HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care provided to man in aged residential care home

Executive summary

1. Mr A, aged 81 years, was admitted to hospital-level care at The Beachfront Home and Hospital (Beachfront; owned and operated by Henrikwest Management Limited) on 29 June 2022 after a hospital stay for treatment of acute cellulitis (a bacterial skin infection). He presented with a complex medical history that affected his quality of life. File information identified that Mr A had limited mobility and required carer assistance with his personal cares. On 15 September 2022, Mr B made a complaint about the adequacy of the care provided to Mr A while he was living at Beachfront.

2. My investigation has found deficiencies in the care provided to Mr A by Henrikwest Management Limited, particularly in relation to his wound management, falls management and mobilisation, continence and nutrition management, and management of his mental health and wellbeing. I have also found significant failures in the standard of documentation kept by staff at Beachfront. Cumulatively, I have found that these failures amount to a breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), which stipulates that every consumer has the right to have services provided with reasonable care and skill.

3. I have also made an adverse comment about Beachfront's communication with Mr A's family, in relation to both his ongoing care needs and the termination of his residential care agreement (RCA), and I am critical that important communication between the parties does not appear to have been documented.

Recommendations

4. Beachfront told the Health and Disability Commissioner (HDC) that it has made several changes to the service it provides since these events:

- Introduction of the V-Care electronic documentation system (V-Care) to improve the accuracy, consistency, and timeliness of documentation.
- 24/7 registered nurse (RN) coverage is maintained, often with more than one RN on site, which enhances clinical leadership and staff support.
- Appointment of a Quality Nurse Manager to focus on policy development, compliance monitoring, and quality improvement.
- Staff training is now supported by V-Care-based modules, ensuring more consistent and standardised delivery, and HDC's online modules have been incorporated into the staff training programme.
- It is developing targeted education modules on effective communication with and about older people and their families, early identification and documentation of changes in residents' care needs, and strategies to support accurate and timely communication of clinical concerns.

Names have been removed (except Henrikwest Management Limited, The Beachfront Home and Hospital, and the clinical advisor on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

5. In light of the significant changes made by Beachfront since these events, I recommend that Beachfront:

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

b) Report back to HDC, within six months of the date of this report, on whether the targeted education modules have been incorporated into the training schedule and the percentage of its staff that have completed training on HDC's online modules. Evidence that this training has been undertaken is also to be provided to HDC.

c) Use an anonymised version of this case to deliver further training on its internal policies that are relevant to this decision, particularly clinical oversight, documentation, and reporting requirements. Evidence that this training has been delivered to all staff at Beachfront is to be provided to HDC within six months of the date of this final report.

Background

6. Mr A had a complex medical history.[1] In June 2022, he was receiving hospital care for acute cellulitis and, on 29 June 2022, was discharged from hospital and admitted to Beachfront for hospital-level care.

Wound management

7. Mr B raised concerns that Mr A's wound bandages were not changed every day and were sometimes left for days without being changed.

8. Clinical records from Mr A's hospital admission state that, in addition to a chronic ulcer on his right leg, an area of concern was identified on his left heel on 22 June 2022. Beachfront progress notes from the day of admission record that a registered nurse (RN) received a verbal handover from the hospital discharging team, which included mention of Mr A's right leg ulcer and left heel wound, and that the wounds were dressed on arrival at Beachfront. An initial nursing plan was implemented and a wound management plan commenced for the right leg ulcer, but further information in the records about the delivery of wound care to the right leg ulcer throughout Mr A's admission is limited. There is no evidence that Mr A's general practitioner (GP) was informed of these wounds.

9. Records show that an RN conducted a 'head-to-toe' skin assessment on admission to check for signs of concern and documented that Mr A had dry skin with circulatory-related ulcers. However, there is no mention of the presence of pressure-related ulcers, and documentation of the assessment is incomplete. Body map images from the review show

[1] Mr A's medical history included stroke, mild cognitive impairment, type 2 diabetes, atrial fibrillation (heart rhythm disorder), carpal tunnel syndrome (pain due to pressure on the medial nerve in the wrist), high blood pressure, impaired kidney function, left hip osteoarthritis (degenerative joint disease causing pain and stiffness), decompensated biventricular failure (where both sides of the heart fail to pump blood effectively), and peripheral vascular disease (where arteries narrow, restricting blood flow to limbs, which frequently causes issues such as slow healing of ulcers), a chronic ulcer on his right leg, and a history of falls.

sites of impaired skin integrity on the right lower leg and left foot, but the written commentary is incomplete. A pressure injury risk assessment identified that Mr A was at medium risk of developing pressure injuries and that he was able to walk occasionally but had very limited mobility. There is no evidence of a pressure injury prevention care plan.

10. On 5 July 2022, a caregiver identified a black spot on Mr A's left heel and noted that his feet were swollen. Progress notes state that an RN was informed, but there is no documentation of RN assessment or follow-up. An injury/wound management form completed for the left heel wound notes that interventions included topical solutions and bandages and that dressings should be changed every two to three days, but there are no entries on the form beyond 15 August 2022.

11. On 4 July 2022, another injury/wound management form for a 'right leg back bottom' area was commenced, and this is assumed to be the chronic right lower leg ulcer, but the documentation is unclear. The form records that the wound was assessed and interventions such as topical solutions and dressings were applied on 4, 7, 10, 14, 17, 20, and 22 July 2022. It appears the wound was also reviewed on 24 July 2022, but there is no entry to show that the wound was re-dressed on that date.

12. On 14 July 2022, an injury/wound management form commenced for a right heel wound, which was classified as black/necrotic (the presence of dead/non-viable tissue caused by a lack of blood supply) with discoloured surrounding skin. The size of the wound was not recorded. The form shows that the right heel wound was assessed and wound care provided (such as topical solutions and dressings) every three days between 14 and 20 July 2022, with reported pain scores of 7, 7, and 6 out of 10 at each review, indicating moderate pain. The form shows that the wound was then reviewed and re-dressed every two days from 20 to 30 July 2022, with decreasing reported pain scores. However, no further information is recorded with respect to this wound.

13. On 20 July 2022, a wound management chart commenced for the right leg ulcer and left heel wound. It showed that the wounds were assessed every two days between 20 July and 28 July 2022, and on 11 and 15 August 2022, with wound care being provided and dressings changed on those days. There are no further recordings on the wound management chart with respect to the left heel wound. A wound management chart records further care being provided for the right leg ulcer, with wound assessment, management, and re-dressing occurring every three days from 17 August to 26 August 2022.

14. On 17 August 2022, a separate injury/wound management form was completed for the right leg ulcer, with documented interventions including the use of topical solutions, dressings, and bandage.

15. On 20 August 2022, a review of the right leg ulcer was completed, but no interventions were recorded, and there are no further entries on the chart beyond that date.

16. There is no evidence that the Vascular Clinic was consulted with respect to any of the wounds in light of Mr A's peripheral vascular disease, and no information is documented about pain management.

Continence and nutrition management

17. Mr B raised concerns that, although Mr A required assistance to go to the toilet, staff would often not attend when Mr A rang his call bell for assistance, which meant he had several incidents of incontinence.

18. Beachfront told HDC that, due to his mobility issues (discussed further below), Mr A had developed functional bladder and faecal incontinence, which often caused him frustration. A continence assessment was completed on admission, and a long-term nursing care plan was implemented on 20 July 2022 following an InterRAI assessment.[2] The care plan identified that Mr A required assistance at all times with personal cares and required toileting aids, but it does not record what toileting aids should be used or what the agreed timeframes for toileting were. The Barthel Index for Activities of Daily Living (a tool that measures a person's ability to complete activities of daily living) completed on 29 June 2022 also showed that Mr A required some help with toileting.

19. Beachfront told HDC that, to support Mr A's independence, staff encouraged him to use a urinal bottle, but this proved problematic over time because his deconditioning meant he had difficulty using it independently. Beachfront said that when the urine bottle was unsuccessful, Mr A was offered the use of a condom catheter,[3] which he pulled out on one occasion and then refused to use. As a next step, Beachfront said it offered two-hourly toileting, meaning that staff would either assist him with the urine bottle or take him to the toilet. Beachfront said that Mr A grew tired of staff asking whether he needed to use the toilet every two hours, and he was then asked to use his call bell instead. It said that once a hoist was recommended to transfer Mr A, toileting him became more complex.

20. There is no record of further continence nursing assessment, care plan review, or evaluation of the interventions being used to manage Mr A's incontinence. The hospital discharge summary had recommended restricting Mr A's daily oral fluid intake, but no guidance is documented about Mr A's hydration needs or fluid monitoring.

21. Mr A's long-term care plan contains a reported weight of 80kg with a body mass index of 26 (overweight) on admission and contains instructions to record monthly weights and monitor for signs of weight fluctuation and/or appetite changes. However, there is no record of this being done.

Falls management and mobilisation

22. In his complaint to HDC, Mr B raised concerns that, on multiple occasions, staff had trouble using equipment correctly and, on one occasion, a staff member used a lifting device that caused Mr A considerable pain and resulted in him having a fall.

23. Hospital discharge information states that Mr A was at a high risk of falls and required assistance to reposition and transfer. Transfer documentation states that Mr A required one

[2] Standardised, evidence-based clinical tools used to evaluate the needs of older adults and those with long-term disabilities. The assessments determine care requirements and create individualised care plans.

[3] An external, non-invasive urinary catheter for men with incontinence, consisting of a condom-like sheath worn over the penis and connected to a tube and collection bag.

to two people to assist with the use of a hoist. Beachfront progress notes from the day of admission state that Mr A required standing hoist transfers and two people to assist him to reposition. A falls risk assessment found that Mr A was at medium risk of falls but that he had suffered no falls in the previous six months. In contrast, hospital discharge information indicates that Mr A fell on 15 June 2022.

24. The Barthel Index was completed on 29 June 2022 and reflects that Mr A was dependent on assistance with bathing and grooming but that he needed major help with transfers, with assistance from one person.

25. Mr A was first assessed by a physiotherapist on 5 July 2022, and evidence shows that the physiotherapist had ongoing input into Mr A's care. The physiotherapy notes state that Mr A was unable to fully weight-bear on his left leg and that he required two people, or the use of a standing hoist, to transfer. Beachfront told HDC that Mr A required assistance from one person except for mobilisation but that during his admission he persistently tried to walk on his own, which resulted in falls. Beachfront said that its physiotherapist recommended the use of a standing hoist to help staff transfer Mr A safely. However, Beachfront said that Mr A felt frustrated around his lack of mobility and would get angry at staff and try to throw himself from the hoist on occasion.

26. Mr A's long-term care plan states that he was unable to weight-bear and had experienced a few falls since his admission, meaning he was now considered a high falls risk; however, the progress notes only contain reference to one fall during a hoist transfer on 21 August 2022. Interventions listed on the long-term care plan included that staff were to use a standing hoist with one person assisting. The long-term care plan does not include any information about nursing assessments in response to falls, or findings from previous falls, or give details about when or how the previous falls occurred. In addition, although the physiotherapist clearly had input into Mr A's care, there is no evidence that physiotherapy input was sought specifically regarding safe transfer processes or equipment suitability following Mr A's fall events. There is also no evidence that Mr A's care plan was reviewed following its initial completion on 20 July 2022.

Mental health and behavioural concerns

27. Mr B raised concerns that Mr A's mental health needs were not properly addressed.

28. Progress notes from July 2022 note that Mr A was adjusting to his new home and that he enjoyed his own company. In August 2022, notes reflect that he was refusing to go to the lounge or attend activities and that he did not mingle with other residents. InterRAI assessments completed on 20 July 2022 and 10 August 2022 reflect that Mr A was experiencing psychological changes and was at risk of social isolation and loneliness. Records also show that Mr A presented with aggressive episodes and that there were potential risks associated with his mental wellbeing. The notes prompted staff to observe Mr A's behaviour and to consider seeking mental health support if signs of concern were identified.

29. Progress notes throughout Mr A's admission show that he was displaying concerning behaviour and having altercations with staff. A behaviour chart was used from 11 July to 24 August 2022, but the notes are sparse and at times barely legible.

30. Clinical records do not contain evidence of incident reports being completed for Mr A's behaviours of concern, of follow-up with relevant mental health services and/or Mr A's GP, of senior clinical oversight, or of a review of interventions. Progress notes and various assessments reflect that Mr A was experiencing chronic pain that affected his mood, but there is no evidence of further pain assessments. Guidance in the long-term care plan regarding support for his mental health is also limited, and there is an absence of collaborative conversations with Mr A and his family around strategies for supportive care.

Termination of RCA

31. Mr B told HDC that he had a conversation with management on 23 August 2022, and the following day Beachfront gave notice terminating Mr A's RCA. Mr B believes that this was because of the discussion between himself and management and for his and Mr A's sister-in-law, Ms C's, breaches of visiting policies. At the time, Mr B was in the process of finding alternative accommodation for Mr A. Following the issuing of the termination notice, Ms C had an in-person meeting with management and the clinical nurse manager. Beachfront told HDC that the letter of termination was issued to Mr A, Mr B, and Ms C because of multiple breaches of Beachfront's Infection Prevention and Control Policies by Mr B and Ms C and that Mr A was given 21 days to find suitable accommodation and that, when accommodation was found, Beachfront supported his move there.

Other comments

32. Beachfront told HDC that it extends its sincere and unreserved apologies to Mr A and his family and acknowledges that some aspects of Mr A's care may not have met the high standards it strives for. Beachfront said that, on review of Mr A's clinical records and staff feedback, it appears that more care may have been provided than what was reflected in the documentation.

33. Beachfront said that the COVID-19 pandemic affected many operational areas, including staff availability, the delivery of education and training, and the consistency of day-to-day routines in 2022. Beachfront said that the pandemic also limited access to group training, which led to some inconsistencies in staff upskilling. In addition, Beachfront said there was a severe nationwide shortage of RNs at the time and, despite ongoing recruitment efforts, maintaining consistent RN coverage was very difficult, which in turn affected clinical oversight, documentation, and leadership.

Responses to provisional opinion

34. Mr B was given the opportunity to respond to the 'Background' section of the provisional report and had no further comments to make.

35. Henrikwest Management Limited was given the opportunity to respond to the provisional opinion and had no comments to make.

Analysis

36. Henrikwest Management Limited was responsible for providing services to Mr A in accordance with the Code. Right 4(1) of the Code states that every consumer has the right to have services provided with reasonable care and skill. I have sought advice from in-house aged care advisor, RN Jane Ferreira, to assist in determining whether Henrikwest Management Limited (trading as the Beachfront Home and Hospital) breached the Code.

37. At the outset, I note RN Ferrera's acknowledgment that the provision of care to Mr A occurred during the COVID-19 pandemic and that this presented challenges and caused distress to residents, family, care teams, and health service providers.

Wound management

38. Beachfront's 'Wound Management Procedures' policy requires that, when an RN is advised of a wound, they will investigate it and decide the best possible treatment and that the treatment should be documented in the care plan alongside other interventions to assist with treatment. The policy also provides that progress notes are to be maintained, that each treatment is signed for and the wound assessed, that specialist input is sought when required, and that an RN will follow-up and sign off when the wound is healed. The policy also notes a national requirement for pressure injuries to always be reported to HealthCert and the funding Health New Zealand region on an incident form and on a section 31[4] form if the pressure injury is stage 3 and above, 'irrespective of where the [pressure injury] was acquired.'

39. With respect to the area of concern that was identified on Mr A's left heel on 5 July 2022, RN Ferreira noted a lack of evidence of RN follow-up, assessment, or implementation of precautionary care. Regarding Mr A's chronic right lower leg wound, RN Ferreira also raised concern about the minimal documentation of the provision of wound care and that, despite a wound management form being completed on 14 July 2022 for the right heel injury, no further information is documented about the wound beyond 30 July 2022.

40. RN Ferreira advised that, despite Mr A being assessed as at medium risk of developing pressure injury, there is minimal evidence that interventions were implemented or reviewed during his admission, and the progress notes show incomplete documentation timelines with missed entries across multiple days. In addition, RN Ferreira advised that there is no evidence that incident management and reporting processes were followed; it is unclear whether Mr A was under the care of the Vascular Clinic despite his peripheral vascular disease placing him at higher risk of pressure injuries; there is no discussion of pain management given the significance and chronic nature of Mr A's wounds; and that, although Mr A's GP was involved in some aspects of his care, there is no evidence that he was informed of the left heel pressure injury. In addition, RN Ferreira noted that the left heel

[4] Pressure injuries in aged residential care must be reported to Te Tāhū Hauora Health Quality & Safety Commission via their adverse events reporting process. Te Tāhū Hauora will share agreed information about reported pressure injuries directly with HealthCert to fulfil reporting obligations under section 31 of the Health and Disability Services (Safety) Act 2001.

injury was an unstageable pressure injury but was not classified as such by Beachfront, and there is no evidence that a section 31 form and incident form was completed, as required.

41. I accept RN Ferreira's advice with respect to Mr A's wound management and am particularly concerned about this aspect of his care in light of his clear and documented immobility and significant medical history.

Continence and nutrition management

42. Beachfront told HDC that Mr A developed functional bladder and faecal incontinence that was often the cause of his frustration. Beachfront told HDC that several different interventions were trialled, but because of Mr A's deconditioning and frustration, it later relied on Mr A using his call bell when he needed to be toileted. Mr A's family raised concerns about staff attendance at Mr A's calls, but Beachfront did not provide HDC with call bell logs, despite being asked for all relevant records, so I am unable to comment on the effectiveness of this intervention.

43. A continence assessment was completed on admission, and the long-term care plan implemented on 20 July 2022 identified that Mr A required assistance at all times with toileting aids. However, despite Mr A's incontinence significantly affecting his daily living, the long-term care plan does not record what toileting aids should be used or the agreed timeframes for toileting. RN Ferreira advised that, beyond the initial care plan, there is no evidence of further nursing assessment, care plan review, initiation of a short-term care plan to guide carer actions, or evaluation of the interventions in place at the time. In addition, despite Mr A's hospital discharge recommending that his daily oral fluid intake be restricted, nursing documentation provides no information about hydration needs or the monitoring of fluid requirements. RN Ferreira also advised that, despite Mr A's care plan requiring monitoring of his weight with monthly weight recordings, there is no evidence that this occurred. I agree.

44. With respect to wound management and continence and nutrition management, RN Ferreira noted deficiencies in the care provided, particularly in relation to a lack of clinical oversight of Mr A's ongoing and evolving needs, poor documentation standards, and non-adherence to reporting requirements, which represent a moderate departure from accepted standards. I agree. Mr A clearly had a complex medical history in several important respects. I am critical of the inconsistent approach taken to Mr A's care and consider the lack of clinical oversight a significant contributing factor.

Falls management and mobilisation

45. Beachfront's documentation contains contrasting information about the level of assistance Mr A required with mobilisation. Hospital transfer documentation states that he required one to two people to assist and the use of a hoist. Progress notes from the day of admission state that he required standing hoist transfers and two people to assist him to reposition. The Barthel assessment on 29 June 2022 states that Mr A required assistance from one person.

46. Beachfront told HDC that Mr A required assistance from one person except for mobilisation and that a physiotherapy review on 5 July 2022 recommended that staff use a standing hoist

to transfer Mr A safely. The physiotherapy notes from the review state that Mr A was unable to fully weight-bear on his left leg and that he required two people, or the use of a standing hoist, to transfer. Mr A's long-term care plan states that staff were to use a standing hoist with one person assisting.

47. RN Ferreira advised that the discrepancies in the transfer instructions are confusing and placed Mr A and staff at increased risks of unsafe resident transfer processes. In addition, Beachfront's 'Moving and Handling Hoist Use' policy states that two people are required to assist for hoist use; however, the guidelines provided to staff instruct that only one staff member is required. RN Ferreira advised that it is concerning that the care plan does not align with Beachfront's policy and that no rationale is recorded for why the plan departs from the policy requirements. I agree.

48. Documented information regarding Mr A's falls risk and history is also inconsistent. Hospital discharge information states that he was at high risk of falls and that one had occurred as recently as 15 June 2022. However, the falls risk assessment undertaken by Beachfront found that Mr A was at medium risk of falls and had suffered no falls in the previous six months. Mr A's long-term care plan (commenced on 20 July) records that he was unable to weight-bear and had experienced a few falls since his admission (but when or how these occurred is not documented) and was at high risk of falls. The care plan does not include any information about nursing assessments being completed in response to falls, or any findings from previous falls, and progress notes only document one fall on 21 August 2022 when Mr A was being transferred by hoist. Although physiotherapy was involved in Mr A's care, there is no evidence that physiotherapy input was sought specifically regarding safe transfer processes or equipment suitability after fall events, particularly in light of the fact that Mr A was frustrated with his declining mobility and would sometimes try to throw himself from the hoist or walk without assistance. There is also no evidence that Mr A's care plan was reviewed at any stage during his admission, which RN Ferreira notes is concerning.

49. RN Ferreira was critical that care plan information contains no reference to incident analysis after falls events and no evidence that physiotherapy input was sought, as above. RN Ferreira also advised that records show minimal evidence of senior RN oversight of follow-up by clinical leaders and minimal evidence of nursing assessment in response to fall events to determine changes in health and wellbeing. RN Ferreira advised that planning, documentation, and evaluation of Mr A's mobility and falls management was lacking, which represents a moderate departure from accepted standards and did not align with appropriate and person-centred care. I agree. I am particularly concerned that, in light of Mr A's clear deteriorating mobility and his distress around this, there appears to have been a lack of oversight and planning to ensure Mr A could maintain his independence safely.

Mental health concerns and behavioural management

50. RN Ferreira advised that Mr A was living with long-term health conditions with signs of increasing frailty that was affecting his quality of life. InterRAI assessments identified physiological changes with a risk of social isolation and loneliness. Progress notes reflect that, by August 2022, Mr A was refusing to go to the lounge or attend activities. Clinical

notes prompted staff to observe changes in Mr A's mental health and signs of concern and that mental health input should be considered.

51. RN Ferreira advised that, even though progress notes stated that Mr A was displaying behaviours of concern, incident reports do not appear to have been completed for such events in line with accepted incident management processes. RN Ferreira advised that it is also unclear whether Mr A's GP was notified of concerns with his wellbeing and that, even though the progress notes reflect that Mr A was experiencing chronic pain that affected his mobility, mood, and behaviour, there is no evidence of pain assessments being carried out.

52. RN Ferreira advised that, although nursing strategies were in place to support Mr A's wellbeing, there is minimal evidence of senior nurse oversight, event evaluation, consideration of goals for care, or family involvement. RN Ferreira noted that, although supportive approaches to redirection and resident care appear to have been offered, there was a mild to moderate departure from accepted standards of care with respect to clinical oversight, the lack of person-centred care planning, and documentation standards. I agree and am critical of this aspect of Beachfront's management of Mr A's care.

Finding

53. There are clear deficiencies in the care provided to Mr A, both in relation to his wound management, continence and nutrition management, falls management and mobilisation, and mental health and behavioural concerns and in relation to the standard of documentation kept by all staff involved in Mr A's care, including RNs, clinical managers, and caregivers. I acknowledge the challenging circumstances under which Beachfront was operating at the time, but these circumstances do not negate the requirement to provide services with reasonable care and skill. Supported by the clinical advice from RN Ferreira, I have identified several shortcomings in the clinical care provided to Mr A, and I consider that those shortcomings are compounded by the extremely poor documentation kept by staff at Beachfront, which has made assessing the care provided to Mr A challenging. In isolation, these issues may appear less significant, but cumulatively they represent a pattern of poor care that, in my view, meant that Mr A was not provided with care of a reasonable standard. Accordingly, I find that Henrikwest Management Limited breached Right 4(1) of the Code for failing to provide services to Mr A with reasonable care and skill.

Communication with family – adverse comment

54. Mr A's family raised concerns about the termination of Mr A's RCA and their ability to visit Mr A during the pandemic. Assessment of the basis for the contractual termination falls outside of HDC's jurisdiction, so I am unable to comment on that aspect of Mr B's complaint.

55. With respect to communication with Mr A's family and visitation, RN Ferreira noted that the care record provides limited evidence of communication with Mr A's family during his admission. She also noted the minimal evidence of collaboration between clinical leaders, Mr A, and his family in response to identified concerns, noting that Beachfront did not provide family communication records and discharge/transfer of care documentation to HDC.

56. With respect to visitation, RN Ferreira noted no evidence of a structured outbreak management plan/risk mitigation plan or agreed plan for visitors, in line with accepted Infection Prevention Control at the time. RN Ferreira advised that it is also unclear whether care home leadership sought professional guidance regarding visiting schedules for residents and perceived transmission risk, which would be expected. RN Ferreira advised that it appears that decisions about visitation were made without input from relevant stakeholders but concluded that evidence was insufficient to inform further comment in this respect.

57. It is difficult for me to comment on the appropriateness of Beachfront's communication with Mr A's family because of the lack of evidence provided to HDC, particularly evidence of communication with Mr A's family about the termination of the RCA, visitation rationale, and other aspects of his care noted above. However, it is clear from the information provided, including Mr B's complaint, that there was a breakdown in communication between Beachfront and Mr A's family. Given Mr A was a vulnerable older person living in a new facility, at a new level of care, and appeared to be struggling to adjust, it was critical that Beachfront had proactive and consistent communication with Mr A's family and that such conversations were documented. I encourage Beachfront to reflect on my comments and those of my expert in this respect.

Conclusion

58. For the reasons outlined above, I consider that Beachfront did not provide services to Mr A with reasonable care and skill. Accordingly, I find Beachfront in breach of Right 4(1) of the Code.

Distribution

59. A copy of this report with details identifying the parties removed, except Henrikwest Management Limited, The Beachfront Home and Hospital, and the clinical advisor, will be sent to HealthCert at the Ministry of Health and Health New Zealand | Te Whatu Ora Waitematā and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Rose Wall
Deputy Health and Disability Commissioner

Appendix A: In-house clinical advice to the Commissioner

The following in-house advice was obtained from registered nurse Jane Ferreira:

'CLINICAL ADVICE – AGED CARE

CONSUMER: Mr [A]

PROVIDER: The Beachfront Care Home

FILE NUMBER: C22HDC02315

DATE: 1 April 2025

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

2. Documents reviewed

- Complaint received 16 September 2022
- Provider responses 23 March 2023 and 12 December 2024
- Clinical records, including admission information, nursing assessments, care plan, progress notes, monitoring forms, medical, allied health, and wound records
- Organisational policies and information, including Health and Safety, Care Planning, Complaints Management, Accidents and Incidents, Adverse Events, Resident Falls, Head Injury Management, Wound Care, and Transition, Exit, Discharge or Transfer
- Templates of assessment and care forms in use.

3. Complaint

[Mr A]'s representatives have raised concern regarding the care provided to [Mr A] while resident at the care home in 2022, particularly oversight and delivery of personal care, wound care, mobility needs, and environmental, social, and service requirements.

Background

[Mr A] was admitted to the care home from hospital on 29 June 2022 at hospital-level care. His medical history included atrial fibrillation, ischaemic heart disease, parietal stroke, mild cognitive impairment, carpal tunnel syndrome, impaired renal function, hypertension, osteoarthritis, decompensated biventricular failure, peripheral vascular disease, type 2 diabetes, chronic right leg ulcer, recent cellulitis, unstageable heel pressure injury, and falls. Records show that [Mr A] was able to participate in all care decisions and make his needs and wishes known. File information identified that he had limited mobility, was at high risk of falls, and required carer assistance to reposition and meet personal care needs. Due to a relationship breakdown regarding care and service concerns, the provider issued [Mr A] with a 21-day notice to terminate his admission agreement. He subsequently transferred to the care of another provider on 30 August 2022.

4. Review of clinical records

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

In particular, comment on:

a) The standard of nursing care relating to the wound care, pressure injury and continence management while [Mr A] was resident at the care home.

Pre-admission information showed that [Mr A] was living with complex long-term health conditions, including chronic wounds, pain and reduced mobility, which impacted his quality of life. Health records outlined his hospital admission, clinical status and reassessment from rest home to hospital level of care. Reviewed clinical notes discuss admission for treatment of left leg cellulitis with blistering and a chronic right leg ulcer (2021) related to peripheral vascular disease. Inpatient records report that an area of concern was identified on [Mr A]'s left heel (22 June 2022) during his hospital stay with evidence of RN involvement in assessment and wound care. While the discharge summary and nursing transfer form discussed [Mr A]'s ongoing care requirements, it appears that information about the suspected unstageable left heel injury (1cm x 1cm) was possibly overlooked in transfer of care reporting. Despite this, the receiving care home is contractually required to have policies in place to guide all resident assessment and care processes. It would be considered accepted practice for the admitting team to complete a holistic nursing assessment on admission to inform appropriate delivery of resident care.

The provider's Resident Admission policy outlines responsibilities and expectations for care home admissions. The policy is supported by a Day of Admission checklist with prompts to complete resident orientation, nursing assessments, initial care plans, and notification to service partners, such as the pharmacy and general practitioner (GP). Progress notes 29 June 2022 report that the duty registered nurse (RN) had received a verbal handover from the discharging team. The progress note entry stated that [Mr A] had two pressure injures, noting that wound dressings had been completed on arrival by the RN/clinical nurse manager. Nursing admission documentation shows that a 'head to toe' skin assessment was completed by the RN to check for signs of concern, such as redness, bruising or compromised skin integrity that would indicate a need for further care. The submitted skin assessment identified that [Mr A] had dry skin with circulatory-related ulcers. Body map images indicate sites of impaired skin integrity (right lower leg and left foot), although supporting written commentary on the tool is incomplete.

Organisational policies state that, if a resident is at risk of developing pressure areas, a specific assessment will be completed, risk minimisation measures implemented, and information documented in the resident's care plan. Records show that a Braden pressure risk assessment was completed, which identified that [Mr A] was at medium risk of injury, but there is minimal evidence that appropriate care interventions were

implemented or reviewed during his admission. Progress notes provide no specific discussion of wound assessment, location, status, reference to wound care information, or commencement of a wound management plan or short-term care plan (STCP), as required in the Wound Management and Care Planning policies. It would be considered accepted practice for nurses to record their actions when reviewing a wound dressing and ensuring that appropriate steps for wound and pressure injury management were in place.

An entry on 5 July 2022 states that a black spot was found on [Mr A]'s left heel, noting that his feet looked swollen and that an RN was informed. There is no evidence of RN follow up, assessment, or implementation of precautionary care. Progress notes show incomplete documentation timelines, with evidence of missing entries across days during [Mr A]'s admission, which is concerning.

Reviewed wound care records show that care was occurring for [Mr A]'s chronic right lower leg wound; however, there is minimal discussion about delivery of wound care in the progress notes. A wound management form was in place for the site, which showed RN involvement in care. A wound management form was also in place for a right heel injury, implemented 14 July 2022, which classified the site as black/necrotic, with discoloured surrounding skin and a pain score of (7/10). Wound size is not recorded. The site was reviewed every three days until 30 July, with no further information supplied. The provider's wound and pressure injury policies provide clear information about care delivery, documentation, and reporting responsibilities. It does not appear that actions were taken per policy guidelines for a site of significant concern. There is no evidence of clinical oversight or holistic review, which would be considered accepted practice in the circumstances. Recommended practice would be to ensure that robust care planning was in place to support the principles of pressure injury management and address related goals for care (HQSC, 2019; HQSC, 2023).

It would be considered accepted practice for clinical leaders to ensure that the organisation's Pressure Injury Prevention and Management policy and Wound Management policy are followed, particularly to guide the appropriate care of wounds and meet related documentation and reporting standards. As outlined on wound care documents, an unstageable heel pressure injury would meet internal and external reporting requirements as a significant event. Notification of a pressure injury to HealthCert was a requirement at the time for pressure injuries stage 3 and above, with evidence of GP consultation and referral made to a Wound Nurse Specialist. The submitted evidence provides no record of incident management and related reporting processes. It is unclear from file information whether [Mr A] was under the care of a vascular clinic, with no discussion of pain management or specific approaches to wound care given his health history. Considering [Mr A]'s recent hospitalisation with compromised cardiac function and cellulitis, it would be recommended to ensure prompt support was sought. Medical and nursing records reflect GP involvement in [Mr A]'s care, noting discussion about COVID-19 care and medication management, but it does not appear from progress notes that nurses informed the GP of the identified heel pressure injury per policy guidelines.

Records show that an initial nursing care plan was implemented on admission, with goals in place. The admission assessment tool acknowledged involvement by [Mr A]'s EPOA for personal care and welfare (not activated). Following InterRAI assessment, a long-term nursing care plan was implemented (20 July 2022), which reflected assessment scores indicating recognised systems and processes were in place. Identified risk areas (ADL [activities of daily living] support, mood and behaviour, pressure injury risk) were discussed in the care plan with supportive interventions noted. The care plan identified that [Mr A] needed assistance at all times with personal care and toileting. Identification of concern and reporting pathways are discussed. Care documentation showed that a continence assessment was completed on admission, and the care plan outlined [Mr A]'s toileting requirements to support continence management. The care plan does not discuss the use of toileting aids, such as access to a urine bottle, or agreed timeframes for toileting. The care plan stated that staff would ensure that [Mr A]'s call bell was within reach to allow him to alert staff that he wanted to be toileted. File information has expressed concern with call bell response times and delayed care; however, call bell records were not submitted to inform further comment. The provider has discussed strategies offered to support continence needs; however, there is no evidence of further nursing assessment, care plan review, or evaluation of current interventions. It appears that a toileting schedule was implemented, but there is no STCP in place to guide carer actions or inform evidence-based decisions, which would be considered accepted practice.

Progress notes state that [Mr A] was refusing a prescribed diuretic medication (Frusemide) as it contributed to urinary urgency and increased episodes of incontinence. Heart failure is considered to be a progressive, chronic condition that worsens frailty (HQSC, 2019; HQSC, 2023). Supportive strategies include medication management, fluid restrictions, weight monitoring, and an appropriate diet. Discharge information recommended restricting [Mr A]'s daily oral fluid intake due to his health history; however, nursing documentation provides no guidance about hydration needs and monitoring of fluid requirements. Nutritional information is incomplete, with no record of his weight on admission, although the care plan reported a weight of 80kg, with body mass index of 26, with instructions to record monthly weights and monitor for signs of loss/gain and appetite changes. Records reflect GP involvement regarding [Mr A]'s decision to refuse treatment, with evidence that nurses attempted to provide health education to [Mr A] to inform his decision-making.

It is unclear whether [Mr A]'s comfort and equipment use was regularly reviewed by the clinical team, such as the use of an appropriate chair to elevate the lower limbs to reduce pain and swelling, with minimal guidance in care planning. There appear to be educational opportunities for improvement in wound care management, signs of peripheral oedema, impacts to circulatory function and wound healing, and the application of nursing interventions.

From the information reviewed and discussion points, I consider there to be moderate deviations in care provision, particularly clinical oversight of wound care and continence

management, documentation standards and reporting processes, which would be viewed similarly by my peers in the circumstances.

Departure from accepted practice: Moderate

b) The nursing oversight related to falls management and manual handling during [Mr A]'s admission.

The organisation's Health and Safety information: Moving and Handling and Hoist Use outlines control measures/risk reduction strategies for use and states that two people will assist when using hoists, with discussion of environmental planning, care and safety needs. Direct care staff are required to complete induction and annual training and meet competency requirements.

Discharge information reported that [Mr A] was at high risk of falls, given his recent falls-related hospital admission, and required carer assistance to reposition and transfer from bed to chair. Admission progress notes introduced [Mr A] and stated that he required standing hoist transfers and two people to assist him to reposition. The admission nursing assessment reported that [Mr A] was '*unable to weight bear, uses full/standing hoist when transferring.'* The initial nursing care plan goal stated to prevent falls: two-person assist using full hoist when transferring.

The admission nursing assessment stated that [Mr A] experienced 'constant pain' in his hips and feet, which contributed to reduced mobility and related feelings of frustration. A Braden pressure risk assessment (15) identified that [Mr A] was at medium risk of pressure injury. The assessment indicated that [Mr A] was not bed/chair bound but able to walk occasionally, although had very limited mobility. The Bartel Index assessment tool reported that [Mr A] required major help to transfer (5) and states '1x person'. The Coombes Falls Risk Assessment tool stated that he was at medium risk of falls, although there appears to be some confusion regarding his 'bedbound' status to inform an accurate assessment. Given [Mr A]'s preadmission fall event, it would be considered accepted practice to ensure that safety measures were implemented to reduce falls risk as he settled into his new environment.

File information reflects physiotherapist assessment and involvement in care, noting that [Mr A] was unable to fully weight bear on his left leg. Records report '*Transfers 2x assist for pivot transfer or standing hoist'*. Progress notes discuss difficulties experienced during moving and handling interactions, and state that [Mr A] became frustrated and impulsive during transfers, which contributed to safety concerns. It appears from behaviour records and progress note entries that his displays of distress were related to toileting urgency and increasing levels of dependence.

The care plan goal (July 2022) was for [Mr A] to remain free from falls. The plan stated that [Mr A] was unable to weight bear and used a chair on wheels (mobile La-Z-Boy) for transport. While not sighted in nursing assessments, the care plan stated that [Mr A] had experienced several fall events since his admission and was considered a high falls risk. Interventions stated, '*staff to use standing hoist 1x person assist in transferring from one*

place to another.' This information is confusing and placed [Mr A] and team members at high risk of unsafe resident transfer processes. It is concerning that stated interventions do not align with policy guidelines, with no rationale provided in [Mr A]'s nursing records. File information reported that [Mr A] required the assistance of one person to attend to personal hygiene needs, two to transfer, and likely one person to assist moving the chair on wheels around the care home.

Care plan information provides no discussion about findings from incident analysis of fall events, particularly given carer comments of distress with risk-taking actions, which raises safety concerns for both [Mr A] and direct-care teams. It does not appear that RNs sought physiotherapy involvement regarding safe transfer processes, staff knowledge and skill, and equipment suitability in the circumstances. While incident reports and post-fall documents were not sighted, behaviour records show minimal evidence of senior nurse oversight, event analysis, and follow-up by clinical leaders. There is minimal evidence of nursing assessment completed in response to these events to determine changes in health and wellbeing, nor consideration given to signs of pain or other unmet needs, with no evidence of care plan review.

Concerns were raised by [Mr A]'s representatives about moving and handling processes, education/training and competency requirements in response to reports that [Mr A] was left alone, attached to the hoist, while peer support was sought. The provider has advised that all staff at the time had attended education and achieved the required moving and handling standard. It is unclear what corrective actions have been implemented by the provider in response to learnings from this complaint. From the evidence reviewed to respond to this question, it appears that recognised falls prevention and management steps were implemented on admission; however, there appears to be a lack of resident follow-up, event analysis, and delivery of appropriate, person-centred care. I consider there to be moderate deviations in the planning, provision, documentation, and evaluation of resident mobility and falls management processes, which would be viewed similarly by my peers.

Departure from accepted practice: Moderate

c) The clinical guidance relating to mental health support for [Mr A] and the provision of allied health support services during admission to Beachfront Home.

Preadmission records reported that [Mr A] was actively involved in his care decisions and known to confidently express his views. As discussed, he was living with long-term health conditions with signs of increasing frailty, which was impacting his quality of life. InterRAI assessment scores identified psychological changes with a risk of social isolation and loneliness. Care records state, '*does not mingle …, frustrated with mobility …, declines participation …, prefers his own room'*. Care documentation identified potential risk and stated to '*observe for new problems in mental health condition/depression as adjusting to new home … to monitor for signs of concern, easily frustrated and angry, consider mental health support.'* Reviewed activities records stated that, in July, [Mr A] was adjusting to his new home, noting that he enjoyed his own company. An entry in August

stated that he was refusing to go to the lounge or attend activities, preferring his own company.

Behaviour monitoring records indicate that [Mr A] was unhappy and dissatisfied with aspects of care. Progress notes discuss displays of concern and altercations with the care team. It appears that incident reports were not completed for these events in line with accepted incident management processes. It is unclear whether the GP was notified of concerns with [Mr A]'s wellbeing or whether a referral to mental health services for older people was considered clinically indicated at the time. Records state that [Mr A] was experiencing chronic pain, which affected his mobility, mood, and behaviour, but there is no evidence supplied of pain assessments or medication administration records to inform further comment about nursing actions. It is unclear from clinical records if [Mr A]'s nominated representatives were informed of his changing needs with displays of distress and invited to participate in a resident review.

From the information reviewed, it appears that nursing strategies were in place to support [Mr A]'s wellbeing, although there is minimal evidence of senior nurse oversight, event evaluation, consideration of goals for care, and whānau involvement. While supportive approaches to redirection and resident care appear to have been offered, there are deviations noted in clinical oversight, person-centred care planning and documentation standards in the circumstances.

Departure from accepted practice: Mild to moderate

d) Whether the level of communication evidenced in the submitted documentation was within accepted standards of nursing care.

Organisational policies discuss responsibilities to open communication and family/whānau involvement in care. The care record provides limited evidence of communication with [Mr A]'s nominated representatives during his admission. There is minimal evidence of collaboration between clinical leaders, [Mr A] and family/whānau in response to identified concerns; however, the organisation's Communication policy and supporting records (family/whānau communication records or meeting minutes) and discharge/transfer of care documentation were not included in the submitted documentation to inform further comment at this time.

e) Whether you consider the management of COVID-19 visitor restrictions during the relevant 2022 period was consistent with requirements and accepted standards of care.

As outlined in Te Whatu Ora | Health New Zealand COVID-19 guiding documents in place at the time, infection prevention and control (IPC) processes are key responsibilities for service providers, with requirements to evidence safe practice in line with Health and Disability Service Standards, clinical governance, and quality improvement processes. The Aged Residential Care (ARC) Guidance under the COVID-19 Response Framework provided sector-specific information about clinical and operational processes required at the time (TWO, 2022). The COVID-19 documents discuss care timeframes with guidance provided about

balancing transmission risk and the risks of loneliness and social isolation for older people living in care homes. Reviewed file documentation provides no evidence of a structured outbreak management plan/risk mitigation plan and agreed plan for visitors in line with accepted IPC practice standards at the time. The provider has expressed difficulty in supporting [Mr A]'s family/whānau visits. It is unclear from the limited evidence provided whether the care home leadership team sought professional guidance regarding visiting schedules for residents and perceived transmission risk. It would be considered accepted practice to seek specialist guidance from regional IPC and Public Health teams, and the Portfolio Manager as funder, about current practice standards in line with service provider responsibilities. From the information reviewed to respond to this question, it appears that the decision to rationalise visiting was made without input from relevant stakeholders; however, there is insufficient evidence to inform further comment at this time.

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

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

References

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Request for additional comment received: 1 May 2025

I have been asked to provide further advice/comment on the following questions:

1. **Whether the way the termination notice was communicated to [Mr A] and his representatives was appropriate.**

The provider's Resident Admission Agreement discusses criteria for eviction (10.10) or termination of stay (11) and states that written notification will be provided to the resident. The ARRC agreement (D4.1d) states that services will '*provide the opportunity for each resident wherever possible, or the residents family/whānau or nominated representative (if any) to be involved in decisions affecting the resident's life…'* The provider's response has discussed their rationale for concluding [Mr A]'s admission agreement.

The provider has stated that care home leaders met with [Mr A]'s representatives to discuss events of concern and the termination process. As actions appear to be based on operational rather than clinical criteria, I am unable to provide further comment at this time.

2. **Did Beachfront take reasonable steps to ensure that [Mr A], or his representatives, understood and accepted the notice of termination.**

Based on the provider's response, it appears that attempts were made to communicate with [Mr A]'s whānau at the time. However, as outlined in question (d), evidence of the organisation's Communication policy or supporting nursing records (family/whānau communication records or meeting minutes) were not included in the submitted documentation. As actions appear to be based on operational rather than clinical criteria, I am unable to provide further comment at this time.

3. **Were the steps taken by Beachfront to ensure continuity of [Mr A]'s care reasonable in the circumstances.**

The ARRC agreement (D21) provides guidance about resident departures and responsibilities to support safe discharge processes and continuity of resident care.

RN progress notes on 30 August 2022 state that [Mr A] had been discharged to the care of another provider and that a handover had been given. However, no evidence was supplied (such as a discharge checklist or written nursing handover to support the transfer of care process) to inform further comment at this time.

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Health and Disability Commissioner'