Ambridge Rose Manor Limited

A Report by the

Deputy Health and Disability Commissioner

(Case 16HDC00720)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. In 2016, Mr A, aged 65 years, suffered a stroke and was admitted to the public hospital. After a period of rehabilitation he was assessed as requiring assistance with all daily living activities, including hoist transfers and a specialised wheelchair to mobilise.

2. An InterRAI assessment confirmed that Mr A required hospital-level care, and he and his family selected Ambridge Rose Manor as his preferred facility. The DHB transferred Mr A to Ambridge Rose Manor on 13 April 2016, where he remained until 20 April 2016.

3. Ambridge Rose Manor has two DHB contracts to provide long-term residential care, age-related residential care, and long-term support/care for chronic health conditions. The DHB transfer form noted that Mr A needed to be seated in an appropriate wheelchair regularly during the day to assist with his recovery and ability to engage in daily activities. The specialist wheelchair was not available when Mr A was discharged to Ambridge Rose Manor.

4. Mr A had executed an enduring power of attorney (EPOA) for property that appointed his daughter, Ms B, as his attorney, and an EPOA for personal care and welfare that appointed his sister, Ms C, as his attorney. Neither EPOA had been activated.

5. On admission, Ambridge Rose Manor instigated the use of a recliner chair for Mr A in lieu of the specialised wheelchair. The facility general practitioner (GP) signed the "physical restraint/enabler form", as did Ms C, and she wrote on the form that she agreed to the use of "the chair".

6. There is no reference to the restraint/enabler consent form in Mr A's notes, or any evidence that Mr A was consulted about having a canvas belt tied around him.

7. Mr A was found on the floor beside the chair on two occasions. He told staff that he had slipped out of the chair and that the footrest kept sliding down. Subsequently he refused to use the chair. The incidents of Mr A slipping out of the chair were noted in incident forms, but no proactive actions were taken at that time to identify and prevent the causes that contributed to him slipping.

8. On 20 April 2016, Mr A was transferred to another care facility.

Findings

9. By failing to verify Mr A's legal status and competency, Ambridge Rose Manor failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).[1]

10. Ambridge Rose Manor's processes regarding restraint were unsatisfactory, and the use of the canvas belt was not in accord with the New Zealand "Health and Disability Services

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

(Restraint Minimisation and Safe Practice) Standards"[2] and Ambridge Rose Manor's own policy. Accordingly, Ambridge Rose Manor breached Right 4(1) of the Code.

11. Ms C's consent to the use of the chair on behalf of Mr A was not legally valid and, while Mr A may have impliedly agreed to use a recliner chair initially, there is no evidence that he consented to the use of the canvas belt. By using the canvas belt without Mr A's consent, Ambridge Rose Manor breached Right 7(1)[3] of the Code.

12. The Deputy Commissioner is critical that while Ambridge Rose Manor responded to the incidents of Mr A slipping from the recliner chair, it was not proactive in ascertaining the causes that contributed to the incidents, and should not have continued to use the recliner chair or the canvas belt.

Recommendations

13. It is recommended that Ambridge Rose Manor Limited:

a) Provide training to all staff on the Code, informed consent, enduring powers of attorney, and restraint, including the provisions of the restraint policy;

b) Provide refresher training to staff on communication and the management of falls and incidents;

c) Review the incident form templates to ensure that all necessary matters are included;

d) Conduct an audit of all current residents' records to ensure that informed consent has been obtained appropriately; and

e) Provide a written apology to Mr A for the failings identified in this report.

Complaint and investigation

14. The Commissioner received a complaint from Ms B[4] about the services provided to her father, Mr A, at Ambridge Rose Manor. The following issue was identified for investigation:

- *Whether Ambridge Rose Manor Limited provided Mr A with an appropriate standard of care in April 2016.*

15. This report is the opinion of Rose Wall, Deputy Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

[2] (NZS 8134.2:2008)
[3] Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."
[4] The complaint was supported by Mr A.

16. The parties directly involved in the investigation were:

Mr A	Consumer
Ms B	Consumer's daughter/complainant
Ms C	Consumer's sister
Ambridge Rose Manor	Provider

Also mentioned in this report:

Dr D	General practitioner
EN E	Enrolled nurse

17. Information from the District Health Board was also reviewed.

18. Independent expert advice was obtained from a registered nurse, Kaye Milligan (**Appendix A**).

Information gathered during investigation

Background

19. Prior to these events, Mr A (aged 65 years) was living and working independently in the community. On 20 January 2016, he was admitted to the public hospital following a stroke. He was subsequently transferred to a ward for ongoing rehabilitation. The DHB told HDC that Mr A was assessed as requiring hospital-level care because he required assistance with all daily living activities, including hoist transfers and a specialised wheelchair to mobilise.

20. The DHB said that an InterRAI Home Care Assessment[5] was completed on 7 April 2016, and confirmed the requirement for hospital-level care under an age-related residential care (ARRC) agreement. Included in the Assessment comments is: "EPOA has been sighted."

21. Mr A and his family selected Ambridge Rose Manor Limited (Ambridge Rose Manor) as their preferred facility, and he was discharged to the facility on 13 April 2016, where he remained until 20 April 2016.

Ambridge Rose Manor

22. Ambridge Rose Manor holds rest home, hospital/geriatric, and hospital/medical certification for 106 dual service beds. It has two DHB contracts to provide long-term residential care, age-related residential care (rest home and hospital), and long-term support/care for chronic health conditions (rest home and hospital). It also has contracts to provide short-term age-related residential care and respite care (rest home), and provides ad hoc respite care at rest home and hospital levels.

[5] A comprehensive clinical assessment of medical, rehabilitation, and support needs and abilities such as mobility and self-care. This information helps nurses to write tailor-made care plans which, when implemented, benefit both residents and staff.

23. Ambridge Rose Manor told HDC that the facility has cared for a number of residents who have suffered strokes and "[w]e are confident that we have the skills and expertise to manage stroke patients requiring either Rest Home or Hospital level of care."

Transfer to Ambridge Rose Manor

24. The DHB's "Transfer of Care to GP" form (transfer form) states that on admission to the public hospital, Mr A had no sitting balance, poor attention, an overactive right upper and lower limb with involuntary movements, and severe left side neglect. At that time he required full assistance with showering, dressing, eating, drinking, and toileting. By the time of discharge he was able to prepare a cup of coffee with set-up assistance and occasional prompting, and could select breakfast items and prepare his breakfast. He was able to complete grooming tasks with set-up assistance and prompting, but required full assistance with dressing and toileting.

25. The transfer form states that a seating assessment was completed on 7 April 2016, which found that Mr A sat in a posterior pelvic tilt. He had a kyphotic spine[6] and external rotation of his left hip. It is noted that an application to the Ministry of Health had been completed for funding for a specialist wheelchair. The transfer form states: "[Mr A] would benefit from an 18x20# standard wheelchair with a supportive personal back and contoured pressure relieving cushion." It states that Mr A needed to be seated in an appropriate wheelchair regularly during the day to prevent him from losing his hip and ankle range of motion and to help his interaction with the world, and that he would benefit from standing if possible.

26. The transfer form lists Mr A's medications as being:

- Amitriptyline (for pain relief)
- Amiodipine (for hypertension)
- Atorvastatin (for secondary stroke protection)
- Laxsol tablets (for constipation)
- Gabapentin (for pain relief)
- Melatonin (to aid sleep)
- Acupan tablets (for pain relief)
- Omeprazole (for gastro-oesophageal protection)
- Paracetamol (for pain relief)
- Warfarin (to avoid blood clotting)

Care plan

27. Ambridge Rose Manor completed an initial care plan on 14 April 2016 using information obtained from the DHB and from Mr A.

28. The following information from the transfer form is not included in the initial care plan:

- The specific recommendation for the use of an 18 x 20# standard wheelchair with supportive personal back and contoured pressure-relieving cushion.

[6] The term "kyphosis" is commonly used to refer to the clinical condition of excess curvature of the upper back (greater than 50 degrees), leading to a stooped forward posture.

- The risk of contractures[7] and the relevant positioning required to prevent them from developing.

29. The initial care plan was not subsequently updated. Ambridge Rose Manor said that an InterRAI Long Term Care Facilities Assessment[8] must be completed within 21 days of a resident's admission, but it did not complete an InterRAI assessment of Mr A because the short duration of his stay meant that he was within the 21-day requirement.

30. Mr A had an "Acute Care Needs/Nursing Care Plan", which notes that he was at risk of aspiration because of his swallowing difficulty, and that he must be awake and seated upright at 90 degrees before commencing feeding. It also states:

> "Resident is on recliner chair restraint for comfort. Resident is not on Restraint monitoring as the above mentioned aid/equipment is not restricting their normal freedom of movement, but resident still to be closely monitored by staff during regular care interventions as per their care plans."

Capacity

31. Mr A had executed an enduring power of attorney (EPOA) for property that appointed his daughter, Ms B, as his attorney, and an EPOA for personal care and welfare that appointed his sister, Ms C, as his attorney. However, neither EPOA had been activated.

32. Ambridge Rose Manor told HDC: "The EPOA is normally sighted by our Quality/Admissions Coordinator, and in this case both [Mr A's] EPOA documents were confirmed by [the Needs Assessment and Service Coordination services]." There are no copies of Mr A's EPOAs in Ambridge Rose Manor's records, and no evidence that it sighted the documents, enquired about activation, or sought to sight the necessary medical certificate.

33. Ambridge Rose Manor stated that cognitively Mr A was very good, and his memory test score upon admission was 25/30, indicating good cognitive function. The admission assessment of cognitive function in communication states that he could use a call bell, did not require a behavioural assessment, and was able to remember recent and past events. His care plan states that he was able to inform staff of his concerns.

Restraint

34. Ambridge Rose Manor stated that upon admission Mr A said that he wanted to sit up in a chair for all meals and wanted to come out of his room. Ambridge Rose Manor said that it instigated the use of a recliner chair to provide Mr A with comfort and a means to transport him easily to the dining room for socialising with other residents.

35. On 14 April 2016, Ms C signed a "physical restraint/enabler consent form" (the form — see **Appendix B**). The form was also signed by the facility general practitioner (GP), Dr D, and

[7] A common consequence of a stroke is the development of muscle contractures — the stiffening of muscles, which limits normal joint movement.

[8] The interRAI Long-Term Care Facilities Assessment System enables comprehensive, standardised evaluation of the needs, strengths, and preferences of persons receiving short-term post-acute care in skilled nursing facilities, as well as persons living in chronic care and nursing home institutional settings.

a registered nurse. Ms C wrote on the form that she agreed to the use of "the chair". Ms C told HDC that when she agreed to the use of the recliner chair, she was aware that there was a safety belt, and expected it to be a safe one.

36. The form states that Dr D had recommended that Mr A be restrained for his own safety and well-being. The form refers to the use of a safety belt or a bed side; however, while the box for a bed side has been crossed out, the box for a safety belt has not been ticked, crossed out, or commented on.

37. Handwritten on the form are the words "recliner chair" and a tick.

38. The form states that staff will monitor the restraint/enabler at two-hourly intervals to ensure that the resident is comfortable and secure. The form also states:

> "The restraint/enabler (circle which is appropriate) will be in the form of a safety belt around their waist whilst in chair or commode, preventing them from leaving their chair unaided or falling off chair, or a bedside preventing them from leaving bed unaided or falling out of bed and sustaining injury to themselves or others."

39. The form required either "restraint" or "enabler" to be circled, but neither was selected.

40. There is no reference to the restraint/enabler consent form in Mr A's notes. However, the recliner chair was prescribed on the medication chart.

41. Ms B stated that when she came to visit her father she discovered him seated in a broken recliner chair with a "hand tied thick piece of canvas around his nipple line to keep him in the chair". In response to my provisional opinion, Ambridge Rose Manor said that the belt used "was an older style 'Blue' lifting belt that had 2x 'D' rings at one end … The belt would have been secured around [Mr A's] waist, although it is possible that his involuntary muscle movements may have caused the belt to move up to this area."

42. The progress notes for 18 April 2016 recorded by Enrolled Nurse (EN) EN E state: "Told staff not to use the lap belt as [Mr A] said it was uncomfortable."

43. There is no evidence that Mr A was consulted about having the canvas belt tied around his chest. Ambridge Rose Manor stated that despite the reference to a safety belt not having been ticked on the physical restraint/enabler consent form, consent had been obtained to utilise a safety belt around Mr A's waist while he was in a chair or commode. Ambridge Rose Manor stated: "[A] handling belt was placed around the recliner chair to minimise the risk of [Mr A] sliding down or falling out."

44. Ambridge Rose Manor added: "The safety belt used was hand tied, however we acknowledge this is not ideal and have since removed these handling belts from circulation in favour of more suitable handling belts."

45. Ambridge Rose Manor stated that Mr A was discharged without the specialist wheelchair on order as referred to in the discharge summary, and said: "Without this specialist equipment, the recliner chair was the only safe option available to ensure upright feeding as required in the care plan." On 16 April 2016, a healthcare assistant reported that Mr A had

complained that the recliner chair was "not good" for him. The complaint was reviewed by a registered nurse, who indicated that Mr A should be repositioned regularly.

46. Ambridge Rose Manor stated that the use of the recliner chair was interpreted by staff as an enabler rather than a restraint, but said that the pre-assessment should have been completed regardless of whether the recliner chair was a restraint or an enabler. Ambridge Rose Manor stated:

> "We believe the Physical Restraint/Enabler Consent Form supplied confirms both the recliner chair and safety belt was agreed to by [Ms C], as the form includes the comments 'the restraint/enabler will be in the form of a safety belt around their waist'."

47. Ambridge Rose Manor stated that, overall, staff had the best intentions to accommodate Mr A's preferences by instigating use of the recliner chair as an enabler, in consultation with the family. It acknowledged that the safety belt box is not ticked, and said that this was an oversight by staff.

Informed consent

48. Mr A's records contain an "Informed Consent Form", which states: "If resident unable to provide consent the Next of Kin, representatives/advocate/whanau can do so on the client's behalf." The form is signed by Ms B as next of kin.

Falls/incidents

49. On 15 April 2016, Mr A was found on the floor near the recliner chair. The incident form states that Mr A told the registered nurse that he had slipped out of the recliner chair.

50. On 16 April 2016, Mr A was reported to have nearly fallen out of bed.

51. On 17 April 2016, Mr A was again found on the floor near the recliner chair. The incident form states that a cleaner said that Mr A had slipped from the chair.

52. The falls/incidents were documented in the progress notes, and it is recorded that Mr A's vital signs were assessed and skin assessments performed, and that he suffered no injuries.

53. Ambridge Rose Manor told HDC that the two falls/incidents were unwitnessed, and that Mr A told staff that he had slipped from the recliner chair. He was attended by the registered nurses, who assessed him at the time. Attempts were made to contact the family to ensure that they were fully informed.

54. The actions to be taken to prevent further falls/incidents were noted on the incident forms as to remind Mr A to call for assistance, and for staff to monitor him regularly. No proactive actions were taken at that time to identify and prevent the causes that contributed to the falls.

55. Ambridge Rose Manor told HDC that its incident policy requires the registered nurse to write a brief report on the incident form and the action taken, and for relatives to be informed. If required, a treatment care plan will be initiated by the registered nurse. The incident policy states that the Clinical Manager and/or Quality Manager will review this

process and, if required, make comment or suggest further action to be taken. Ambridge Rose Manor stated: "The forms are reviewed by Owner/CEO or general manager for analysis and then resolved to ensure any action taken prevents recurrence." Ambridge Rose Manor told HDC that incidents are reviewed weekly by the Quality Manager, and resolved by another member of the management team. Trends are collated for the month and tabled at monthly management meetings for review.

56. Ambridge Rose Manor said that, because of the short duration of Mr A's stay, the incident forms were never resolved or analysed at a management level, but were included in a verbal handover to another facility when Mr A was subsequently transferred.

Suitability of recliner chair

57. Ambridge Rose Manor stated that the recliner chair had no footplates, but it did have a retractable footrest. On 18 April 2016, it is documented that Mr A refused to sit in the recliner chair, but no reason for his refusal is documented.

58. On 18 April 2016, EN E reported to Ms B that Mr A was not sitting properly on the recliner chair and that he kept sliding off the chair. EN E documented that Mr A said that the chair's footrest kept sliding down, causing him to slip. This was reported to the Quality Manager, who requested that Mr A be put into a different recliner chair. EN E recorded in the progress notes that she told a healthcare assistant to tell the afternoon staff to use a different chair, and not to use the lap belt because Mr A had said that he was uncomfortable.

59. Ambridge Rose Manor told HDC that it does not accept that the recliner chair was broken, but does accept that the footrest needed tightening. In response to my provisional opinion, Ambridge Rose Manor said that there were no other suitable wheelchairs available, and it had used the recliner chair while waiting for the specialist wheelchair that was on order.

60. Ambridge Rose Manor stated that because of the time lapse it is unable to verify if and when it was advised that the chair was "unsafe" prior to the chair being exchanged on 18 April 2016, and added:

> "However assuming this is the case, we agreed that there was a communication breakdown which should not have occurred, and we will be presenting this example to our staff in our next staff meeting."

61. The medication chart records that on 19 April 2016 Dr D prescribed "recline chair", and that it was stopped on 22 April 2016.

Incontinence care

62. Ms B said that on one occasion when she visited her father she asked the healthcare assistant to change Mr A's clothing as he had soiled himself, but the healthcare assistant declined to do so because Mr A had been changed recently. Ambridge Rose Manor said that it has been unable to ascertain who made that comment, and added:

> "Clearly these remarks are unacceptable, as bowel motions are often unpredictable and need to be dealt with in a timely manner for the dignity, health and comfort of the Resident."

Bedrails

63. Ms B stated that she requested bedrails for Mr A to prevent him falling out of bed. Ambridge Rose Manor told HDC that it has plenty of bedrails available, and was disappointed that Ms B's request was not communicated to management. It stated that if the request had been communicated, bedrails would have been instigated without delay.

Transfer

64. Ms B told HDC that she arranged for her father to be moved because she felt that he was unsafe at Ambridge Rose Manor. On 20 April 2016, Mr A was transferred to another facility.

Ambridge Rose Manor — further information

65. Ambridge Rose Manor stated that recently it reviewed its physical restraint/enabler consent form and has implemented a more user-friendly restraint/enabler flow chart guide for staff to follow. It stated that its incident policy was reviewed immediately after Mr A's departure, as it accepted that incidents could occur in quick succession and establish a trend that needed to be addressed sooner than the weekly review in place at the time. It stated that it now has seven-day clinical management cover, providing robust daily monitoring to ensure that quick succession incidents are reviewed for trends.

66. Ambridge Rose Manor said that it has reviewed its monitoring of recliner chairs and increased this to a weekly check that is signed off by the clinical support staff member. It stated that the restraint co-ordinator/registered nurse supervisor now provides a weekly clinical report to the management team and conducts a monthly equipment inventory to ensure that there are adequate supplies to meet the needs of residents.

67. Ambridge Rose Manor stated: "For the avoidance of doubt in future our Quality Manager has reviewed [the restraint/enabler consent] form to include more specific tick boxes which lists the recliner chair as a separate entity."

68. Ambridge Rose Manor stated that it has undertaken communication training with all healthcare assistants, and has reinforced the importance of appropriate communication with families and the focus on residents' well-being, rather than task completion.

69. Ambridge Rose Manor acknowledged that there was a communication breakdown with Mr A's family, and said that many of the concerns could have been addressed more efficiently. It stated: "We therefore unreservedly apologise to [Mr A] and his family for this situation."

Restraint Minimisation and Safe Practice Policy (2015)

70. The Restraint Minimisation and Safe Practice Policy in place at Ambridge Rose Manor at the time states that the purpose of the policy establishes standards in relation to the use of restraint, and is compliant with the New Zealand standards (see below). The intent of the policy is to cover all acts of restraint where it is required to keep the resident safe, or in situations where restraint is used against the resident's will.

71. The Policy states:

> "• Restraint Coordinator/Clinical Manager is delegated role with relevant authorities and responsibilities.

- An Approval Group (Clinical Management Team), headed by the Restraint Coordinator/Clinical Manager, meets weekly or as required, to discuss and review enablers, restraints, training and policy. Meeting is minuted and outcomes reported back through staff meeting.
- Restraint usage is kept to an absolute minimum.
- Restraint decisions are always in collaboration with a Doctor.
- Written clinical justification is required for the administration of any restraint.
- It must only be done after de-escalation and an alternative has been attempted and found to be inadequate.
- Policy is reviewed bi-annually (or when legislation changes) by Approval Group (Management Team) (Management Team).
- All staff are trained/educated re this policy and procedures, de-escalation techniques and managing challenging behaviours. This training is ongoing and training has been approved by Approval Group (Management Team) (Management Team) and reflects the restraint/enablers approved in this facility.

Procedure

- Any recommendation for restraint must be referred to the Restraint Coordinator/Clinical Manager.
- The Restraint Coordinator/Clinical Manager must then discuss this with the Doctor.
- Alternatives to restraint must be discussed and noted in the care-plan.
- If the Doctor considers that restraint for safety is justified then he/she must write this clearly in the resident's notes and must put a time limit and method on the chart.
- There must be appropriate communication with the resident and their family/whanau/caregivers of all decisions relating to restraint and this must occur in a timely manner.
- Any restraint prescribed can only be instigated after consent has been obtained. It will only be justified if an appropriate assessment is made of the need to take the action each time the restraint is exercised and the decision to exercise restraint is reasonable in the circumstances.
- Resident's rights to be maintained at all times and chosen method for restraint to be the least intrusive and restrictive and for the shortest time possible.
- Each assessment will ascertain the individual's needs:

  Background and how this might influence their behaviour

  General and cultural needs and how to meet these

  Desired outcomes and goals

  Recognising triggers for changes in behaviour

  The most effective manner of restraint is used ensuring safety to all.

- Resident and relatives are informed regarding restraint and what it involves and our policy.
- If required the resident will be referred to other services.
- Evaluation through resident's care plan or specific restraint evaluation if the intervention was a one off."

Responses to provisional opinion

72. Ms B made no comment in response to the "information gathered" section of my provisional opinion.

73. In response to my provisional opinion, Ambridge Rose Manor provided the following information:

- It stated that it had sought and been provided with legal advice in relation to legal capacity, informed consent, enduring powers of attorney, and activation of enduring powers of attorney.
- It acknowledged that the particular safety belt used should not have been used by its staff for that purpose, and said that it has been removed from circulation.
- It stated that it is likely that Mr A was asked directly whether he agreed to the use of the safety belt, and that he agreed to its use verbally, but this was not documented as it ought to have been. Ambridge Rose Manor cannot verify this because it has been unable to contact the registered nurse responsible for Mr A's care at the time.
- It stated that as Mr A was able to communicate his views, it is reasonable to conclude that he did consent to the use of the safety belt.
- It stated that it was most recently audited for certification by the Ministry of Health's auditors in March 2017 and received full compliance against all audit requirements, and HealthCERT has issued it with a four-year certificate.

74. Ambridge Rose Manor also provided HDC with its complaints policy.

Standards

75. The New Zealand "Health and Disability Services (Restraint Minimisation and Safe Practice) Standards" (NZS 8134.2:2008) (the Standards) state that restraint should be used only in the context of good clinical practice and after all less restrictive interventions have been attempted and found to be inappropriate. The Standards state:

> "Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of this Standard, and currently accepted good practice.
>
> …

Enablers

Both enablers and restraint limit the normal freedom of movement of the consumer. It is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention. Where the intent is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler. Additionally, the use of enablers should be the least restrictive option to safely meet the needs of the consumer.

Ethical and Legal Considerations

Any unauthorised restriction of a consumer's freedom of movement could be seen as false imprisonment and could result in an action for assault. Organisations should develop clear policies and procedures to guide service providers and seek legal advice to ensure the practice they are specifying is legal.

Observation and Care During Restraint

The organisation's policies and procedures should guide services in ensuring adequate and appropriate observation, care, dignity, respect, and on-going assessment occurs to minimise the risk of harm to consumer during restraint. The frequency and level of observation and assessment should be appropriate to the level of risk associated with the restraint procedure, and the setting in which it is occurring. They should reflect current accepted good practice and the requirements of this Standard."

Opinion: Ambridge Rose Manor Limited — breach

Introduction

76. Mr A suffered a stroke on 20 January 2016 and was treated at the public hospital until he was discharged to Ambridge Rose Manor on 13 April 2016. This opinion considers the care provided to Mr A between 13 April 2016 and 20 April 2016 while he resided at Ambridge Rose Manor. I am particularly concerned about the consent practices and the restraint process at Ambridge Rose Manor.

Legal status

77. Ambridge Rose Manor stated that cognitively Mr A was very good, and his memory test score upon admission was 25/30, indicating good cognitive function. The admission assessment of cognitive function for communication states that he could use a call bell, did not require a behavioural assessment, and was able to remember recent and past events. His care plan states that he was able to inform staff of his concerns.

78. However, it is apparent that staff at Ambridge Rose Manor believed that Mr A lacked the competence to make decisions on his own behalf. Mr A's records contain an "Informed Consent Form", which states: "If resident unable to consent the Next of Kin, representatives/advocates/whanau can do so on the client's behalf." The form was signed by Mr A's daughter, Ms B, as next of kin. Further, Ambridge Rose Manor had Mr A's sister,

Ms C, sign the consent form purportedly consenting to the use of a safety belt around Mr A's waist while he was in a chair.

79. Mr A had executed an EPOA for property appointing Ms B as his attorney, and an EPOA for personal care and welfare appointing Ms C as his attorney. However, neither EPOA had been activated by medical certification, and there were no grounds to believe that Mr A was mentally incapable.[9] Consequently, pursuant to Right 7 of the Code, services, including restraint, could be provided to Mr A only if he made informed choices and gave informed consent.

80. Ambridge Rose Manor had a responsibility to verify Mr A's legal status, and to be clear about the legal basis on which it was to provide services. Whilst that is important for all health and disability service providers, the fact that Ambridge Rose Manor regularly provides care to residents who have suffered strokes means that it should have been particularly vigilant in respecting the rights of residents. In my view, it was not acceptable for Ambridge Rose Manor to assume that Mr A was not competent to make decisions for himself, and this shows a lack of respect for him and little awareness of the psychological impact that the loss of autonomy can have on vulnerable residents.

81. Ambridge Rose Manor should have considered whether Mr A had the capacity to make decisions on his own behalf. Given that there was no evidence that Mr A was unable to make decisions for himself, Ambridge Rose Manor should not have arranged for family members to consent to his treatment and restraint. In addition, given that Ambridge Rose Manor relied on the EPOA to provide consent for the restraint, I am concerned that Ambridge Rose Manor did not sight the certification required to activate the EPOA for personal care and welfare, or otherwise ensure that it was activated. Ambridge Rose Manor should not have relied on the Needs Assessment and Service Coordination services assessment for that information. Furthermore, Ambridge Rose Manor should have been aware that as the EPOA for property, Ms B had no authority to give informed consent for Mr A's personal care should he become incompetent. I find it very concerning that a facility of this nature should clearly fail to be aware of the legal process in relation to consent for the care of residents such as Mr A. In my view, Ambridge Rose Manor failed to provide services to Mr A with reasonable care and skill and, accordingly, breached Right 4(1) of the Code.

Restraint

82. This Office has stated previously that restraint is a significant matter,[10] and a provider should ensure that consent has been obtained and policies have been complied with before restraining a resident.

[9] If the relevant decision is a significant matter relating to the donor's personal care and welfare, the attorney can act only if a relevant health practitioner has certified, or the court has determined, that the person is mentally incapable. The attorney must not act in respect of any other matter relating to the donor's personal care and welfare unless the attorney believes on reasonable grounds that the donor is mentally incapable (section 98(3) of the Protection of Personal and Property Rights Act 1988).
[10] Opinion 10HDC01231, page 18, available at www.hdc.org.nz.

83. The Standards provide that restraint should be used only in the context of good clinical practice and after all less restrictive interventions have been attempted and been found to be inadequate. The Standards state:

> "Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of this standard and current accepted good practice."

84. Mr A was hand tied into a recliner chair by way of a canvas belt around his waist, but the belt slipped up to his chest. Ambridge Rose Manor stated that Mr A wanted to sit in a chair for his meals, and to come out of his room. It said that the use of the recliner chair was interpreted by staff as an enabler rather than a restraint, and noted that Mr A's Acute Care Needs/Nursing Care Plan states that he was on recliner chair restraint for comfort. The Care Plan states:

> "Resident is not on restraint monitoring as the above mentioned aid/equipment is not restricting their normal freedom of movement, but resident is still to be closely monitored by staff during regular care interventions as per their care plan."

85. The Standards state:

> "Both enablers and restraint limit the normal freedom of movement of the consumer. It is not the properties of the equipment, device or furniture that determines whether or not it is an enabler or restraint but rather the intent of the intervention. Where the intent is to promote independence, comfort and safety, and the intervention is voluntary, this constitutes an enabler. Additionally, the use of enablers should be the least restrictive option to safely meet the needs of the consumer."

86. Ambridge Rose Manor also noted that, although Dr D signed the restraint/enabler consent form, the restraint was not documented in Mr A's notes, although the recliner chair was prescribed on the medication chart. In addition, it noted that a restraint/enabler pre-assessment is missing, and should have been completed regardless of whether the recliner chair was interpreted by staff as a restraint or an enabler. Ambridge Rose Manor stated that it believes that both the recliner chair and safety belt were agreed to by Ms C, as the form includes the comment, "The restrainer/enabler will be in the form of a safety belt around their waist", and although the safety belt box is not ticked, this was an oversight by staff. Ambridge Rose Manor stated that staff had the best intentions to accommodate Mr A's preferences by instigating use of the recliner as an enabler in consultation with the family.

87. In response to my provisional opinion, Ambridge Rose Manor stated that, as Mr A was able to communicate his views, it is reasonable to conclude that he consented to the use of the safety belt. However, it was unable to verify this, and no consent is recorded.

88. As mentioned above, Ms C's consent to the use of the chair on behalf of Mr A was not legally valid. I remain of the view that although initially Mr A may have impliedly agreed to the use of the chair, there is no evidence that he consented to the use of the canvas belt. In my view, the use of the belt was not voluntary, and effectively became a restraint rather than an enabler.

89. My expert advisor, RN Kaye Milligan, advised me that Ambridge Rose Manor did not meet the required standard or its own policy with regard to the restraint of Mr A. The areas where Ambridge Rose Manor did not do so include:

- There is no written clinical justification for restraint.
- There is no record of an alternative to restraint being attempted and found to be inadequate.
- There is no record that the Restraint Coordinator/Clinical Manager discussed the issue of restraint with the GP, although both the GP and the registered nurse did sign the consent form.
- There is no documentation of alternatives to restraint on the care plan.
- The GP did not document in Mr A's notes that restraint for safety was justified.
- There are no assessments of the need for restraint on each occasion it was applied.
- There is no documentation in the clinical records, and monitoring of Mr A's clinical outcomes and the risks associated with the use of the restraint are not documented.
- There are no instructions in the care plans to monitor the restraint.
- There is no documented Restraint/Enabler Pre-assessment — initial assessment.
- There is no documentation of communication with Mr A or his family regarding restraint.

90. In addition, RN Milligan advised that use of the canvas restraint was not appropriate, and a registered nurse should have assessed Mr A and consulted with the Restraint Coordinator/Clinical Manager to arrange an appropriate safety belt or vest.

91. In my view, Ambridge Rose Manor's processes were unsatisfactory. Restraint is a serious matter, and attention to correct processes is essential. The use of the canvas belt was not in accord with the Standards and Ambridge Rose Manor's own policy. Accordingly, Ambridge Rose Manor Ltd breached Right 4(1) of the Code.

92. Mr A may have impliedly agreed to use a recliner chair initially, but there is no evidence that he consented to the use of the canvas belt. Therefore, by using the canvas belt without Mr A's consent, Ambridge Rose Manor breached Right 7(1) of the Code.

Falls/incidents — adverse comment

93. Mr A fell from the recliner chair on 15 April 2016 and 17 April 2016. He expressed concern about the suitability of the recliner chair, for example, on 16 April 2016 he said that it was "no good" for him. However, his concerns appear not to have been responded to promptly, and subsequently he fell from the chair the following day (17 April 2016).

94. On 18 April 2016, Mr A refused to sit in the recliner chair, and said that the chair's footrest kept sliding down, causing him to slip. The recliner chair had a retractable footrest, and Ambridge Rose Manor accepts that the footrest needed tightening. This was reported to the Quality Manager, who requested that Mr A be put into a different recliner chair.

95. RN Milligan advised me that the documentation of the assessments of Mr A after the falls/incidents is minimal (vital signs, skin assessment, and no injuries) but appears to be

adequate in this context. The actions to prevent further falls were noted to comprise reminding Mr A to call for assistance, and for staff to monitor Mr A regularly.

96. RN Milligan stated that Ambridge Rose Manor responded to the falls/incidents, but was not proactive regarding the causes that contributed to them. The incident form does not require a detailed consideration of causative factors, nor does it require consideration of other falls or factors that could be linked. It appears that the falls/incidents were dealt with separately, rather than there being consideration of a developing pattern.

97. In response to my provisional opinion, Ambridge Rose Manor said that it used the recliner chair while waiting for the specialist wheelchair that was on order, and there were no other suitable wheelchairs available.

98. I remain of the view that Ambridge Rose Manor should have acted sooner. It is not acceptable that, despite Mr A slipping or falling from the chair twice and expressing concern about the recliner chair, no action resulted until 18 April 2016 when he refused to use the chair. I consider that Ambridge Rose Manor should have investigated the cause of these incidents rather than treating them as separate events. It should not have continued to use the recliner chair or the canvas belt to minimise the risk of falls.

Communication with family — other comment

99. There were times where Ms B reported her concerns about her father's care to staff at Ambridge Rose Manor. However, the response was unsatisfactory. These incidents included Ms B's concerns about her father slipping from the chair, that when she arrived to visit she found that he had soiled himself, and that rails on the bed were not provided. Ambridge Rose Manor said it was disappointed that Ms B's request about the rails was not communicated to management. In response to my provisional opinion, it said that it has "very robust systems for communication with relatives".

100. As this Office has stated previously:[11] "It is important to be communicating with families, keeping them up-to-date with changes in health status of loved ones (which is inevitable in Aged Care), informing them of incidents and accidents — after all they have entrusted the care of their loved ones to [the facility]."

101. I accept that Ambridge Rose Manor had a complaints process available and in its response acknowledged the importance of staff escalating concerns raised by family members. I note that, since these events, Ambridge Rose Manor has undertaken communication training with all healthcare assistants, and has reinforced the importance of appropriate communication with families and of ensuring a focus on residents' well-being rather than task completion. As noted by Ambridge Rose Manor, many of the concerns raised by Mr A's family could have been addressed more efficiently.

[11] Opinion 11HDC00528, available at www.hdc.org.nz.

Recommendations

102. In response to a recommendation in my provisional opinion, Ambridge Rose Manor sought, and was provided with, legal advice in relation to legal capacity, informed consent, enduring powers of attorney, and activation of enduring powers of attorney.

103. I recommend that within three months of the date of this report, Ambridge Rose Manor undertake the following and report back to HDC with evidence of the outcome:

a) Provide training to all staff on the Code of Rights, informed consent, enduring powers of attorney, and restraint, including the provisions of the restraint policy. The training schedule, including regular refresher training, is to be provided to HDC.

b) Provide refresher training to staff on communication and the management of falls and incidents.

c) Review the incident form templates to ensure that all necessary matters are included, and provide HDC with the amended forms.

d) Conduct an audit of all current residents' records to ensure that informed consent has been obtained appropriately, and report back to HDC on the outcome.

104. I recommend that Ambridge Rose Manor provide a written apology to Mr A for the failings identified in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Mr A.

Follow-up action

105. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Ambridge Rose Manor Limited, will be sent to the DHB and HealthCERT, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent nursing advice to the Commissioner

The following expert advice was obtained from Kaye Milligan, registered nurse:

"**[Mr A]/Ambridge Rose Manor**

I have been asked to provide advice to the Commissioner on case number: C16HDC00720**.** I have read and agree to follow the guidelines 'Guidelines for Independent Advisors'.

My qualifications are Registered Nurse, PhD, Master of Arts (Hons), Bachelor of Arts (Nursing), and Diploma of Teaching (Tertiary). I have worked as a registered nurse for approximately 40 years in clinical practice and in nursing education. My teaching experiences include undergraduate nursing students (including teaching in older persons' health), registered nurses and postgraduate students. My clinical practice as a registered nurse includes surgical services and also Assessment, Treatment and Rehabilitation of Older Adults. My PhD thesis was a case study of the clinical decisions that Registered Nurses in Residential Aged Care in NZ make.

The aim of this report is to provide the Commissioner with advice about whether there are concerns about the treatment provided by Ambridge Rose Manor to [Mr A]. In particular I will provide advice on:

- the adequacy of [Mr A's] initial assessment
- the processes followed prior to the use of restraint in the recliner chair
- the appropriateness of the restraint used on [Mr A] in the recliner chair
- Ambridge Rose Manor's policies relating to restraint
- the decision to continue to use the recliner chair despite [Mr A's] falls and the inadequacy of the foot plates.

List of documents and records reviewed. Copies of:

- the complaint by [Ms B], [Mr A's] daughter, to the Health and Disability Commissioner (HDC)
- the response from Ambridge Rose Manor to the complaint
- clinical notes from Ambridge Rose Manor
- Ambridge Rose Manor's Restraint Minimisation and Safe Practice Policy, Section 26.0, from the Nursing Manual.

List of resources referred to:

Health and Disability Commissioner. (1996). Code of Health and Disability Services Consumers' Rights. Retrieved from http://www.hdc.org.nz/the-act--code/the-code-of-rights

Nursing Council of New Zealand. (2007). Competencies for Registered Nurses. Retrieved from http://www.nursingcouncil.org.nz/Nurses

Ministry of Health. (2008). *Standards New Zealand Health and Disability Services (Core) Standards. Wellington, New Zealand.* Retrieved from: http://www.health.govt.nz/system/files/documents/pages/81341-2008-nzs-health-and-disability-services-core.pdf

Ministry of Health. (2008). *Standards New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards. Wellington, New Zealand.* Retrieved from: https://www.health.govt.nz/system/files/documents/pages/81342-2008-nzs-health-and-disability-services-restraint-minimisation.pdf

Ministry of Health. (2016). *Age related residential care services agreement. DHB Shared Services.* Retrieved from: http://centraltas.co.nz/health-of-older-people/national-agreements

1. Comments on the adequacy of [Mr A's] initial assessment:

Documentation titled 'transfer of care to GP Adult rehabilitation service' was completed on discharge from [the DHB] on 13/4/16 and provided relevant medical details and an interdisciplinary report to be used on admission to Ambridge Rose Manor. The Ambridge Rose Manor documentation shows a care plan was completed on the 14/4/16, with assessment data obtained from the discharge notes from [the DHB] and from [Mr A]. This initial care plan was completed, as required, on admission and is able to cover the time period until the InterRAI LTCF must be completed within 21 days of admission. The most relevant assessment details from [the DHB] information have been included in the Initial Care Plan. Two details that are omitted are:

1) the specific recommendation for the use of an '18 x 20# standard wheelchair with supportive personal back and contoured pressure relieving cushion'.
2) the risk of contractures with the relevant positioning required to prevent these from developing.

However, the progress notes documented by [EN E] on 13/4/16 state that referral for funding for a wheelchair for back support had been applied for by the OT[1]. The need for position changes is included in the care plan which states under 'Skin/Tissue/Oral/Dental' that [Mr A] is to be repositioned 2 hourly when in bed. The progress notes documented by [EN E] on 13/4/16 state that he wishes to sit up for all meals in a chair.

While it would be ideal that all instructions were included on admission it can take several days while the resident settles in to the new environment for his abilities in this context to become evident. Most care plans take several days to weeks to fully develop.

Summary: in my professional opinion the initial assessment is adequate and of an acceptable standard.

2. **Comments on the processes followed prior to the use of restraint in the recliner chair, including adequacy of the consent form signed prior to this restraint:**

[1] It appears not all of the documentation on the progress notes may have printed — for the purposes of this review.

Documentation shows [Dr D] authorised the use of a recliner chair on 19/4/16 as everyday equipment and stopped this equipment on 22/4/16 (medication chart).
It is stated on the Physical Restraint/Enabler Consent Form on 14/4/16 that [Dr D] recommended [Mr A] was restrained for his own safety and well-being. [Dr D] has initialled this form. The registered nurse has signed the form. [Mr A's] sister (using EPOA) signed the form on 14/4/16 and stated she agreed to the use of a recliner chair. She did not state that she agreed with the use of a safety belt. The safety belt is not ticked, crossed out or commented on.

The Ambridge Rose Manor Restraint Minimisation and Safe Practice Policy (2015) states:

- that there must be written clinical justification for restraint: this is missing
- an alternative to restraint should be attempted and found to be inadequate: this is missing
- the Restraint Co-ordinator/Clinical Manager must discuss the issue of restraint with the doctor: there is no documented evidence this occurred however as the GP and registered nurse both signed the consent form it could be inferred this discussion occurred
- the alternatives to restraint should be documented on the care plan: this is missing
- the Restraint Co-ordinator/Clinical Manager ensures care plans are updated: there is no documentation on the care plan
- the doctor must document in the resident's notes that restraint for safety is justified: this is missing apart from the consent form being initialled by the GP
- restraint can be instigated after an appropriate assessment is made of the need for restraint on each occasion it is applied: all assessments are missing
- adequate documentation in the clinical records and monitoring of the resident's clinical outcomes is required and also risks associated with the use of restraint must be documented: this is missing
- instructions to monitor the restraint must be documented in the care plans: this is missing
- a documented Restraint/Enabler Pre Assessment — initial assessment should have been completed: this is missing
- there is no evidence of the communication with [Mr A] or his family regarding restraint

The use of restraint is not the main concern of the complaint which infers that family members were reasonably accepting of the need for some sort of restraint but not the type of restraint used. In their response to this complaint Ambridge Rose Manor have removed the hand tied belts however there is no recognition of the assessment, monitoring and evaluation requirements of the restraint policy nor the significance of ensuring all aspects are met in order to protect a vulnerable resident.

Summary: in my professional opinion Ambridge Rose Manor did not meet the required standard, nor their own policy, in regards to restraint. The signed consent form is not adequate as it is difficult to interpret whether the consent for the use of the recliner

chair includes the use of a safety belt or just the recliner chair. In my opinion restraint using a safety belt was not agreed to however restraint using the recliner chair was agreed to.

This is a moderate departure from the standard of accepted practice.

I consider that my registered nurse peers would view the topic of restraint from a nursing perspective as a very challenging area in their practice that has ethical and legal implications; that there is a large volume of paper-work required; that it is important that everyone follows every step of the policy accurately; and that it is challenging to manage and also document effectively but that it is very important to get right. I also consider my peers would consider the overall system influences the effectiveness of the processes used to apply the policy.

3. The appropriateness of the restraint used on [Mr A] in the recliner chair:

The use of a canvas belt/hand tied belt is not appropriate. All care givers should have completed relevant education and so should understand what acceptable practice is. The registered nurse should assess the resident and consult with the Restraint Co-ordinator/Clinical Manager to arrange an appropriate safety belt or vest. The Ambridge Rose Manor Restraint Minimisation and Safe Practice Policy (2015) states that restraint techniques must be approved by the Restraint Approval Group and therefore it is assumed the use of a canvas belt/hand tied belt was considered acceptable by this group.

In summary: in my professional opinion the canvas restraint is not appropriate.

This is a mild departure from the standard of accepted practice.

4. Comments on Ambridge Rose Manor's policies relating to restraint:

[Ambridge]Rose Manor has a 37 page Restraint Minimisation and Safe Practice Policy which is broadly congruent with the Ministry of Health (2008) *Standards New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards.*

Summary**:** in my professional opinion the [Ambridge] Rose Manor Restraint Minimisation and Safe Practice Policy meets the required standards.

5. Comments on the decision to continue to use the recliner chair despite [Mr A's] falls and the inadequacy of the foot plates, and on whether these incidents were appropriately reported:

[Mr A] was found on the floor near the recliner chair on 15/4/16 and 17/4/16. On 15/4 the incident form documents that [Mr A] informed the registered nurse he had slipped out of the chair and on 17/4 the cleaner stated [Mr A] slipped from the chair. [A Registered nurse] documented the first incident on the appropriate form and [another registered nurse] documented the second. It was documented in the progress notes that these incidents had occurred however that is all that was documented for that shift. The assessments that were documented were vital signs, skin assessment and no injuries. This assessment is minimal but appears to be adequate in this context. The actions to

prevent further falls were noted to comprise reminding the resident to call for assistance and for staff to monitor [Mr A] regularly. These actions were responses to the incidents but were not proactive regarding the causes that contributed to the falls. The incident form does not require a detailed consideration of causative factors, nor does it require consideration of other falls or factors that could be linked. It appears the incidents were dealt with as separate incidents rather than consideration of a developing pattern.

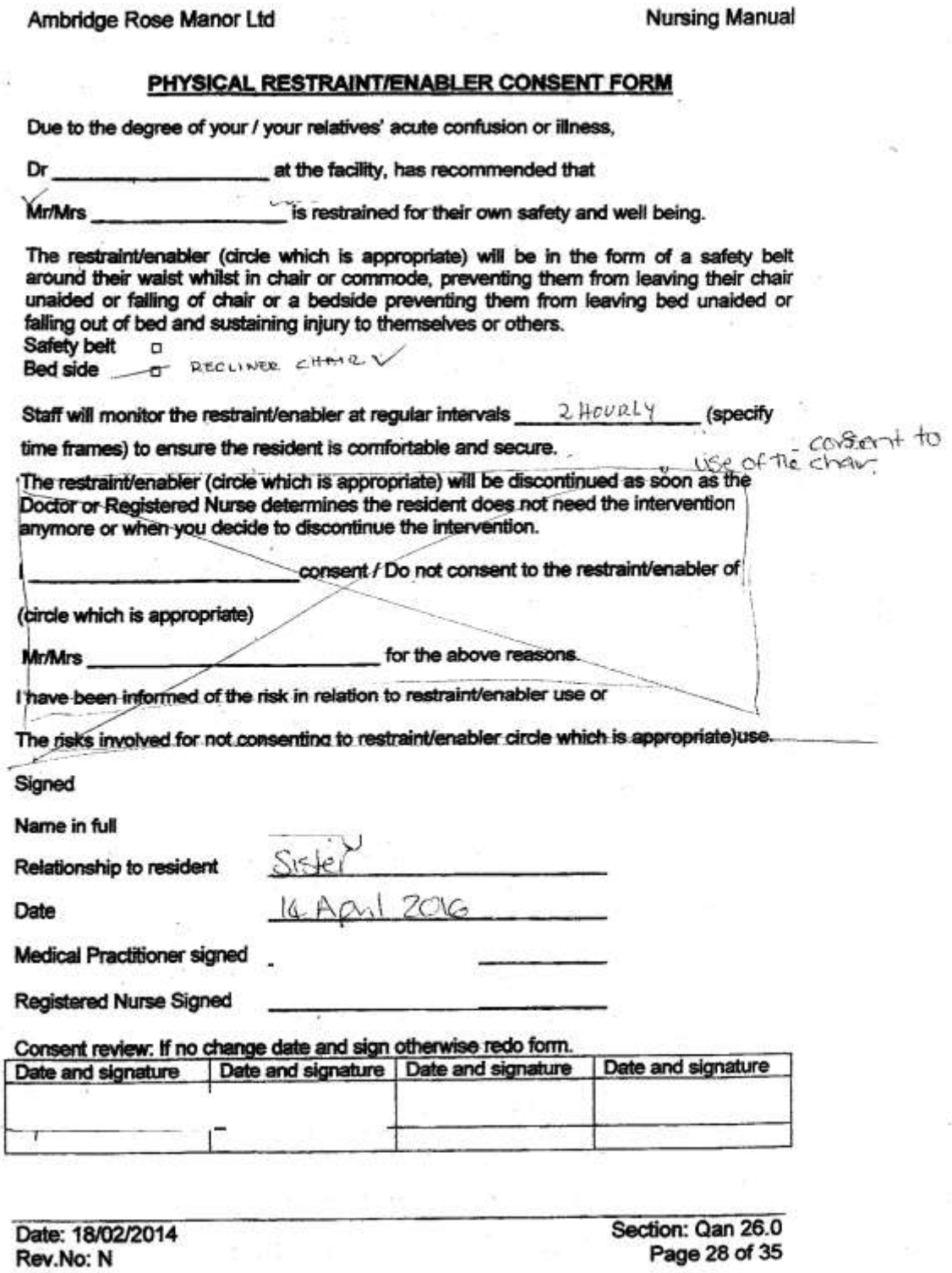
The documentation related to the recliner chair is limited. There is documentation in the progress notes:

- 16/4/16 the health care assistant reported [Mr A] complained that the chair was not good for him and this complaint was reviewed by the registered nurse who indicated [Mr A] be repositioned regularly. Later that day [Mr A] was reported to have nearly fallen out of the bed as he had moved a lot on the bed.
- 18/4/16 [EN E] reported to [Mr A's] daughter that [Mr A] was not sitting properly on the chair and was sliding off. She also documented that [Mr A] stated that the foot rest kept sliding down causing him to slip. This was reported to the quality manager who requested [Mr A] be put onto another recliner chair. This information was handed on but it is not subsequently documented that the change actually took place.
- 18/4/16 [Mr A] refused to be put into the recliner chair but no reason is documented.

[Mr A] slipped from the recliner chair twice (15/4 and 17/4) and was also reported to have nearly fallen out of bed once (16/4). It appears that once he stated the foot rest was a problem (18/4) that the chair was replaced. It is not clear whether the footrest was a problem prior. It is also not clear if the footrest was loose prior and this should have been evident to the health care assistants and the registered nurses.

In summary: in my professional opinion the recliner chair was faulty but it is not clear this contributed to the falls and there is no clear evidence that it should not have been used. The two incidents of [Mr A] falling to the floor were adequately reported on the required incident form, however there was no extra documentation in the progress notes and the falls appear to have been considered as separate incidents. The required standards were met."

Appendix B: Physical Restraint/Enabler Consent Form



Ambridge Rose Manor Ltd Nursing Manual

PHYSICAL RESTRAINT/ENABLER CONSENT FORM

Due to the degree of your / your relatives' acute confusion or illness,

Dr _____ at the facility, has recommended that

Mr/Mrs _____ is restrained for their own safety and well being.

The restraint/enabler (circle which is appropriate) will be in the form of a safety belt around their waist whilst in chair or commode, preventing them from leaving their chair unaided or falling of chair or a bedside preventing them from leaving bed unaided or falling out of bed and sustaining injury to themselves or others.

Safety belt ☐

Bed side ☐ RECLINER CHAIR ✓

Staff will monitor the restraint/enabler at regular intervals 2 HOURLY (specify time frames) to ensure the resident is comfortable and secure.

consent to use of the chair

The restraint/enabler (circle which is appropriate) will be discontinued as soon as the Doctor or Registered Nurse determines the resident does not need the intervention anymore or when you decide to discontinue the intervention.

I _____ consent / Do not consent to the restraint/enabler of

(circle which is appropriate)

Mr/Mrs _____ for the above reasons.

I have been informed of the risk in relation to restraint/enabler use or

The risks involved for not consenting to restraint/enabler circle which is appropriate)use.

Signed

Name in full

Relationship to resident Sister

Date 16 April 2016

Medical Practitioner signed _____

Registered Nurse Signed _____

Consent review: If no change date and sign otherwise redo form.

Date and signature	Date and signature	Date and signature	Date and signature

Date: 18/02/2014
Rev.No: N

Section: Qan 26.0
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Names have been removed (except Ambridge Rose Manor Ltd and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.