Mr A's care and advised that in all three areas, the care provided by Manor Park Private Hospital fell below the accepted standard of care. I accept RN Ferreira's advice.

18. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[7] requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that Fullerton Investments Limited (trading as Manor Park Private Hospital) did not provide services to Mr A with reasonable care and skill and breached Right 4(1) of the Code.

**Changes made since events**

19. Manor Park Private Hospital told HDC:

> '[A]s a team, we have looked at areas for improvement to ensure that we give the best possible care to our residents following best practice and ensuring we are accountable as individuals for our practice.'

20. Following Mr A's care at Manor Park Private Hospital, the following changes were made:

- The clinical coordinators received training on wound care and managing pressure injuries, provided by Health New Zealand | Te Whatu Ora (Health NZ).
- It aligned its Wound Assessment and Care Plan to that used by Health NZ.
- Its staff regularly refer to the district nursing service for wound management advice.
- Extensive training was provided to staff regarding expectations around the standard of documentation.
- A senior nurse was engaged to review its policies and procedures around wound management, falls management, the management of weight and nutritional needs of the residents, and the standard of documentation. This was done to identify and implement further training and learnings for staff.

**Recommendations**

21. I recommend that Fullerton Investments Limited (trading as Manor Park Private Hospital):

a) Provide a written apology to Mr A's family for the issues identified in this report. The apology is to be sent to HDC, for forwarding to the family, within three weeks of the date of this report.

b) Provide evidence of education and training, within three months of the date of this report, in the following areas:

   i. Managing pressure injuries

   ii. Managing a resident's weight and nutritional needs

   iii. Falls management

   iv. Maintaining documentation to a high standard

[7] Right 4(1) states: 'Every consumer has the right to have services provided with reasonable care and skill.'

**Follow-up actions**

22. A copy of this report with details identifying the parties removed, except the advisor on this case and Fullerton Investments Limited (trading as Manor Park Private Hospital), will be sent to HealthCERT and Health NZ and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
**Aged Care Commissioner**

**Appendix A: In-house clinical advice to Aged Care Commissioner**

The following in-house advice was obtained from RN Ferreira:

'1. Thank you for the request that I provide clinical advice in relation to the complaint about the care provided by Manor Park Private Hospital. In preparing the advice on this case, to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

**2. Documents reviewed.**

- Letter of complaint received 4 March 2024
- Provider's response dated 16 June, 22 October, 3 December 2024
- Clinical records including assessments, care plans, progress notes, monitoring forms, incident reports, communication records, medical records.
- Organisational policies and resources including Consumer and Family/Whānau Participation, Falls Prevention and Management, Nutritional Plans, Pressure Injury Prevention, Assessment and Management, Weight Management, Wound Prevention and Management, Orientation Schedule
- Additional information received 22 October 2024 and 3 December, including weight chart, observations, wound care, assessment and care information.

**3. Complaint**

Mr [A]'s daughter has raised concern about the care provided to her father while resident at the care home. Her concerns relate to management of falls, pressure injuries, weight loss, care and communication.

Background

Mr [A] was admitted to the care home from hospital on 30 [Month1] 2023. Prior to admission Mr [A] resided at rest home level care. Due to increasing presentations of stress and distress he was reassessed as requiring specialist dementia care (stage 5). Mr [A]'s medical history included Alzheimer's dementia with BPSD [behavioural and psychological symptoms of dementia], angioedema, chronic kidney disease (CKD), gout, hypertension and hypothyroidism. Admission information stated that he was independently mobile and required carer supervision and assistance with activities of daily living. In [Month3] 2023, Mr [A] became unwell with reports of fatigue, poor oral intake, pain and reduced mobility following an unwitnessed fall event. He was seen by the care home's General Practitioner (GP) post-fall with treatment commenced for a suspected hypoactive delirium. On [Day6 Month3] 2023, Mr [A] was identified with bilateral heel redness indicating suspected pressure injuries. Pressure-relieving interventions were commenced; however, the sites continued to decline to unstageable. Records show that Mr [A] had experienced a marked weight loss with ongoing mobility concerns during this time. In response to the observed clinical decline and behavioural plateau, Mr [A] was reviewed by Older Person's Mental Health Services and subsequently reassessed to hospital-level care. On 8 [Month5] 2024, Mr [A] was transferred to the care of another provider to be closer to his family.

**4. Review of clinical records**

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

In particular, comment on:

**a) Did the assessment, monitoring and treatment of Mr [A]'s pressure injuries, and communication to his family representative regarding the onset and progress of the pressure injuries, meet acceptable guidelines and standards of nursing practice?**

The organisation's Pressure Injury Prevention and Management policy (2023) references health standards and recommended guidelines about accepted standards of wound care practice. The policy states that the care home "*will assess the potential for, and endeavour to prevent the occurrence of pressure injuries"*.

The policy discusses the use of clinical assessment tools, including a requirement to complete skin assessments on admission, and utilise pressure injury risk scores within the InterRAI assessment to inform care planning. The policy notes that assessments will be routinely repeated six-monthly, or when a resident's needs/condition changes, which is considered accepted practice. General principles are discussed such as internal and external reporting responsibilities and referral criteria for wound nurse specialist (WNS) advice.

Admission information, including health records, progress notes and an initial care plan described Mr [A] as able to reposition and mobilise independently, with skin integrity assessed as "fully intact". Nutritional needs and continence requirements were discussed. Pressure-injury risk factors were not reflected in the initial care plan, which may suggest that Mr [A] was clinically considered at low risk of developing a pressure injury at the time of assessment.

Entries in the care record report changes in Mr [A]'s wellbeing from [Day1 Month3] 2023, noting signs of confusion, lethargy with an unsteady gait and reduced oral intake. Signs of post-fall pain with poor oral intake and declining mobility are reported from [Day3 Month3] 2023. While there is evidence of regular involvement by the General Practitioner (GP) in Mr [A]'s care, there appears to be a lack of essential nursing documentation commenced to guide Mr [A]'s care requirements at this time.

Further entries in the care record discuss changes in Mr [A]'s level of mobility, noting that he required assistance from two people to meet his needs. Night shift entries state that Mr [A] was asleep on all checks, but it is unclear whether he was still able to reposition himself independently given reports of recent pain and reduced mobility. It does not appear that pressure injury risk factors were considered at this time or the mobility/transfer plan reviewed.

Progress notes report changes in Mr [A]'s skin integrity from [Day6 Month3] 2023, with an RN describing his right heel as "*quite red with nil evidence of blood"*.

The RN has discussed difficulty in completing a proper skin assessment as Mr [A] was seated in a lounge chair, asleep. It is unclear why a nursing assessment was not completed in the privacy of his bedroom at an appropriate time during the shift, with his consent. There does not appear to be evidence of further nursing assessment, implementation of proactive care interventions or regular monitoring of the at-risk site after the heel redness was reported. It is unclear if concerns were escalated to the clinical manager and communicated to the wider care team.

The Wound Prevention and Management policy (2023) states that wound care needs will be reflected in the resident's care plan, with evidence of delivery reported in short-term care plans, wound care plans and nursing progress notes. Essential discussion points refer to administration of prescribed pain relief medications prior to delivery of wound care, assessment and documentation of findings, and communication processes about wound status and progress.

Carer entries [Day7 Month3] 2023 describe Mr [A]'s legs as "*swollen … appears to show pain moving right leg"* with Mr [A] remaining on bedrest. The Pressure Injury Prevention and Management policy recommends that the resident is assisted to reposition at regular intervals to reduce the risk of further injury, with an aim to "*relieve or redistribute pressure to a vulnerable area".* Care guidelines discuss skin care interventions, equipment use (such as slide sheets, transfer aids or pressure-relieving devices), and indications for health professional involvement. RN notes [Day8 Month3] 2023 state that bilateral heel injuries were identified, with blistering on right heel noted as "*a pressure injury starting"*. The report stated that a photograph was not taken and that specialist advice was not required. Wound staging and wound care goals are not discussed.

Wound management records show that following wound assessment, protective dressing was applied to both heel injuries with care instructions to use a cloud chair, elevate Mr [A]'s heels, apply an air mattress and use foot booties but it is unclear from nursing records when these items were introduced.

Progress notes state to ensure that Mr [A] was assisted to lie on his side rather than his back; however, there is no evidence of physiotherapist involvement regarding the appropriateness of this intervention, particularly given reports of hip and leg discomfort. It does not appear that a short-term care plan (STCP) was commenced to guide Mr [A]'s requirements in the circumstances. There is no evidence of regular nursing oversight of pain management, nutritional needs to support wound healing or use of a repositioning form to evidence pressure-relieving interventions. It does not appear that Mr [A]'s falls risk and safety needs were reviewed given the proposed introduction of new equipment and care routines, with no evidence that an incident report was completed. It is concerning to note that there is no evidence of communication with Mr [A]'s nominated representative regarding the identified pressure injuries which would be considered accepted practice in the circumstances.

The Health Quality & Safety Commission (HQSC) Frailty Care Guides provide information about prevention and treatment of pressure injuries to inform nursing practice. The tool includes a recommended bundle of care to guide clinical decisions and related actions based on assessed risk. Discussion points include a review of pressure-relieving

equipment (mattress, cushions, heel protectors), position changes, management of continence, visual skin checks each shift and review of nutritional needs, with monitoring of food and fluid intake, and increased frequency of weight monitoring. Records show that bilateral heel pressure injuries were identified on [Day8 Month3] 2023 and communicated to Mr [A]'s GP on [Day1 Month4] 2024. Clinical notes [Day2 Month4] 2024 discuss a GP review for heel pain and wound care concerns. Pressure-relieving strategies, pain monitoring and nutritional needs were reviewed by the GP although nursing documentation does not discuss a plan for specific assessment and care interventions, with still no evidence that an STCP was developed or monitoring records implemented. The RN entry states "*needs pressure mattress"*, which indicates that delays had occurred in providing the planned pressure-relieving equipment [Day8 Month3] 2023.

The Individualised Skin Integrity care plan (Nov 2023) provides guidance about resident skin care and escalation processes, noting that nurses "*will complete a thorough head-to-toe skin integrity assessment at least six-monthly … or more as needed".* The care plan provides no evidence of care updates or evaluation processes in response to signs of Mr [A]'s compromised skin integrity, with no reference made to wound assessment and care documentation. Entries in the care record state that Mr [A]'s sacral area was red due to being up all day. There is no evidence of reassessment of skin or pressure injury risk using recognised screening tools (e.g., Braden, Waterlow) with no evidence of changes made to a mobility/transfer plan given Mr [A]'s functional decline. It does not appear that monitoring of nutritional intake and risk of weight loss was considered in response to carer reports of reduced oral intake at this time.

Wound records discuss dressing frequency as "twice weekly". This was changed to "three times weekly" in [Month5] 2024. Wound care records show that the heel sites were assessed on [Day8 Month3] 2023 then next reviewed on 5, 9, 17, 19, 23, 28 [Month4] and 2, 5, 6 and 7 [Month5] 2024 which appear to indicate inconsistencies in delivery of wound care. On [Day1 Month4] 2024 wound plans report that the affected heel sites were considered 100% necrotic. Progress notes discuss delivery of wound care and signs of ongoing decline. Entries 17 and 19 [Month4] discuss further breakdown of the heel sites, GP review, and referral for wound nurse specialist (WNS) involvement. Visual images of the wounds were not supplied to inform further comment about wound progression or treatment rationale. The care record provides no evidence of specific communication provided to Mr [A]'s nominated representative regarding wound status, progress and treatment plans which would be considered accepted practice, particularly at this level of care.

As outlined in the HQSC guides, if a wound is not progressing according to the treatment plan, referral and consultation with a specialist is recommended. The Pressure Injury and Prevention policy states to seek WNS input for complex wounds (stage 4 or unstageable) or if a wound has not healed within four weeks.

The provider has been unable to find evidence of a referral made by the care home to WNS services and outlined issues with access to specialist services at the time. Given known service issues, it is unclear whether wound care advice was sought from alternative teams such as district nurses or other hospital-based specialists.

It appears that an incident report was not completed for the care home acquired pressure injuries in line with adverse event/incident management principles, nor notification provided to external stakeholders in line with service provider responsibilities. There is no evidence of event analysis completed by care home leaders nor implementation of corrective actions in response to the identified injuries, in line with quality improvement methodology.

Records show that Mr [A] was reassessed to hospital level care and transferred to another provider on [Day2 Month5] 2024. Progress notes state that a verbal nursing handover was provided to the clinical manager on [Day1 Month5] with nursing records prepared for transfer to support continuity of care. A nursing transfer form was not included in the submitted evidence to be able to clarify if communication occurred between providers about Mr [A]'s skin integrity, existing pressure injuries and current plan of care.

From the evidence reviewed it appears that the assessment, management and delivery of pressure injury care was below accepted nursing practice in the circumstances. While GP notes are very comprehensive regarding Mr [A]'s care, there are identified concerns with nursing assessment, timely delivery of wound care, evaluation processes, communication and documentation standards which would be viewed similarly by my peers.

- Departure from accepted practice: Moderate to serious.

**b) Did the assessment and treatment of Mr [A] following his fall on [Day3 Month3] 2023 meet acceptable guidelines and standards of nursing practice?**

The Falls Assessment, Management and Reporting for Residents policy (2022) states that resident falls risk will be assessed on admission, following a significant change in mobility, following recurrent falls, and six monthly as part of the resident review process. The policy outlines prevention strategies, care actions, reporting processes and criteria for physiotherapy involvement. Limited guidance is provided about unwitnessed falls and indications for neurological observations which may present an improvement opportunity.

It would be expected that following a fall event, a resident would be assessed by an RN according to Falls policy guidelines, and risk assessments completed with appropriate interventions in place. This would include providing the resident with a safe environment, continued RN oversight with focused carer support to ensure activities of daily living were safely met in line with care plan interventions. Any identified deviation from the resident's baseline, or known presentation, would require escalation to a senior nurse, communication with whānau/family, and involvement by specialist health professionals.

The care record shows that at 5.30pm on [Day3 Month3] 2023 Mr [A] was found by a carer lying on the floor of his room following an unwitnessed fall event. A post-fall assessment was completed by an RN which identified a right elbow skin tear but no other apparent concerns. The incident report (part one) stated that Mr [A] was assisted to stand and was "*very unstable on his feet*". Part two of the report stated that a wound management plan was completed, (not sighted); however, progress notes provide no

discussion about wound status, pain assessment or care provided. The RN reported that vital signs were recorded and that Mr [A] walked to the lounge after dinner. It appears that Mr [A]'s wife, as nominated representative, was not informed of the fall event at the time, with nursing information indicating that she wished to be updated for major injury only.

The incident report stated that neurological observations were commenced following the unwitnessed fall event. Records show inconsistency in provision of neurological observations with assessments recorded at 6pm on [Day3 Month3], 1pm on [Day4 Month3], and twice on [Day5 Month3] (3.30pm, 9.45pm) then discontinued without rationale, which would not be considered accepted practice. Health resources recommend a post-fall monitoring process for 24 to 48 hours; however, a supporting care home policy regarding protocols for clinical observations was not provided to inform further comment at this time.

Progress notes [Day4 Month3] 2023 state that Mr [A]'s bed was "*still playing up*". It is unclear whether environmental factors and equipment safety contributed to the fall event on [Day3 Month3], what review process was completed by managers or corrective actions implemented as part of event investigation responsibilities. The incident report notes that GP follow up occurred on 12 [Month3] 2023 with commentary provided about Mr [A]'s recent health decline, but it does not appear that falls risk was reviewed, contributing factors to the fall event considered or that care and safety needs were revised at the time.

As outlined in the Health Quality & Safety Commission's (HQSC) Frailty Care Guides, older people who are experiencing an infection are at greater risk of fall events and developing delirium (HQSC, 2019; HQSC, 2023). Factors for nursing consideration would include monitoring a resident's vital signs, fluid intake, continence needs and elimination patterns, pain, mobility, decision-making, personal care requirements and safety needs. Partnered with this are responsibilities to communication and documentation standards to ensure well informed care partnerships occur between the resident, their whānau/family and care team, to support delivery of appropriate care.

RN progress notes [Day4 Month3] 2023 state that Mr [A] appeared unwell with poor oral intake and had remained in bed. His wife had visited and expressed concern regarding his presentation. Vital signs were recorded with concerns suggested about temperature, and reports of non-specific pain. On [Day5 Month3] Mr [A] presented with poor mobility, pain with difficulty weight bearing, and signs of unwellness. He was assessed by two RNs regarding a suspected hip/leg fracture with vital signs recorded twice during the shift. Records show the GP was informed at the time. As a comment, it is also considered acceptable for RNs working in an aged residential care setting to seek paramedic support to inform clinical decision-making regarding further post-fall care (HQSC, 2019; HQSC, 2023).

Records show that Mr [A] was seen by his GP on 12, 15, 19 and 22 [Month3] 2023 with comprehensive clinical notes discussing assessment and care interventions. The medical impression of Mr [A]'s health decline was a hypoactive delirium related to an underlying infection of unclear source, with no apparent indication of fracture. While a detailed medical treatment plan was in place, there is no nursing evidence to show that

an STCP was developed to guide Mr [A]'s care requirements in the circumstances. Medical notes provide regular discussion of communication with Mr [A]'s wife regarding his clinical care; however, there is very little evidence of care updates provided to her by the nursing team at the time.

Records show that Mr [A] had an unsteady gait and was prescribed medications that may have increased his risk of falls. The Individualised Mobility care plan (Nov 2023) provides generic falls prevention strategies, with no discussion of falls risk. The specific care plan provides no evidence of evaluation or changes made to care or equipment requirements in response to Mr [A]'s functional decline, which would be considered accepted practice.

From the information reviewed to respond to this question, it appears that systems and processes were in place at the care home. Records show that the care team were responsive to the fall event and followed their recommended framework of reporting; however, there are apparent opportunities for improvement in clinical oversight and documentation standards regarding the quality and consistency of care information. Based on the discussion points raised, I consider there to be moderate deviations in practice in the circumstances, and this would be viewed similarly by my peers.

- Departure from accepted practice: Moderate

**c) Did the assessment, monitoring and interventions to address Mr [A]'s oral intake and weight meet acceptable guidelines and standards of practice?**

The Nutritional Plans policy states that dietary needs will be reviewed on resident admission, updated six-monthly, or when necessary. Records show that a nutritional plan was completed for Mr [A] on admission noting that he required supervision with meals and tolerated a large, normal diet.

The Weight Management policy states that residents will maintain a healthy weight, and where changes are identified that appropriate actions will be taken. The policy states that residents will be weighed on admission and monthly thereafter, with results discussed at relevant clinical review meetings. Where variations are noted, the policy outlines actions to be taken, including the development of an STCP.

Records report Mr [A]'s weight on admission as (92.6kg). Progress notes describe the settling-in phase, with comments of sleep difficulties, agitation with episodes of distress and heightened mobility. Carer entries describe daily care occurring with comments such as "eating and drinking well". A monthly weight was recorded in [Month2] 2023 of (90.9kg) indicating a (1.7kg) loss since admission. It is unclear whether the GP was notified or Mr [A]'s wife, as nominated representative, was informed. It appears that increased weight monitoring was not considered as clinically indicated at this time.

The care record stated that Mr [A] appeared "off" and slightly confused on [Day1 Month3] 2023, although food and fluid intake was described as good. Entries on [Day2 Month3] state that oral intake was poor at dinnertime but fluid intake good. On [Day3 Month3] Mr [A] appeared sleepy and unsteady, requiring the assistance of two carers, with reports of a fluctuating appetite. RN records reflect that observations were recorded and an alternative meal offered. Further entries in the care record discuss a decline in oral intake; however, there is no evidence that an STCP was developed to

guide care continuity across shifts, or any interventions commenced to monitor this, such as a nutritional record or fluid balance chart to support evidence-based clinical decision-making.

As outlined in the Frailty Guides, altered nutritional intake and unwellness can significantly impact an older person's quality of life, with malnutrition contributing to decreased wound healing. GP records 19 [Month4] 2024 show that Mr [A] was commenced on a nutritional supplement (Ensure) three times daily, with zinc and vitamin C in response to concerns with weight loss and wound healing (bilateral heel pressure injuries). His nutritional plan was updated the same day, which showed that Mr [A] required a nutritional supplement with a high-protein, medium-sized, normal textured diet. However, there is no evidence of any nursing documentation implemented in response to GP orders, in line with the organisation's policy guidelines.

Nursing records show that Mr [A]'s weight was recorded as (90.0kg) in [Month3] 2023 and (76.4kg) in [Month4] 2024 which potentially indicates a significant loss of weight (13.6kg). Medical records provide comprehensive evidence of clinical interventions and planned care, noting that weight loss was likely due to recent health problems. The three-monthly medical review dated 31 [Month4] 2024 noted that different scales had been used, raising a question regarding equipment accuracy. However, RN progress notes provide no discussion of weight recordings, identified discrepancies, nursing actions (such as reweighing, checking scale calibration) or clinical escalation which is concerning. Provider information dated 10 [Month5] 2024 reported Mr [A]'s admission weight as (73kg) which may suggest that he had experienced significant deconditioning related to his health decline during the timeframe in question.

From the evidence reviewed to respond to this question and related discussion points, there appear to be moderate to serious deviations in recognised nursing approaches to the management of weight and nutritional needs, and this would be viewed similarly by my peers in the circumstances.

- Departure from accepted practice: Moderate to serious.

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

**References**

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