CHT Healthcare Trust

Healthcare Assistant, Ms C

A Report by the

Deputy Health and Disability Commissioner

(Case 13HDC01495)

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Executive summary

1. The Hospital (operated by CHT Healthcare Trust (CHT)) is a facility which provides residential care for older people. It has a dementia care unit for residents who require specialist care.

2. Mrs A (aged 82 years at the time of the events) suffered from worsening dementia and had previously been cared for at home by her family. In late 2013, Mrs A was admitted to the dementia unit at the Hospital for respite care, and remained there for 9 days[1]. During Mrs A's brief admission she sustained a number of injuries.

3. Mrs A's admission assessment, undertaken on the day following admission, contained contradictory information. An initial care plan was also developed the day following admission, and it did not contain certain details about Mrs A's behaviour and preferences. In addition, there was confusion about the medications taken by Mrs A.

4. Ms C, a healthcare assistant (HCA) on duty in the dementia unit on the night of Day 6, physically abused Mrs A. Ms C grabbed Mrs A's upper arms, causing bruising, and slapped Mrs A's upper thigh, causing bruising.

5. HCA Ms D, who observed and overheard the physical abuse of Mrs A, did not report the incident overnight, and did not complete an incident form. The following morning (Day 7), HCA Ms H reported to registered nurse (RN) RN I that there was some bruising on Mrs A's body. While it was noted that Mrs A had fingermark bruises on her upper arms, the incident report completed did not refer to other details such as Mrs A's complaints that the bruising was caused by a staff member, or that she had been "bashed on the knee".

6. After breakfast on Day 7, Mrs A was not able to walk, which was not normal for her as usually she mobilised freely. RN I examined Mrs A's left leg and found it was swollen and shiny, so contacted Mrs A's GP and advised him of the swelling and enquired about an X-ray. The GP was not informed of Mrs A's other injuries.

7. CHT commenced an internal investigation into the circumstances relating to Mrs A's injuries, and Ms C was suspended.

8. On Day 9, Mrs A was taken by her family to the public hospital, and was discharged the next day into the care of her family.

9. Following the internal investigation, Ms C was dismissed from her employment at the Hospital for serious misconduct. The matter was referred to the Police.

10. In early 2014, Mrs A died at her granddaughter's home.

11. In early 2015, Ms C appeared in the District Court and entered a guilty plea to a charge of assault in relation to this incident.

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[1] Relevant dates are referred to as Day 1 – Day 10 to protect privacy.

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12. In mid 2013, there had been an allegation of Ms C physically abusing another resident at CHT. CHT had investigated the allegation, and Ms C had remained in the employment of CHT and undergone further training and supervision.

Findings summary

13. Ms C failed to provide services to Mrs A that complied with professional and ethical standards and, accordingly, she breached Right 4(2) of the Code.[2]

14. The initial care plan and incident reports did not contain adequate information, and the initial care plan was not updated to take into account changes in Mrs A's condition. The medication management was suboptimal, and CHT staff failed to assess Mrs A's injuries adequately and manage them appropriately. CHT is responsible for the multiple shortcomings in the care its staff provided to Mrs A and, accordingly, CHT did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.[3]

15. Adverse comment is made that Ms C did not receive additional training on abuse and neglect following the incident in mid 2013.

16. Adverse comment is also made about Ms D's failure to take further action at the time that Ms C physically abused Mrs A, in particular, that she did not report the incident to the registered nurse on duty at the time, did not complete an incident form, and did not mention it at staff handover at the end of the night shift. It is acknowledged that Ms D subsequently disclosed the incident to CHT management during an interview for the internal investigation shortly after Mrs A's discharge from the Hospital.

Complaint and investigation

17. The Commissioner received a complaint from Ms B regarding the care provided to Mrs A at the Hospital. The following issues were identified for investigation:

- *Whether healthcare assistant Ms C provided appropriate services to Mrs A.*
- *Whether CHT Healthcare Trust (operating as the Hospital) provided appropriate services to Mrs A.*

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

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[2] Right 4(2) of the Code states that every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.

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

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19. The parties directly involved in the investigation were:

Mrs A	Consumer
Ms B	Complainant/consumer's granddaughter
Ms C	Healthcare assistant
CHT Healthcare Trust	Provider
Ms D	Healthcare assistant

Also mentioned in this report:

Ms E	Mrs A's daughter
Mr F	Mrs A's son
Ms G	Mrs A's daughter
Ms H	Healthcare assistant
Ms I	Registered nurse
Ms J	Facility manager
RN K	Registered nurse
RN L	Registered nurse
Dr M	General practitioner
Ms N	Healthcare assistant
RN O	Registered nurse
RN P	Registered nurse
RN Q	Registered nurse
RN R	Registered nurse

20. Information compiled for The New Zealand Police investigation was reviewed.

21. Independent expert advice was obtained from registered nurse Christine Howard-Brown (**Appendix A**).

Information gathered during investigation

Background

22. Mrs A (aged 82 years at the time of the events) suffered from worsening dementia, and had previously been cared for at home by her daughter, Ms E, for approximately five years.

23. In late 2013, Mrs A was admitted to the dementia unit at the Hospital for respite care, and remained there for nine days.

The Hospital

24. The Hospital is a facility that provides residential care for older people. It has a dementia care unit for residents who require specialist care. It is operated by CHT Healthcare Trust (CHT), which is a not-for-profit organisation that was established in 1962.

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Care provided at the Hospital

Admission

25. Mrs A was admitted to the Hospital's dementia unit on Sunday, Day 1. Ms E stated to the Police that on Day 1, prior to her mother's admission to the Hospital, she brushed her mother's hair, during which she observed her mother's head, and no bruising was present at that time.

26. In response to the provisional opinion, Mrs A's granddaughter, Ms B, said she told the Hospital Manager, Ms J, that her grandmother was wandering all the time and had been picked up by the Police, which was the reason the family thought that the dementia unit would be safer for her.

27. No progress notes were recorded on the day of admission. The admission assessment was undertaken the day following Mrs A's admission. The assessment record was filled out by RN L, and contains contradictory information. It states "no wandering", yet the consent form records information from Ms B that her "nan is very fast and can walk off and get lost quickly". The falls risk assessment was that Mrs A was a low falls risk. The falls risk also documents that Mrs A's granddaughter had reported three falls. However, the circumstances of these falls are recorded as "not known", and "one or more [falls] between 3 and 12 months ago" is circled on the falls risk assessment tool. The assessment record states that Mrs A was continent, but also that she wore "pullup[s]" (an incontinence product).

28. With regard to Mrs A's medication, Ms B advised that when she and her other family members took Mrs A to the Hospital at around 1pm on Sunday Day 1, Mrs A had already taken her breakfast and lunchtime medication. Ms B said she told the registered nurse that Mrs A's bedtime medication should be given at 6.00pm and, if she was still awake at 9.00pm, she needed to be given her sleeping tablets to prevent her from wandering at night. However, Ms B noted that it is first recorded that Mrs A was administered her medication on Day 2, rather than on the evening of Day 1.

29. Ms B said she did not give the registered nurse a prescription on admission, as Ms J had told her that all she needed to give the registered nurse was a list from Mrs A's doctor stating which medications she was on. Ms B said she handed over Mrs A's blister packs, which contained 20 full days' medication and one day's medication that did not contain the breakfast and lunch medication, because it had already been given that day. Ms B said she also gave the registered nurse Mrs A's sleeping tablets.

30. The admission assessment states that Mrs A had taken four medications in the previous 24-hour period. However, she had seven medications prescribed. The Hospital advised that Mrs A had four prescriptions covering a period of three months, but the medications provided by the family were not consistent with the prescriptions, so staff discarded the inconsistent medications. There is no documentation of this, and no medication reconciliation was undertaken. CHT told HDC that the discrepancy should have been recorded in the progress notes and reported as a medication error in the incident reporting system; unfortunately, this did not happen and the family were not informed of the medication being discarded.

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31. On Day 2, an initial care plan was developed by RN L. It notes "wandering" as an issue, but does not contain the details about Mrs A's behaviour and preferences, which were contained in the documents completed by the family. The care plan makes no mention of Mrs A having an increased risk of cerebral bleed, as is documented in a discharge summary from the DHB prior to Mrs A's admission to the Hospital, which was held on file. In response to the provisional opinion, CHT said that this document was not available to staff when Mrs A was admitted to the Hospital, and so staff were not aware of Mrs A's increased risk of a cerebral bleed. There is no record of Mrs A having had a medical assessment while at the Hospital.

Injuries

Injury to head

32. Mrs A's son, Mr F, stated to the Police that he visited his mother at the Hospital every day, and noted that she appeared distressed on some of the days when he visited.

33. On Day 3, RN I recorded that she had noticed a bruise on the back of Mrs A's head. An incident report notes that the bruise appeared to have been there since prior to admission, as it looked old. RN I recorded: "[A]sked family about it and they told [me] she had a surgery on her head few years ago and the bruise was present from that time." In response to the provisional opinion, Ms B said she told the registered nurse that Mrs A had had an operation a few months previously to drain blood out of her brain, and that that might have been the bruise.

34. Mr F stated that the family first noticed the bruise when he and two other family members were visiting Mrs A. He said that his mother tended to wear a hat all of the time, and that he would not remove it "for the sake of her dignity". He said that other family members asked him to come to look at the bruise, and he described it as follows:

> "[A] perfectly round circle on the top left of her head, it was a dark blue, on the back of her head. It was an awkward position to have a bruise on the head, you couldn't get it by leaning back & hitting your head on a wall."

35. In response to the provisional opinion, Ms B said that she saw the bruise on Mrs A's head when her grandmother took off her hat, and that the bruise was "obviously" what the registered nurse had asked Ms B about the previous day. Ms B stated:

> "It was so BIG and yellow and nowhere near where she had her head drained. I approached the RN and told them that that was not present when we admitted her into the unit. I know this as fact because we had changed her out of her church clothes and church hat and put her home clothes on and cap on. The RN told me that maybe a resident had done it to her that night and that there was nothing they could do about that [emphasis in original]."

36. Ms E stated to the Police that previously her mother had had an operation relating to a blood clot on her brain, and had a scar on the right-hand side of her head, but the bruise that she observed was at the middle of the top of her mother's head, and not in

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the same position as the scar. Ms E stated to the Police that she asked her mother what had happened to her, but her mother could not remember.

37. On Day 4, RN I recorded:

> "Family concerned of the bruise on her head. They told me it was not there when she came. Observed it and found that the bruise was the one which I reported them yesterday. They told me yesterday that it was from the surgery [she] had and yesterday was not taking the hat [off] for me to show it to them. Today in the presence of family I showed them and bruise was about 2.5cm by 2.5cm on the back of her head. The surrounding area is black. She didn't complain of any pain when touched."

38. RN I checked and found no incident reports or progress notes to suggest that Mrs A had suffered a head injury since her admission. As the family were concerned that something might have happened to Mrs A on Day 2, RN I told them that no incidents had been reported.

Injury to finger

39. In response to the provisional opinion, Ms B said that on Day 5 she mentioned to the registered nurse on duty that Mrs A had a swollen index finger. Ms B stated that Mrs A said she did not know what had happened to it. Ms B said the registered nurse told her that he could give Mrs A Panadol or put some cream on it.

40. Ms B said that she again raised concerns about a bruise on Mrs A's left index finger on Friday Day 6. When asked by RN K, Mrs A reported that she had hurt her finger while undertaking "kitchen duties". RN K recorded that "[Mrs A] denied having any pain".

41. Ms B told RN K that Mr F had witnessed an altercation between Mrs A and another resident. In relation to this event, Mr F told the Police:

> "[I] found her arguing with a male resident in his room. He was yelling at her to get out of his room [and] she thought it was her room. I intervened [and] moved my Mum away [and] backed out [and] the guy closed the door with a lot of force."

42. Ms E stated to the Police that, when she visited Mrs A on Friday Day 6, she noticed that Mrs A had a bruise on her pointer finger, which ran from the top of her fingernail to the second knuckle. Ms E said that she asked her mother what had happened, and her mother replied: "I think I just jammed it in the door."

43. No incident report was filled in in relation to this injury, but the progress notes state that staff were advised to "keep a close eye" on Mrs A.

Night duty — Day 6/Day 7

Ms D's account

44. On the night of Day 6/Day 7, Ms D worked in the dementia unit with Ms C. The records state that Mrs A was wandering and went into another resident's room, which

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made that resident uncomfortable and aggressive. The records state that Mrs A was frightened and hid in the bathroom, and so she was taken to the dining room, and, at around 2am, she was taken to her bed. The records also state that there were “no other concerns to report”.

45. When subsequently interviewed by CHT shortly after Mrs A’s discharge from the Hospital, Ms D stated:

> “I want to tell you about another incident that happened that night. When we come to work, me and [Ms C], she hates the people up. She wants them all asleep, on that night (Fri) we came. [Mrs A] was up and we stayed with her in the lounge. She kept talking and [Ms C] told her to stop talking go back to sleep and she said I go sleep if I want to go sleep. [Mrs A] went on and on around about after 12. [Ms C] is not happy and said stop talking to [Mrs A]. [Mrs A] I don’t want to listen you talk too much. [Mrs A] kept answering back and said you stop, no one stops me.”

46. Ms D said that Ms C was angry, and grabbed Mrs A’s arms, pulled her up, and took her to her room. Ms D stated that Mrs A shouted, “Leave me alone.” While Ms C and Mrs A were in Mrs A’s room, Ms D heard a bang, and Mrs A screaming and shouting, “Leave me alone it hurts it’s sore don’t punch me.”

47. Ms D said that she went to see what was happening and, when she got to Mrs A’s room, Mrs A was sitting on her bed breathing with short breaths and rubbing her leg. When Ms D asked Mrs A what had happened, Mrs A said, “She punched me, she pressed me and pulled my hair.” Ms D said that when she asked Ms C what had happened, Ms C did not reply or turn around. Ms D took Mrs A back to the lounge and, at that time, Ms C went to the hospital unit to assist with a “round”, and returned at about 2am. Ms D said that during the time Ms C was away, no other staff apart from herself were in the dementia unit.

48. Ms D said that at about 3am she asked Mrs A if she wanted to go to bed. Mrs A said that she did but, when she tried to get up, she said that her knee was sore, and she limped to her room. Ms D stated: “[T]he RN help[ed] and looked at the knee.” When asked whether an incident report was filled out, Ms D replied: “The RN said he was going to do it.” Ms D apologised for not reporting the incident sooner.[4]

Ms C’s account

49. At a subsequent disciplinary meeting (see below), Ms C stated that Mrs A was awake at the start of the duty on the night of Day 6/Day 7, and that, at around 12.45am, she was agitated and trying to open another resident’s door. Ms C stated that Mrs A was “scratching and punching”, and did not want to go to her room. Ms C said that, at that stage, she went to the hospital unit to help with the “round”, and returned at around 2.15am.

[4] It appears that Ms D reported Mrs A’s sore knee to the registered nurse, but did not report the incident between Ms C and Mrs A to the registered nurse.

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50. Ms C stated that Mrs A was walking with a limp due to a sore knee. Ms C said that Ms D took Mrs A to her room and put her to bed, and the day staff arrived and took over her care at 7am.

51. When showed photographs of Mrs A's bruises (taken by RN I on Day 7), Ms C stated that she did not cause the injuries on Mrs A's arms and leg, but she may have caused a bruise when Mrs A pulled away from her when she tried to resist being put to bed. Ms C denied that she punched Mrs A's leg, and denied telling Mrs A to "shut up".

Day 7

52. Ms D did not inform the registered nurse on duty at the time of the incident, and did not mention it at handover at the end of the night shift. At 7.30am on Day 7, HCA Ms H reported to RN I that there was some bruising on Mrs A's body.

53. RN I assessed Mrs A and recorded that Mrs A said that she had been treated very roughly by the younger night nurse with short hair, and that the nurse had bashed her on the knee.[5] RN I noted that Mrs A was not able to walk, which was not normal for her, as usually she mobilised freely. RN I recorded:

> "When she sat on the chair for her breakfast I went to examine the bruises and found she has bruises on her left and right upper arm. The bruises look very new (red in colour and like fingermarks). The marks of 2 fingers was seen on her left upper arm and right upper arm. I asked her what happened. She verbalised [to] me that one of the nurses dealt very roughly with her yesterday night. While I was talking with her I found scratch marks on the resident's left lower arm. I enquired with her and she told me that it may be the result of the night nurse holding me. When I asked her about the bruises on the upper arm she complained of pain."

54. At 8.00am an incident report completed by Ms H was entered into the electronic record by RN I. It states: "As [r]eported by a HCA, She found bruising on a [resident's] both upper arms and a scratch on her left lower arm." There are no further details recorded.

55. RN I noted that when Mrs A attempted to stand up after breakfast, she cried out loudly and, on examination, RN I found that Mrs A's left leg was swollen, and that the swelling was shiny, but no bruises or injuries to that area were noted.

56. RN I contacted Mrs A's GP, Dr M, advised him of the swelling, and enquired whether Mrs A required an X-ray. There is no documented evidence that RN I informed Dr M of the alleged injury to Mrs A's knee, or of her other injuries. RN I noted that the GP said that the swelling was because of Mrs A's history of heart failure and gout, and advised that her leg should be elevated and bandaged, and that there was no need for any medication, but if there was no reduction in the oedema within two days then an X-ray should be arranged or Mrs A should be referred to Dr M.

[5] CHT advised HDC that HCA Ms C was identified by Mrs A's description.

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57. RN I recorded that she applied a crêpe bandage secured with Tubigrip[6] and elevated Mrs A's leg, and that Mrs A was settled. RN I recorded around 10am that she "informed daughter about the bruise and swelling and about GPs discussion".

58. CHT stated that attempts were made to contact Mrs A's son, Mr F, as he was the nominated first contact, but he could not be contacted. This is not recorded in the notes, but was incorporated into a timeline created by CHT as part of an internal investigation following the events. Ms B stated that she rang CHT in the morning but was not told about Mrs A's injuries, despite her being the second emergency contact. Ms B said that Mrs A's daughter, Ms G, visited later in the day and discovered what had happened to Mrs A. Ms G then contacted Ms B, Ms E and Mrs A's husband and asked them to come to the Hospital.

59. Ms B told HDC that she had lengthy discussions with RN I, who assured the family that Mrs A needed to stay at the Hospital to have her injury monitored and be given appropriate care and medication. Ms B stated: "[W]e made the decision for her to stay because we felt they were better equipped [to care] for her."

60. On the morning of Day 7, RN I asked HCA Ms N to talk to Mrs A and to find out exactly what had happened. Ms N stated to the Police that Mrs A said that the night nurse was very rough, and she pulled up both sleeves of her shirt to show the bruises on her upper arms. Ms N said she asked Mrs A what happened, and Mrs A repeated "the night nurse", and said it was "the night nurse with a short hair". When asked what the nurse did to her, Mrs A told Ms N that the nurse grabbed her upper arms and pushed her, told her to go to her room and sleep and punched her knees. Ms N stated that Mrs A said: "It's not just me but the (nurse) is doing it at night to the people staying in here." Ms N noted that Mrs A said that the nurse had told her to "shut up" and "shut her mouth". Ms N reported the conversation to RN I.

61. Ms E stated that, at about 1pm, she and her father visited Mrs A. Ms E said that she discussed Mrs A's sore knee with RN I, who said that she had called the GP and that the swelling was related to Mrs A's history of gout. Ms E said that she had been looking after her mother for five years, and her mother had never suffered from gout.[7]

62. Mrs A's husband stated to the Police that he started to get really angry at the staff because Mrs A was fine when she was admitted. He said he started shouting at the staff because he wanted to find out who had done this to Mrs A. After some discussion, the family decided not to take Mrs A home, with the agreement that Mrs A's husband could stay with Mrs A overnight if he wished.

63. RN I informed Ms J of the situation and emailed to her photographs of the bruises. RN I noted that Ms J told her to record the information about the incident. Ms J contacted the area manager who instructed Ms J to commence an investigation into

[6] A compression bandage.

[7] In response to the provisional opinion, Ms B said she later contacted Dr M and asked him why he had said that Mrs A had a history of gout, because she had never had that problem and only had rheumatism. Ms B said Dr M told her that he had told the registered nurse that he assumed Mrs A had gout because the registered nurse could not see any bruising.

HDC

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the circumstances relating to Mrs A's injuries, and to suspend Ms C. Ms C was suspended that day, but Ms J did not assess Mrs A or speak with her family at that time.

64. No short-term care plan was developed in response to Mrs A's injuries, and there is no evidence of further contact with Dr M regarding Mrs A's injuries.

65. At 7.00pm on Day 7, a healthcare assistant reported to RN P that she had found bruising on Mrs A's left upper thigh, and a further incident form was completed. RN P recorded that she applied arnica cream[8] to the bruising.

Days 8-10

66. CHT told HDC that on Day 8, Mrs A "appeared to be managing to walk around the unit with a slight limp but without any complaints of pain". Clinical notes recorded on Day 8 state that Mrs A was to be supervised when mobilising. In response to the provisional opinion, Ms B said that Mrs A could not walk independently after the incident, so staff at the Hospital gave her a walker chair to be pushed around on. Ms B said that after the incident Mrs A was never again able to walk independently.

67. On Day 9 at 7.30am, Ms B visited Mrs A. In response to the provisional opinion, Ms B said that she found Mrs A crying uncontrollably, and that Mrs A "begged me to get her out of there". After discussion with Ms G, they decided to discharge Mrs A from the Hospital. Ms B stated: "[W]e told the caregivers and RN that we are discharging her and taking her to the public hospital to have injuries noted and checked out."

68. Ms B said she was concerned about Mrs A's swollen leg and, in addition, when they showered Mrs A before going to the public hospital they discovered that she had bruising on her forehead and behind her neck.

69. On Day 10, Mrs A was discharged from the public hospital to Ms B's home. Ms B said that Mrs A was afraid and had sleepless nights and, after three days of attempting to rebuild Mrs A's confidence and reassure her she was not going back to the Hospital, Mrs A suffered a stroke.

CHT investigation

70. CHT commenced an internal investigation after RN I contacted Ms J on Day 7. The CHT investigation report states:

> "Investigation of the alleged abuse suffered by [Mrs A] was led by [Ms J] and consisted of a review of the clinical record, incident reports and statements taken from staff that had been on duty at the time of the alleged abuse and on the following shift. Photographs of the bruising were taken to assist with the investigation. The investigation was completed as a disciplinary process under CHT policy and procedure."

[8] Arnica cream is a natural remedy used to assist the body's natural response to injury and bruising.

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71. Shortly after Mrs A's discharge from the Hospital, Ms C was dismissed from her employment at the Hospital for serious misconduct. A couple of weeks after the incident, the area manager made a complaint to the Police about Ms C's alleged physical abuse of Mrs A.

72. CHT stated that, following the investigation, it did not feel it was necessary to make major changes to its policies, as they were robust, but not followed by Ms C. A memo was circulated to staff to remind staff of their responsibility to provide competent and safe care to residents, and encouraging staff to report suspected abuse to their manager. The investigation report was finalised a few weeks after the incident. An addition was made to the employee Code of Conduct in early 2014 to state that any staff member dismissed for serious misconduct related to abuse or theft will be referred to the CEO to consider whether a referral to the Police is appropriate.

CHT policies and procedures

73. CHT's Standards of Care policy, as it applied at the time of these events, provided a definition of abuse and stated that residents will be protected at all times from abuse and neglect. It also stated that staff will receive training during orientation and as part of the refresher training in relation to definitions of abuse and neglect, signs and symptoms, and what to do when abuse or neglect is suspected. It stated: "All injuries found on residents will be recorded as part of the CHT risk management system and these will be monitored on a monthly basis." It also provided that, if risk or abuse is suspected, residents and/or the next of kin will be advised of the complaint process.

74. The Residents' Incidents/Accidents Procedure also provided a definition of abuse. It specified that it is the employee's responsibility to ensure the safety of the resident, and fill in an incident/accident form when an incident/accident occurs. It further stated that it is the responsibility of the person in charge to ensure that the accident is investigated to the best of his or her ability, and preventative action is implemented to ensure or minimise the possibility of such an accident occuring again. The person in charge is to provide staff training in abuse and neglect and incident/accident reporting annually, and more often where there has been an increase in the number of incidents/accidents or where abuse or neglect is suspected.

75. The CHT employee Code of Conduct and Disciplinary Procedure stated that "[e]mployees shall … report any observed incidents of resident abuse or neglect", and that the following acts constitute misconduct so serious it may justify termination of employment without notice:

> "Any action or inaction which seriously affects the quality of care, the safety of, and the physical and mental wellbeing of residents and or employees.
>
> …
>
> Physical or verbal intimidation or violence towards employees, residents, visitors while at any CHT premises or while providing services to resident[s]."

76. At the time of these events, there were mandatory training requirements at the Hospital that supported healthcare assistants receiving ongoing training in abuse and

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neglect, Code of Rights, challenging behaviour, restraint minimisation, and cultural safety, among other things.

77. A Health and Disability Services Standards surveillance audit was carried out in early 2014. This audit found that the cultural safety training and restraint minimisation training were not current for all staff. The audit report also states that the following criterion was fully attained: "The service develops and implements policies and procedures that are aligned with current good practice and service delivery, meet the requirements of legislation, and are reviewed at regular intervals as defined by policy."

Ms C

78. Ms C commenced employment at the Hospital in 2007. Four performance appraisals for Ms C were provided to HDC by CHT, dated early 2009, 2010, 2011 and 2012. A further performance appraisal was due in early 2013, but it did not occur. Ms C's manager's comments from the performance appraisal in early 2012 were that Ms C was a hard-working and thoroughly reliable healthcare assistant.

79. CHT advised that Ms C had completed its mandatory training programme, an external training run through Career Force and Health ED Trust (ACE programme).[9] The ACE programme includes training specifically related to caring for residents suffering from dementia, including training in relation to challenging behaviour and de-escalation. CHT advised HDC that the CHT mandatory training programme and policies, procedures and employee Code of Conduct provide a framework to outline clearly the expectations of staff, to ensure that they always provide safe care to the residents they are supporting. CHT stated:

> "In this case, despite all her training and knowledge of CHT's policies, [Ms C] acted in a way that was completely divorced from CHT's goal to provide great care to older people."

Previous incident

80. CHT advised that there had been a previous allegation of physical abuse by Ms C towards a resident in the dementia unit at the Hospital in mid 2013. The aftermath of the incident was witnessed by staff members, and it was reported to the registered nurse at the time. CHT said that the incident involved Ms C's actions when she discovered a partially undressed female resident in a male resident's room. CHT advised that Ms C was attempting to de-escalate the situation by removing the female resident from the male resident's room, and that her attempts to do so agitated both residents. The information provided in response to the second provisional opinion states that Ms C acknowledged that she physically restrained the resident, and that she knew she was not allowed to do so. The female resident was found to have bruising to

[9] This programme focuses on knowledge and skills that support workers use on a daily basis, and therefore need to learn as soon as possible to work in their role effectively. The programme contains 10 unit standards (41 credits) towards the National Certificate in Health Disability and Aged Support (Core Competencies) (Level 3).

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both upper arms and left outer thigh, a skin tear on her left hand, and an injury on her forehead.

81. In response to the second provisional opinion, CHT advised HDC that Ms C was suspended the day after that incident. A disciplinary investigation was commenced and, a couple of weeks later, a meeting was held during which Ms C gave an explanation for her actions on the day of that incident. The information provided to HDC states that, during that meeting, Ms C explained: "[The resident] was kicking and punching and [Ms C] had held her shoulders, evident from the bruising and skin tears. However [Ms C] had not bruised [the resident's] thigh and did not know how that injury had come about." In the meeting, Ms C acknowledged that when a patient is aggressive, they should be left until they become calm, and she advised she would get advice next time. It was also identified that, at the time of that incident, Ms C had also left the dementia unit unattended for a period of time.

82. CHT concluded that Ms C did not wilfully intend to abuse the resident, but did not follow the correct process which, in that case, would have been to use the emergency button to summon someone to assist her or, alternatively, to leave the resident to calm down. It stated: "[Ms C] had acted with good intentions in attempting to remove [the resident] from what she perceived to be an unsafe situation." In addition to stating that "CHT concluded that, on the balance of probabilities, [Ms C] had not intended to physically abuse [the resident]", CHT also stated that the allegations of physical abuse were found not to have been proven.

83. Shortly after the meeting Ms C was issued with a written warning for failing to follow the correct process, and CHT proposed that Ms C be provided with additional training and supervision. CHT stated that it was "satisfied that [Ms C] had undertaken relevant training. Therefore, at the time, there did not appear to be any immediate need to provide [Ms C] with any additional training on abuse and neglect. Rather, CHT identified that … [Ms C] had issues with sexuality and intimacy. Therefore, it was suggested that she take sexuality and intimacy training."

84. In response to the second provisional opinion, CHT stated that its investigation of the mid 2013 incident was in accordance with "best practice" from an employment law perspective, and it had responded as a fair and reasonable employer. It stated that it had asked Ms C whether she would be able to work morning shifts, but she had said she was unable to do so because of other commitments. CHT stated that Ms C remained on night duty, but was rostered to work shifts with RN O, who supervised her and provided her with four sessions of on-the-job training on sexuality and intimacy.

85. CHT told HDC that subsequently Ms C received further training, including continence and toileting, health and safety, training in understanding dementia and associated behaviour, challenging behaviour, manual handling, moving and handling, Code of Rights — privacy and dignity/informed consent and advocacy, and accident and incident reporting.

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86. The "understanding dementia and associated behaviour" training included dealing with agitation and aggression, wandering and delirium. It did not include training on abuse and neglect.

Police involvement

87. As noted above, following the internal investigation, Ms C was dismissed from her employment at the Hospital, and the area manager made a complaint to the Police about Ms C's alleged physical abuse of Mrs A.

88. During the Police interview in mid 2014, Ms C admitted that she had held Mrs A by the arms while she was trying to put her to bed. At that time, Mrs A was lying on her side on her bed. The Police officer asked Ms C whether she caused bruising on Mrs A's upper arms, and Ms C said that she had. She replied: "[W]hen you [are] holding the people like this [you] always [get] marks when you hold hard." Ms C told the Police that Mrs A was trying to kick her.

89. The Police officer showed Ms C pictures of bruising on Mrs A's upper thighs. He asked whether Ms C had caused the bruising, and she said that she had. When asked how she caused the bruising, she said, "[L]ike this," and motioned slapping of her upper thigh and stated that this was, "hard, hard because I want to stop her … kicking [me]". Ms C denied hurting Mrs A's knee.

90. The Police officer asked Ms C what she was meant to do if a resident did not want to lie down on his or her bed, to which she replied, "[D]on't force." Ms C acknowledged that she should not have held Mrs A down, and stated: "I know [what] I've done, I didn't follow the patient's rights."

91. In early 2015, Ms C appeared in the District Court and entered a guilty plea to a charge of assault.

92. Despite being advised of the notification of this investigation, Ms C has failed to respond to requests for information.

Subsequent events

93. In her complaint to HDC, Ms B raised concerns about CHT's response to these events. In particular, she stated:

> "A female staff member was dismissed as a result of my grandmother's bruising to her arms and that was it. No apology or sympathy for what my grandmother had been through! I asked [Ms J] what about the bruising that happened to her inner and outer thighs? [Ms J] said this was the first she has heard and to send in this complaint to her."

94. The Hospital underwent a routine two-day aged residential care surveillance audit in early 2014. In late 2014, the Ministry of Health advised HDC that an unannounced surveillance had been conducted on one day of the two-day audit, at which there were five standards identified as partially attained, with two rated moderate risk and three rated low risk. The moderate risk findings were around care planning interventions

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and medicine management. The low risk findings were around quality and risk management, human resource management (staff appraisals and training) and care planning evaluation.

Mrs A

95. In early 2014, Mrs A died at Ms B's home. Ms B stated: "This has been a very horrific ordeal for all of us, and very traumatising for my poor grandmother."

Responses to provisional opinion

96. Ms C did not respond to the provisional opinion. Responses were received from Ms B and CHT,[10] and have been incorporated into the report where appropriate.

97. CHT further submitted:

- It condemns Ms C's actions and has a zero tolerance for abuse and failure to report abuse.
- It does not accept that a progress entry is required each day. It submitted that the contractual requirement for residents in dementia level care is to have a progress note entered at least weekly or more frequently if there is a reason to do so. CHT said that it met that contractual requirement.
- It does not accept that two staff were required to be on duty in the dementia unit at all times. It submitted that the contractual requirement is that at least one care staff member is to be on duty in the dementia unit at all times, and a second staff member must be available and on call.
- There is no evidence that Mrs A suffered from incontinence. She required some prompting to go to the toilet and wore pull-ups for "peace of mind".
- With regard to the injury to Mrs A's finger, there was sufficient assessment in that RN K spoke to Mrs A, who said that she had done it herself while working in the kitchen, and it was not causing her any pain or discomfort. In those circumstances no further assessment was warranted.
- It accepts that Ms C's 2013 performance appraisal was overdue. In 2012, her appraisal included a goal of completing her ACE advanced training. The ACE dementia training completed by Ms C in 2010 included challenging behaviour, de-escalation skills, abuse and neglect.
- It does not accept that either Mrs A's finger injury or the bruise to her head required a short-term care plan.
- It agreed that the criticisms about the suboptimal medication management and failure to develop a short-term care plan to address Mrs A's bruised arms on Day 7 are valid. CHT stated, however: "The absence of a written short term care plan did not mean that CHT staff were not caring for the injuries as there is evidence in

[10] CHT confirmed that Ms D was made aware of the sections of the provisional opinion relevant to her. Ms D did not comment on the provisional opinion.

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the progress notes to support that care was being provided and the injuries were monitored by the registered nurses on duty."

- It does not accept the criticisms of the admission process. It stated: "[I]n fact there was no issue of wandering because [Mrs A] was in a secure facility and was not at risk of wandering out of the facility." It further stated that incontinence was not an issue that needed management, and that it is not uncommon for residents admitted from home for respite care to have incomplete medical records.
- It accepts that its communication with the family was not optimal, and noted that it sent a letter of apology to Ms B in early 2014.

Responses to second provisional opinion

98. In response to the second provisional opinion, CHT provided new information and made further submissions, which have been incorporated into the report where appropriate. In addition, CHT provided an expert opinion prepared by RN Q and RN R. Both RNs Q and R are endorsed in the scope of nurse practitioner older adults. The opinion states:

- The contractual requirement to conduct an assessment within 24 hours of admission was complied with; however, best practice would be to complete the admission assessment as soon as convenient after the client presents to the facility. It should include a physical assessment of current health status including skin integrity.
- The Vcare[11] nursing care plan was not completed. Although assessments were completed, not all relevant information was transferred to the care plan. The deficits in the care plan could be attributed to a lack of information.
- Information about Mrs A's behaviour was detailed in the lifestyle questionnaire but not in the care plan. The opinion states: "It is very important in the care of people with dementia to have clear information about behaviours and to highlight potential areas of conflict with other residents and requirements for care."
- The Vcare nursing plan should have been changed to reflect changes in Mrs A's health status, or a short-term care plan should have been used instead.
- Medication reconciliation is expected with every admission and discharge in residential aged care. The medication reconciliation should have included allergies and adverse drug reactions. The GP should have been contacted to ascertain which medications Mrs A should have been taking and, if required, to request an updated list of prescribed medications signed by the GP.
- There is a variation across aged care facilities in the use of progress notes, and no requirement to write daily progress notes unless to document changes in health status or other changes. The progress notes were adequate. However, it "would make sense" to document the date and time on which a respite resident arrived, and any other relevant information.

[11] Vcare is software for rest homes and retirement villages. It allows for electronic management of care plans.

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- It is usual practice for incident forms to be completed and a nursing assessment to occur whenever injuries occur or are discovered. If the injury is likely to have a significant impact on the person's health status, the registered nurse completes a full assessment, seeks a medical opinion, fills in an incident form and notifies the facility manager or clinical coordinator. The opinion also stated: "[N]otifying the DHB would be considered mandatory and should be conducted with urgency."
- Timely, clear and thorough communication with the appropriate family members by senior staff should have occurred, acknowledging the seriousness of the incident during which Ms C assaulted Mrs A.
- Following the incident on Day 6/Day 7, the registered nurse should have completed a full skin assessment to ascertain the extent of the bruising. The opinion states:

  > "In cases such as this we would expect that once the assessment was completed the Registered Nurse would contact the GP providing a full report of her assessment including the finger markings so that he could make an informed decision about intervention."

- The assessment of Mrs A and the tools used were adequate for a medically stable person receiving respite care, and the progress notes were adequate.
- Overall, the care provided by CHT was of an adequate standard in the circumstances.

99. CHT further provided a legal opinion on the employment issues regarding Ms C, which states that CHT acted as a fair and reasonable employer in respect of the mid 2013 incident, and that it did all that it could to minimise the potential harm to residents, bearing in mind the information available at the time. It stated that if CHT had removed Ms C from night duty following the incident in mid 2013, she would have had "a relatively strong unjustified disadvantage claim against CHT". The legal opinion also stated that, had CHT dismissed Ms C at that time, the Authority or a court would have been likely to have found that she had been unjustifiably dismissed.

100. CHT submitted that Ms C did not require training on abuse and neglect following the mid 2013 incident because she did not intend to physically abuse the resident, and there was no question of neglect. It stated that it identified that Ms C "had received relevant training and knew what to do, there was simply an issue in putting her training into practice in the particular situation that arose … the key issue that was identified by CHT … at the time was [Ms C's] issues with patient intimacy and sexuality. Therefore, this was the key area where CHT noted that additional training may be helpful for [Ms C], not abuse and neglect."

101. CHT submitted that, as Ms C had been through a disciplinary process in mid 2013, during which she was "chastised for her wrongdoing and counselled on what was expected of her", and had received additional training and supervision, she was well aware of the issues with her performance and what was expected of her moving forward. It submitted that the lack of a performance appraisal in 2013 had no bearing on the incident with Mrs A.

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102. CHT disputed the finding that its policies do not provide sufficient detail, and said they are intended only to provide guidance, and not to cover every eventuality. CHT stated that it is advisable to draft policies broadly, "to provide employers with flexibility". It stated: "[I]t is apparent that the safety of residents is paramount to CHT's policies."

103. CHT submitted that it considers that its disciplinary policy is fit for purpose and does not require any amendment. It considers that its "Standard of Care" policy covers abuse and neglect, and it provides training on challenging behaviour, deescalation skills, abuse and neglect.

104. CHT submitted that its current policies and code of conduct material encourages a culture of asking questions and reporting concerns.

Opinion: Ms C — Breach

105. The core issue in this case is Ms C's treatment of Mrs A overnight on Day 6/Day 7.

106. On the evening of Day 6, Mrs A was wandering and went into another resident's room, which made the other resident uncomfortable and aggressive. Mrs A became frightened and hid in the bathroom, so Ms D took her to the dining room.

107. Ms D said that, at around midnight, Ms C told Mrs A to stop talking and, when she continued talking, Ms C attempted to put Mrs A to bed. Ms D said that Ms C was angry, grabbed Mrs A's arms, pulled her up, and took her to her room. Ms D stated that Mrs A shouted, "Leave me alone."

108. Ms D stated that while Ms C and Mrs A were in Mrs A's room, Ms D heard a bang and Mrs A screaming and shouting, "Leave me alone it hurts it's sore don't punch me." When Ms D went to Mrs A's room to see what was happening, Mrs A was sitting on her bed, breathing with short breaths and rubbing her leg. Ms D asked Mrs A what had happened, and Mrs A said: "She punched me, she pressed me and pulled my hair."

109. The following day another healthcare assistant, Ms N, spoke to Mrs A, who said that the night nurse was very rough. Mrs A showed Ms N the bruises on her upper arms. Ms N asked Mrs A what had happened, and she said that it was the night nurse with short hair. When asked what the nurse did to her, Mrs A told Ms N that the nurse grabbed her upper arms and pushed her, told her to go to her room and go to sleep, and punched her knees.

110. Mrs A consistently described having been physically abused by a night nurse with short hair. CHT identified HCA Ms C as the staff member matching Mrs A's description. I find the consistency in Mrs A's accounts of the cause of her injuries compelling, and it is supported by the evidence of Ms D.

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111. Ms C told CHT that she did not cause the injuries on Mrs A's arms and leg, but she may have caused a bruise when Mrs A pulled away from her when she tried to resist being put to bed. However, Ms C later told Police that she had caused the bruising on Mrs A's upper arms, and that she had caused the bruising on her upper thigh. When asked how she caused the thigh bruising, Ms C motioned slapping her upper thigh and stated that this was "hard" because she wanted Mrs A to stop kicking at her. Ms C denied that she punched Mrs A's leg or that she told Mrs A to "shut up". Ms C acknowledged that she forced Mrs A to bed when she should not have, and that she "didn't follow the patient's rights". Ms C subsequently pleaded guilty to a charge that she assaulted Mrs A on or about Day 6.

112. As this Office has stated previously: "[I]t is … plainly unprofessional to physically assault a patient. This is so fundamental that it requires little further comment."[12] Furthermore, the Health and Disability Services (Core) Standards[13] place an obligation on providers to ensure that "[c]onsumers are kept safe and are not subjected to, or at risk of, abuse and/or neglect".

113. I acknowledge that working with an agitated and uncooperative resident can be challenging. However, the use of unreasonable force is completely unacceptable — whatever the circumstances. Furthermore, there was a marked imbalance of power between Mrs A, an elderly dementia patient, and Ms C, an experienced healthcare assistant. People with dementia can be particularly vulnerable to abuse, and the fact that the person has dementia can make it harder to establish whether abuse is taking place, and by whom.

114. Ms C's response to the situation was clearly inappropriate. To act in this way towards an elderly and vulnerable patient is a very serious departure from fundamental professional and ethical standards, and is clearly unacceptable. In my view, Ms C failed to provide services to Mrs A that complied with professional and ethical standards and, accordingly, she breached Right 4(2) of the Code.

Opinion: CHT Healthcare Trust

115. Mrs A resided at the Hospital for respite care from Day 1 - Day 9. During that period she suffered a number of injuries. CHT had a duty to provide Mrs A with services of an appropriate standard. I have concerns about the services provided to Mrs A by multiple CHT staff.

Standard of care — Breach

Admission assessment and care planning

116. The assessment record completed on the day following Mrs A's admission contains contradictory information. For example, the assessment record states that there was

[12] 05HDC13588 and reiterated in 07HDC20395 and 12HDC01008, available at www.hdc.org.nz.

[13] NZS 8134.1:2008, standard 1.3.7.

HDC

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"no wandering", and yet the family had advised that Mrs A was very fast and could walk off and get lost quickly. I have considered CHT's submission that there was no issue of wandering because Mrs A was in a secure facility and was not at risk of wandering out of the facility. However, I note the comments of my expert nursing advisor, RN Howard-Brown, that "assessing the extent or nature of wandering is important because it will provide information to inform care planning, for example, such as to whether the resident may wander into other residents' rooms".

117. I note that no progress notes were recorded on the day of admission. CHT submitted that the only contractual requirement for residents in dementia level care is to have a progress note entered at least weekly or more frequently if there is a reason to do so. However, RN Howard-Brown stated that it is usual practice for rest home and dementia services to have at a minimum one progress entry each day. I also note the opinion of RNs Q and R, as provided to CHT, that it would "make sense" to document in the progress notes the date and time on which a respite resident arrived, and any other relevant information.

118. There was confusion about the medications taken by Mrs A, in that she had four prescriptions covering a period of three months, but the medications provided by the family were not consistent with those prescriptions. However, CHT staff did not carry out a medicines reconciliation, and discarded the inconsistent medications. RN Howard-Brown advised that a medicines reconciliation is required under the Medicines Care Guides for Residential Aged Care, and stated: "[F]urther action should have been undertaken rather than simply discarding some of [the medications]." I note that in their opinion for CHT, RN Q and RN R also advised that medication reconciliation is expected with every admission and discharge in residential aged care, and that the medication reconciliation should have included allergies and adverse drug reactions.

119. RN Howard-Brown also noted that the initial care plan did not contain details about Mrs A's behaviour and preferences, which her family had told CHT staff. RN Howard-Brown noted that in order to provide appropriate care to dementia residents, detail about preferences and behaviours and de-escalation techniques are very important, and should be documented in the care plan, and the care plan should be updated in response to changes in the resident's condition. RNs Q and R also noted that the nursing care plan had not been completed, as not all relevant information from the assessments had been transferred to the care plan. RNs Q and R also noted that information about Mrs A's behaviour had been detailed in the lifestyle questionnaire but not in the care plan. Their opinion states: "It is very important in the care of people with dementia to have clear information about behaviours and to highlight potential areas of conflict with other residents and requirements for care."

120. RN Q and RN R opined that the assessment and tools used were adequate for a medically stable person receiving respite care, and that the progress notes were adequate. However, they were of the view that best practice would be to complete the admission assessment as soon as convenient after the client presents to the facility, and that it should include a physical assessment of current health status including skin integrity.

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Management of injuries

121. RN Howard-Brown advised that there was insufficient follow-through in relation to the bruise on Mrs A's head after the family alerted staff that the bruise was new. Although the injury to Mrs A's head was originally thought to have been there at the time of admission, on Day 3 family members told RN I that this was incorrect. RN I checked but found no incident reports or progress notes to suggest that Mrs A had suffered a head injury since her admission, and told the family that no incidents had been reported. RN Howard-Brown advised me that Mrs A's care plan should have been revised at that time.

122. On Day 6, Ms B raised concerns about a bruise on Mrs A's left index finger. RN K appears to have noted the bruising, but did not undertake further assessment other than recording that Mrs A denied having any pain. In response to the provisional opinion, CHT submitted that no further assessment was warranted because when RN K spoke to Mrs A she said she had done it herself while working in the kitchen, and it was not causing her any pain or discomfort. I note RN Howard-Brown's comment that "[a]ny reported injury of a dementia resident needs a more thorough assessment than [an injury of] someone who is a reliable historian that can explain the event". I remain of the view that there was insufficient investigation of the injury to Mrs A's finger.

123. RN I assessed Mrs A on the morning following the incident overnight on Day 6/Day 7, during which Ms C physically abused Mrs A. RN I contacted Dr M and advised him of the swelling on Mrs A's left leg. There is no evidence that RN I informed Dr M of the allegation that Mrs A had been "bashed" on the knee, or that she had other injuries associated with alleged physical abuse. Dr M advised that Mrs A's leg should be elevated and bandaged, and that there was no need for any medication, but that if there was no reduction in the oedema within two days then an X-ray should be arranged. Dr M was not contacted again in relation to Mrs A's injuries. I accept RN Howard-Brown's advice that appropriate measures were not put in place following the incident to ensure that a thorough nursing and medical assessment of Mrs A occurred. RN Howard-Brown stated that a short-term care plan should have been developed at that time, to ensure appropriate onward observation and management of Mrs A's injuries; this was not done, nor was Mrs A's initial care plan updated in response to changes in her condition.

124. I also note that RN Q and RN R considered that the registered nurse should have completed a full skin assessment to ascertain the extent of the bruising. They stated:

> "In cases such as this we would expect that once the assessment was completed the Registered Nurse would contact the GP providing a full report of her assessment including the finger markings so that he could make an informed decision about intervention."

125. Although the unit manager, Ms J, was informed of Mrs A's injuries, she did not assess Mrs A or speak with her family. RN Howard-Brown advised:

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> "[I]n such a serious incident, current accepted practice would include the most senior clinical staff member having a high level of direct involvement. If this had occurred, a full assessment, appropriate referral to the general practitioner and better communication with the family could have been anticipated."

126. RN Q and RN R were also of the view that timely, clear and thorough communication with the appropriate family members by senior staff should have occurred, acknowledging the seriousness of the incident. They also considered that "notifying the DHB would be considered mandatory and should be conducted with urgency".

127. I am also concerned that Ms D did not take any action at the time of the physical abuse of Mrs A, despite having observed and overheard Ms C abusing Mrs A. Ms D did not report the incident overnight, and did not complete an incident form. In my view, in light of the vulnerability of residents, particularly those suffering from dementia, it is essential that staff are encouraged and empowered to report any abuse.

Incident reporting

128. No incident report was completed in relation to Mrs A's finger injury, and the incident report filled in on the morning of Day 7 does not reference Mrs A's complaints that the bruising was caused by a staff member. The records of this incident in the clinical notes are more detailed than in the electronic incident record. RN Howard-Brown noted that the electronic incident report form omitted clinically relevant information.

Conclusion

129. The initial care plan and incident reports did not contain adequate information, and the initial care plan was not updated to take into account changes in Mrs A's condition. The medication management was suboptimal, and CHT staff failed to assess Mrs A's injuries adequately, and to manage them appropriately. In my view, CHT is responsible for these multiple failures by its staff and, accordingly, I find that CHT did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Risk of harm — Adverse comment

130. I note that Ms C had appropriate orientation and initial training, and I accept that she had completed ACE dementia training in 2010.

131. CHT's Standards of Care policy and its Residents' Accident/Incident Procedure both referred to abuse and neglect. RN Howard-Brown advised that the policies are consistent with current practice; however, she noted that they did not provide sufficient detail, for example, to consider the safety of other residents or the notification process to the funder, DHB and Police, or the involvement of Age Concern or Advocacy Services. In response to the second provisional opinion, CHT disputed that its policies do not provide sufficient detail, and said they are intended only to provide guidance, and not to cover every eventuality. CHT stated that it is advisable to draft policies broadly, "to provide employers with flexibility".

132. CHT was aware that an allegation had been made that Ms C had physically abused a resident in the dementia unit in mid 2013. Ms C was suspended the day after the

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incident while the incident was investigated. In response to the provisional opinion, CHT noted that the subsequent disciplinary investigation found both that physical abuse was not proven and that Ms C "did not wilfully intend to abuse" the resident. Following a disciplinary meeting, Ms C was issued with a formal warning for failing to follow the correct process and either use the emergency button to summon someone to assist her or leave the resident to calm down.

133. Ms C remained on night duty, and she underwent further training, including continence and toileting, health and safety, training in understanding dementia and associated behaviour, challenging behaviour, manual handling, moving and handling, Code of Rights — privacy and dignity/informed consent and advocacy, and accident and incident reporting. Although these steps are not documented, I accept CHT's submission that Ms C was rostered to work shifts with RN O, who supervised her and provided her with four sessions of on-the-job training on sexuality and intimacy.

134. I accept that, following the mid 2013 incident, CHT responded appropriately by commencing a disciplinary investigation. I also accept that, following its investigation, CHT provided Ms C with additional training and support relevant to what it identified as key issues arising out of the mid 2013 incident. However, I note that the training Ms C underwent following the incident did not address issues concerning abuse and neglect. In response to the second provisional opinion, CHT stated that it was not necessary to provide Ms C with additional training on abuse and neglect following the mid 2013 incident because Ms C did not intend to physically abuse the resident and there was no question of neglect.

135. RN Howard-Brown advised:

> "[I]t is unclear why actions were not taken to provide additional training on abuse and neglect or increased supervision given as a precautionary measure as rough handling and witnessed behaviour of [Ms C] that another staff member had reported as abusive."

136. Notwithstanding CHT's finding that Ms C "did not wilfully intend to abuse" the resident, in response to the second provisional opinion, CHT provided information that during the investigation Ms C acknowledged that she physically restrained the resident and that she knew she was not allowed to do so. The resident was found to have bruising to both upper arms and left outer thigh, a skin tear on her left hand, and an injury on her forehead. Ms C agreed that she had held the resident's shoulders and accepted that the marks on the resident's upper arms and left hand were from her actions. In these circumstances, I remain of the view that Ms C should have received additional training on abuse and neglect following the mid 2013 incident.

137. Despite the incident in mid 2013, Ms C did not undergo a performance appraisal in 2013. I note CHT's submissions that the lack of a performance appraisal in 2013 had no bearing on these events. However, I remain of the view that regular appraisal meetings are a valuable tool for providing feedback to employees, and would have been particularly valuable for Ms C following the earlier incident.

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138. I note that although Mrs A referred to other residents potentially being abused by Ms C, in her conversation with Ms N on the morning of Day 7, there is no evidence that this was followed up by CHT at that time.

Communication with family — Other comment

139. Mrs A's family have some concerns about CHT's communication with them. In particular, Ms B stated that when she contacted Ms J a couple of weeks after Mrs A's discharge from the Hospital, she was not offered an apology or sympathy for what her grandmother had been through. As noted by RN Howard-Brown, while a family member was notified of two incidents involving Mrs A, that family member was not the primary contact person or Mrs A's Enduring Power of Attorney for Personal Care and Welfare, as identified in the clinical records. Nevertheless, I accept that unsuccessful attempts were made to contact Mr F.

140. Furthermore, I note that the unit manager, Ms J, did not contact Mrs A's family on Day 7, after she was informed of Mrs A's injuries. CHT has accepted that its communication with the family was not optimal, and noted that it sent a letter to Ms B in early 2014.

141. RN Howard-Brown advised:

> "The position description for the unit manager includes having a functional relationship with residents and maintaining competency in clinical practice and to contribute to direct patient care as required. Although a Saturday, in such a serious incident, current accepted practice would include the most senior clinical staff member having a high level of direct involvement."

142. I accept RN Howard-Brown's advice. I am concerned at the poor level of communication by CHT staff with Mrs A's family.

Opinion: Ms D — Adverse comment

143. Ms D was on duty in the dementia unit with Ms C at the Hospital overnight on Day 6/Day 7. To her credit, when she became aware that Ms C had physically abused Mrs A, she intervened and took Mrs A back to the lounge.

144. However, I am concerned that Ms D did not take any further action at the time of the abuse, despite having observed and overheard Ms C abusing Mrs A. Ms D did not report the abuse incident to the registered nurse on duty overnight, did not complete an incident form, and did not mention it at staff handover at the end of the night shift. The records state: "[N]o other concerns to report." However, I acknowledge that Ms D told CHT management about the incident when she was interviewed a few days after Mrs A's discharge from the Hospital.

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145. It is the responsibility of all members of the healthcare team to speak up immediately when they become aware of circumstances that place residents at risk. I am critical that Ms D did not do so, and that she did not document the incident appropriately.

Recommendations

146. I recommend that Ms C apologise to Mrs A's family for her breach of the Code, with the letter to be sent to HDC for forwarding to the parties within three weeks of the date of this report.

147. I recommend that CHT Healthcare Trust apologise to Mrs A's family for its breach of the Code, with the letter to be sent to HDC for forwarding to the parties within three weeks of the date of this report.

148. In my provisional report I recommended that CHT Healthcare Trust:

a) Review the effectiveness of its processes for medication management. CHT advised that it has reviewed its practice relating to medicine administration and documentation at the Hospital.

b) Review its employment/disciplinary policy and make appropriate changes to reflect its duty to minimise risk to residents. CHT advised that its disciplinary policy reflects the duty to minimise risk to residents.

c) Develop a training schedule to ensure that all staff receive ongoing training in challenging behaviour, de-escalation skills, abuse and neglect. CHT advised that these matters are part of its mandatory training programme. It advised that all mandatory training is now up to date for the Hospital staff, and this is checked in a monthly unit review with the CEO and by six-monthly internal auditing.

149. I further recommend that CHT Healthcare Trust comply with the following recommendations, and report to HDC within three months of the date of this report:

a) Provide regular refresher training to staff on the abuse and neglect policy.

b) Include in its ongoing refresher training for all staff, information that the practice in CHT Healthcare is that the asking of questions and reporting of concerns is expected and accepted from all staff.

c) Supply a copy of the training material in relation to abuse and neglect.

d) Review the effectiveness of its processes for assessments and care planning, and reinforce to staff the importance of clear, accurate documentation.

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Follow-up actions

150.
- Ms C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

- A partially anonymised copy of this report, naming CHT Healthcare Trust and the expert who advised HDC on this case, will be sent to the DHB, and it will be advised of Ms C's name in covering correspondence.

- A partially anonymised copy of this report, naming CHT Healthcare Trust and the expert who advised HDC on this case, will be sent to HealthCERT (Ministry of Health), and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided not to issue proceedings.

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Appendix A — Independent expert nursing advice to the Commissioner

The following expert advice was obtained from Registered Nurse Ms Christine Howard-Brown. The information in italics was added by RN Howard-Brown after reviewing CHT's submissions in response to the provisional opinion:

"Thank you for your request on behalf of the Commissioner to provide an opinion on a number of issues related to the complaint concerning [Mrs A]. I am a registered nurse, lead quality auditor and hold a Masters of Business Administration. I have worked in secondary and tertiary care hospitals including community services as a clinical nurse specialist, nursing advisor and duty manager before I commenced working as a quality auditor in health and disability services in 2003. The majority of my experience in aged residential care relates to service reviews, programme evaluations, service improvement initiatives, audits and inspections undertaken in the last eleven years. I am also a part time PhD candidate at Otago University. My thesis relates to primary healthcare and aged residential care.

To the best of my knowledge I have no personal or professional conflict of interest. I have read and agree to follow the Commissioner's Guidelines for Independent Advisors.

I have reviewed the information documented on file including the background to this complaint, sequence of events and issues presented in the letter requesting an opinion.

I have been asked to provide an opinion on the appropriateness of the standard of care, policies and procedures, training of the Health Care Assistant (HCA), response to the incident, findings of [the DHB's] investigation and appropriateness of the management of an earlier incident. I have been asked to make recommendations for improvement of systems and policies at [the Hospital] and make any additional comments.

To support my opinion I have referred to the Family Violence Intervention Guidelines Elder Abuse and Neglect 2007, Ministry of Health; the *Community Health Transitional and Support Services — Short Term Residential Care Services for People in Contracted Residential facilities Tier Level two Service Specification*, Aged Related Residential Care Services Agreement for the Provision of Aged Related Residential Care 2013; the Health and Disability Services (Safety) Act 2001; The Health and Disability Services Standards NZS8134:2008; Medicines Care Guides for Residential Aged Care 2011, Ministry of Health.

Brief factual summary

[Mrs A] (82 years old) was admitted to the dementia unit at [the Hospital] on [Day 1] for respite care.

On [Day 3], registered nurse [RN I] noted a bruise on the back of [Mrs A's] head. An event report notes the bruise seemed to have been there since prior to admission as it looked old. [RN I] questioned [Mrs A's] family about the bruise and they suggested it was an old bruise from a previous surgical event. However the next day the family were concerned that the bruise had appeared while [Mrs A] was at [the Hospital]. [RN

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I] checked and found no incident reports or progress notes to suggest [Mrs A] had suffered a head injury since her admission.

On [Day 6], [Mrs A's] granddaughter, [Ms B], raised concerns about a bruise on [Mrs A's] left index finger. When asked by [RN K], [Mrs A] reported she had hurt her finger while undertaking 'kitchen duties'. However, [Ms B] reported to [RN K] that her uncle, [Mr F], witnessed an altercation when [Mrs A] entered another resident's room that 'would have turned physical if he wasn't there to intervene'.

HCA Ms D was on duty overnight on [Day 6/Day 7] with Ms C.

At around 7.30am on [Day 7], HCA [Ms H] reported to [RN I] that [Mrs A] had some bruising on her body, and that [Mrs A] had reported she was treated roughly by the night nurse with the short hair and had been bashed on the knee. An event report was filled out detailing that an HCA had found bruising on both of [Mrs A's] upper arms and a scratch on her lower left arm. It is unclear when the report was filled in, or by whom, but the event time is recorded as 8.00am.

[RN I] examined [Mrs A's] knee and noted her left leg was swollen and that the swelling was 'shiny'. [RN I] contacted [Mrs A's] GP, [Dr M], requesting an X-ray. [Dr M] suggested the swelling was likely to have been caused by her known medical problems including heart failure and gout, and recommended elevating and bandaging the leg. He suggested if there was no reduction in oedema in two days to request X-ray or GP review.

An event report was filled out at 7.00pm by [RN P], detailing that a HCA had found bruising over [Mrs A's] left thigh.

CHT provided this Office with a copy of the minutes of a meeting, which took place [a few days after Mrs A's discharge from the Hospital], between [Ms D] and [the Hospital] manager, [Ms J]. It is recorded that on the night of [Day 6/Day 7], [Ms D] witnessed [Ms C] argue with [Mrs A] in the lounge about her refusal to go to bed. [Ms D] stated that [Ms C] grabbed [Mrs A's] arms and pulled her into her room. She heard a bang in the room, and [Mrs A] shouting "leave me alone it hurts its sore don't punch me". [Ms D] stated she went into the room and saw [Mrs A] taking short breaths and rubbing her leg. [Ms D] said she asked what happened and that [Mrs A] told her, 'she punched me, she pressed me and pulled my hair'. [Ms D] took [Mrs A] back to the lounge.

[Ms B] and [Mrs A's] daughter, [Ms G], visited [Mrs A] at 7.30am on Day 9. They were concerned about her swollen knee, and decided to take her to the public hospital. [Mrs A] was discharged home from the public hospital [Day 10]. She was taken back to the public hospital [the following day] having suffered a stroke. [Mrs A] died [in early 2014].

CHT investigated the alleged assault by [Ms C]. [Ms C] was dismissed from her employment with CHT due to serious misconduct. The matter was referred to the Police and [Ms C] has been charged with common assault.

Previous issue

It was alleged by other staff that [Ms C] physically abused another resident at [the Hospital] in mid 2013. CHT investigated the incident and it was decided that [Ms C] did not wilfully intend to abuse the resident; however, she did not follow the correct

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process and use the emergency button to summon assistance from another staff member.

Complaint
[Mrs A's] granddaughter, [Ms B] complained to HDC and CHT. Her complaints are:

1. That [Mrs A] received unexplained injuries while in [the Hospital].
2. That the stroke [Mrs A] subsequently suffered was as a result of the 'excessive bruising and neglect of [the Hospital staff].
3. That [Mrs A] was admitted to [the Hospital] with 21 days' supply of sleeping tablets, but was only returned 10 days' supply when she was discharged.
4. That when she contacted [Ms J] [a couple of weeks after Mrs A's discharge from the Hospital], and was told a female staff member was dismissed as a result of [Mrs A's] bruising, [Ms J] did not offer her an apology or sympathy for what her grandmother had experienced.

Further information
[The] DHB undertook an investigation into [Ms B's] complaint. The key findings were that CHT took appropriate actions to address an episode of potential physical abuse. However, the investigation identified that, due to lack of documentation, effective and timely communication with [Mrs A's] family could not be evidenced.

Opinion on specific questions posed by the Commissioner
1. Did [the Hospital] provide [Mrs A] with an appropriate standard of care?

Admission process
Progress notes were not recorded on the day of admission and there was one other day where there were no progress notes. It is usual practice for rest home and dementia services *and consistent with Health and Disability Services Standards* to have at a minimum one progress entry each day.

An admission assessment was undertaken the day following admission. *The service specification relevant for respite residents requires an assessment to be completed within 24 hours of admission*. The assessment record contains contradictory information. For example, it includes 'no wandering' yet special instructions on the consent form from the EPOA states 'my nan is very fast and can walk off and get lost quickly'. *Assessing the extent or nature of wandering is important because it will provide information to inform care planning, for example such as to whether the resident may wander into other residents' rooms*. The assessment stated four medications taken in the last 24 hour period yet [Mrs A] had seven medications prescribed. *The service specification relevant for respite residents requires a complete medication reconciliation on admission of which no documentation of this was provided for review*. The falls risk assessment was inaccurately *recorded* which resulted in a low falls risk as opposed to medium risk. The recorded history of falls was inadequate and subsequently did not inform care planning. The assessment states [Mrs A] as being continent but other records state chronic urinary incontinence.

An initial care plan was developed the day following admission. Wandering was included in the care plan but it did not contain details about [Mrs A's] behaviour and preferences which were contained in other documents completed by the family. It is not unusual for respite residents' care plans or initial care plans to be less detailed than

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long term [residents'] care plans. However to provide appropriate care to dementia residents, detail about preferences and behaviours and de-escalation techniques are very important and should have been documented in the care plan. The care plan provides no instructions for management of continence[1] (and makes no mention of [Mrs A's] increased risk of cerebral bleed as documented in a discharge summary from [the] DHB [prior to Mrs A's admission to the Hospital]. *Information from [the] DHB that provided this information may or may not have been available to the facility.*

Medications

It was stated in the investigation report that the reason for medications being discarded was due to them not matching what was prescribed. However, there is no documentation of this. It is not uncommon for respite residents' medications not to reconcile with what is prescribed. A medication reconciliation is *required and* usually undertaken which at the very least would include discussion with the prescriber or pharmacist who has dispensed the medication. The Medicines Care Guides for Residential Aged Care includes a section on medicines reconciliation which states that medicines reconciliation should be carried out when residents go to and from care (i.e. all admissions, transfers and discharges). As there were four prescriptions covering a period of three months which were relied upon by [the Hospital], and medications provided by the family were not consistent with these prescriptions further action should have been undertaken rather than simply discarding some of them. The EPOA should have been informed of any changes or discrepancies.

Unexplained injuries

There was insufficient follow-through about the bruise on [Mrs A's] head as although the family initially thought this to be an old blemish when they visited the following day, they alerted staff that they thought this was new. The care plan was not revised to reflect the increased supervision of [Mrs A] that was discussed with the family and documented in the progress notes.

There was insufficient investigation of the injury to [Mrs A's] finger. *Any reported injury of a dementia resident needs a more thorough assessment than someone who is a reliable historian that can explain the event.*

In response to new bruising on [Mrs A's] arms it appears the registered nurse examined the bruises identified by the HCA but did not do a full assessment. Later that day additional bruising was found and also reported. There was no record of this bruising being reported to the family.

The general practitioner, although called was not given sufficient information as the advice provided was not related to injury management. *The RN should have required an assessment for suspected abuse.*

A short term care plan was not developed in response to [Mrs A's] injuries which required pain relief, some bandaging and observation. Developing a short term care plan is a contractual requirement and is current accepted practice where a resident's condition changes.

[1] Eg. *that Mrs A required prompting for the toilet … or why she needed pull-ups or the size/ frequency they should be changed.*

HDC

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Notification to family
A family member was notified of two incidents but this was not the primary contact person or EPOA as identified in the notes *as it was reported the phone of the primary contact person was out of service*. Other family members visited and were concerned. Documentation does not include that they were offered the opportunity or given information to make a complaint as per [the Hospital] policy. Progress notes include references to an apology and that an investigation would commence.

CHT did not treat the family's concerns as a verbal complaint. In not doing this, the complaints process was not used.

Unit manager
A registered nurse informed the unit manager of [Mrs A's] injuries on [Day 7]. She provided advice but did not assess the resident or speak with the family. The position description for the unit manager includes having a functional relationship with residents and maintaining competency in clinical practice and to contribute to direct patient care as required. Although a Saturday, in such a serious incident, current accepted practice would include the most senior clinical staff member having a high level of direct involvement. If this had occurred, a full assessment, appropriate referral to the general practitioner and better communication with the family could have been anticipated.

Medication errors
Consistent with the investigation by [the] DHB, records indicate medication errors occurred during [Mrs A's] stay. There were two occasions where there is no record of medicine administration. There is another instance of either a documentation error or an administration error as the incorrect dose was recorded as administered. There are no incident forms or reporting of these events.

Incident reporting
Incident forms were completed for three events. A hand written incident form for one event has more detail than the copy in the electronic reporting system. The electronic incident form omitted clinically relevant information. There was another reported injury in the progress notes that did not have a corresponding incident report. The witnessed abuse of [Mrs A] by the other HCA was also not reported but disclosed at the investigation. Incident records were not recorded as closed-out but this may be because the investigation overrode the completion of the incident review process.

Staffing levels
A copy of CHT's skill mix and roster policy was not available for review. However, correspondence on file includes a requirement for two staff to be on duty within the dementia unit at all times to ensure a safe environment. There are multiple references to night staff working alone within the dementia service for periods of time when the second staff member goes to help in the hospital service.

Conclusion
It can be concluded that [Mrs A] did not receive an appropriate standard of care from [the Hospital] as staff other than [Ms C] did not provide reasonable care consistent with current accepted practice or as contractually required. Most rest homes would tend to use the complaints process to help document and manage correspondence

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where concerns had been raised by the family who were clearly distressed and unhappy with the situation.

Incomplete reporting and assessments that result in insufficient information to guide care and safety of a resident would be considered a significant departure from accepted practice for a dementia service.

2. Did [Ms C] provide [Mrs A] with an appropriate standard of care?

By [Ms C's] own admission she abused [Mrs A]. Some of the physical and verbal abuse was also witnessed by another HCA (who failed to report this). Although suffering from dementia, [Mrs A] was also able to provide an account of her abuse to more than one staff member that identified [Ms C]. [Ms C's] actions do not comply with legal obligations, health and disability services standards or company policy.

It can be concluded that [Ms C] did not provide [Mrs A] with an appropriate standard of care.

3. Did [the Hospital] have appropriate policies and procedures in place to prevent incidences of resident abuse?

Policies and procedures provided are consistent with current accepted practice. *The Standards of Care policy (last revised [early] 2014) includes a section on abuse and neglect. The Standards of Care policy and Incident and Accident procedure which also includes management of abuse and neglect do not* provide sufficient detail, for example, to consider the safety of other residents or the notification process to the funder, DHB and Police or involvement of Age Concern or Advocacy Services. *The Standards of Care policy does however reference the Age Concern publication 'Elder abuse and neglect — a handbook for those working with older people' stating this is available as a reference in each residential unit.*

A copy of the Health and Disability Services Standards surveillance audit report indicates there were no findings at the certification audit made in respect of policies and procedures.

It appears that there are mandatory training requirements at [the Hospital] that support staff receiving ongoing training in abuse and neglect, Code of Rights, challenging behaviour, restraint minimisation and cultural safety. Each of these areas have a close relationship in ensuring staff have the necessary training to prevent resident abuse. The surveillance audit found cultural safety training and restraint minimisation validation training were not current for all staff.

Training schedules *provided* for review for 2013 *show in-service training included manual handling, code of rights, accident and incident reporting, death and dying, understanding dementia and associated behaviour, pain management and health and safety with good attendance rates.*

4. Did [Ms C] have appropriate training for her HCA role, in particular, training in relation to de-escalation of difficult behaviours, working with dementia patients, and the use of restraint?

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Orientation
[Ms C] commenced casual employment with CHT in late 2007 as a HCA. Records reviewed included signed checklists and orientation questions which indicated she received an orientation consistent with requirements of the Aged Residential Care Services Agreement. It is not clear whether [Ms C] commenced work in the dementia unit or the hospital service and when she commenced full time employment with CHT. This is likely to be available through payroll information but was not provided for review.

Training and performance appraisals
[Ms C] completed Aged Care Education NZ (ACE) programme requirements throughout 2007 and 2008 before gaining the National Certificate for Support of the Older Person Level 3 in 2009 and four NZQA Dementia Care Units in 2010 which are required of HCAs working in dementia services.

Within her human resources records there were a number of additional certificates of attendance for a variety of in-service training sessions completed in 2009–2012. During this time [Ms C] received training in safe patient handling, incidents and accidents documentation, Code of Rights, complaints, and stress. She also attended a series of four seminars for care assistants in Palliative Care and an Alzheimer's NZ Behaviours that Challenge course in 2011. There is an undated and unsigned questionnaire on challenging behaviour and de-escalation unsigned and not dated competency assessment for the minimisation and safe use of restraint. A medication administration competency test was completed in 2012.

[Ms C's] performance appraisal for 2012 identified a goal to complete the ACE Advanced National Certificate in Dementia. The appraisal noted her in-service training dates against CHT requirements. Restraint training was recorded as last provided in late 2010, challenging behaviour in mid 2011, and abuse and neglect in late 2011. By CHTs requirements, restraint training was due and others due in 2013.

There were four performance appraisals provided for review dated 2009, 2010, 2011 and 2012.

A performance appraisal due in 2013 was not provided for review. *Training records provided for 2013 showed [Ms C] attended one hour sessions on moving and manual handling, challenging behaviour, code of rights/privacy/informed consent/advocacy, accident and incident reporting, death and dying, understanding dementia and associated behaviour, pain management and health and safety/hazard ID.*

There was an undated questionnaire completed for continence and toileting.

Conclusion
It can be concluded that [Ms C] had an appropriate orientation and training specific to dementia care during her employment. Evidence *was provided of on-going training in challenging behaviour and dementia. There was no evidence of on-going training* in abuse and neglect since 2011 and restraint since 2010. The Restraint Minimisation and Safe Practice Standard requires on-going education including alternative interventions to restraint and prevention and/or de-escalation techniques. Both the Health and

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Disability Services Standards and Aged Related Residential Care Services Agreement require ongoing education.

Her last performance appraisal was overdue.

5. Was the incident of [Day 6/Day 7] appropriately responded to by CHT, and have appropriate measures been put in place since the incident?

Initial actions
The HCA who identified bruising, appropriately reported this to the senior staff on duty and an incident report was completed. The assessment by the registered nurse was not well documented and doesn't appear to have been a full assessment.

It appears that incorrect information was provided to the general practitioner and that there was not an insistence that the general practitioner come and undertake an assessment of [Mrs A].

A care plan was not updated or written to ensure appropriate onward observation and management of [Mrs A's] injuries. However, progress notes indicate care was provided.

Safety of others
Information provided by CHT does not indicate that any assessment was undertaken as to the safety of other residents in the dementia service. Age Concern or Advocacy Services were not used to support such an assessment or to provide additional training to all staff. Additional training is warranted because a HCA had not reported the incident of suspected abuse.

Family notification
The primary contact and EPOA were not contacted *(but an effort was made to contact them)* and other family members were contacted. The family's concerns were not adequately managed by the service. This ultimately led to them seeking a medical assessment by taking [Mrs A] to the public hospital. The complaints process was not used.

Onward actions
It was appropriate that [Ms C] was suspended from full duties pending an investigation and that this was done prior to her next shift.

As this was a serious event, the DHB should have been notified with immediate effect as required under the Aged Related Residential Care Services Agreement. The DHB was made aware of the event through a complaint raised by the family with the DHB [a few days after Mrs A's discharge from the Hospital]. The Police were notified [a few days later]. Upon notification to the Police there is no record in the documentation provided that [the Hospital] notified the Ministry of Health although this is stated as having occurred in the DHB investigation report.

Conclusion
It can be concluded that CHT partially responded appropriately to the incident in that the staff member was suspended, an incident report completed, a limited assessment occurred and an investigation was commenced. Appropriate measures were not put in

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place following the incident to ensure a thorough nursing and medical assessment of [Mrs A] occurred and that the safety of other residents was determined and staff training provided. Communication with family was insufficient and the complaints process was not used. Notifications to the funder did not occur.

6. Do you agree with the findings of [the] DHB investigation report and do you have any further comments to add regarding that investigation?

Two investigation reports are on record. The second report is an extension to the first in respect of the complaint related to [Mrs A's] medications.

The first investigation report provides a good timeline of events but did not comment on several aspects you would anticipate. For example, why the DHB had not been notified of the event with immediate effect at the time of the incident; why CHT failed to have [Mrs A] medically reviewed and why the unit manager had not taken a more active role in the management of the event at the time (despite it being a Saturday).

Issues of insufficient documentation and communication were addressed in part. The investigation found no documented evidence of medicine reconciliation and determined that the reasoning given by CHT as to why medication was missing was plausible and made no recommendation. Additionally, the issue that another HCA witnessed some abuse and had heard an altercation in [Mrs A's] room and had gone into the room to find her distressed and in pain but did not report this was not addressed.

It was noted that CHT's response to the event in addition to [Ms C's] dismissal had been to send a memo to staff reminding them of a zero tolerance of abuse and an amendment to its employee code of conduct had been made. No comment was made about the need for additional training for staff in relation to abuse and neglect and reporting obligations consistent with its own policy.

The CHT investigation did not provide any assurance that other residents had not been abused. Age Concern or Advocacy Services had not been involved. The DHB investigation report made no comment on these factors.

A detailed review to identify or failure to report medications not being administered as prescribed was not covered in the first investigation report.

There were no recommendations or requirements arising from the DHB investigation other than completing two actions — one to send a letter to the complainant and another to evidence staff are aware of CHT's complaints policy in respect of a verbal complaint. Other factors noted such as there being no short term care plan and missing progress note entries had no corresponding requirements.

In my opinion the DHB investigation should have been an on-site investigation. This may have assisted in gaining a level of assurance that other residents had not been abused and were not at risk, and an opportunity to determine the extent of risk associated with the multiple issues arising from the complaint. On the basis of my findings above, I am not in agreement with all the findings and conclusions reached from the DHB investigation. For example the DHB investigation report concludes that

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appropriate steps were taken in respect to identifying the incident of physical abuse, and following up with an investigation and actioning the investigation findings.

The second investigation report included an on-site visit and demonstrates a comprehensive review which resulted in appropriate recommendations in relation to medication management which I am in agreement with.

7. Did CHT respond appropriately to the earlier incident of alleged abuse by [Ms C] on a resident ([mid] 2013)?

There was a witnessed account of *alleged* abuse to another resident by [Ms C] in [mid] 2013. A disciplinary process was followed. This included notification and meetings with [Ms C] who also had union representation. However, records reviewed do not indicate the DHB was notified of the incident which should have been considered serious requiring notification under the Aged Related Residential Care Services Agreement. In the account described, it was clear that the resident concerned had sustained a physical injury and *was not treated respectfully*. The physical *injuries sustained* were of a similar nature to that of [Mrs A].

[Ms C] was apologetic and stated she was aware of the current policies and expectations for managing challenging behaviour and that her behaviour had gone beyond rough handling. *The result of the investigation by CHT was that the allegation of physical abuse was not proven. [Ms C] was issued with a written warning for failing to follow the correct process. Her disciplinary record was not available to review, however, information provided by CHT indicates the incident was associated with physically handling a resident when trying to re-direct them from another resident's room and training in the following months occurred.*

Irrespective of [Ms C's] apology, it is unclear why *actions were not taken to provide additional training on abuse and neglect or increase supervision given as a precautionary measure as rough handling and witnessed behaviour of [Ms C] that another staff member had reported as abusiv*e. It would be usual practice for the HCA to be taken off night duty *for a period of time to complete additional training without having to come into the facility on days off or interrupting sleep patterns and have higher levels of supervision*.

From the documentation available to review, it can be concluded that the incident of abuse that occurred [in mid] 2013 was managed as a handling issue. There was insufficient enquiry as to whether this was an isolated event. CHT *potentially* put residents at risk through its inaction in response to this event. The management of this event is inconsistent with current accepted practice and CHT policy.

The management of this event would be considered a significant departure from expected practice.

8. Do you have any recommendations for improvements of systems and policies that could be made at [the Hospital] (if you consider these are necessary)?

This case demonstrates system and policy implementation failures across the service which contributed to the abuse of [Mrs A]. The safety of other residents in the

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dementia unit could not be assured by the investigation processes that followed *alleged* abuse in [mid] and *substantiated abuse* in [late] 2013.

There are multiple improvements required to assessment, care planning, medication management, family communication, escalation processes, incident reporting, documentation and training *(especially in abuse and neglect; restraint minimisation)*. The issues primarily relate to policy and procedure implementation and ensuring on-going training for staff. In addition to improvements in service delivery, it is also recommended that the incident and accident procedure is updated to include more detail about the management of abuse or neglect or to alternatively develop a separate policy and procedure related to the prevention and management of abuse or neglect.

9. Are there any other matters regarding the care provided by [the Hospital] or [Ms C] to [Mrs A] that you consider warrant comment?

I have no further comments.

Christine Howard-Brown”

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