Registered Nurse, Mrs B

Registered Nurse, Ms C

Oceania Care Company (No 1) Ltd

(trading as Villa Gardens Home and Hospital)

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC17105)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mrs A was admitted to Villa Gardens Home and Hospital in 2002 with her husband. When he died in 2004, Mrs A was exhibiting symptoms of dementia. In December 2006, Mrs A was reassessed and transferred to the Villa Gardens dementia unit. In July 2007, Mrs A's family became concerned about her physical, mental and emotional condition and made a number of complaints to the Villa Gardens management. In October 2007, Mrs A's condition deteriorated further. On 18 December a consultant psychiatrist undertook a psychiatric assessment of Mrs A and noted that she had not had a shower in over 12 months and was taking only about 75% of her prescribed antipsychotic, quetiapine. The decision was made to reassess Mrs A on 9 January 2008 for a final decision about her ongoing care. On 9 January, Mrs A was reassessed by the psychiatrist with view to transfer to a suitable facility. After discussion and legal advice about the manner of the transfer, an agreement was reached between the psychiatrist and the family. Mrs A was transferred later that day to the psychogeriatric ward at the public hospital under the Mental Health (Compulsory Assessment and Treatment) Act 1992.

Complaint

On 17 January 2008 the Commissioner received a complaint from Mrs D about the services provided to her mother, Mrs A, by Villa Gardens Home and Hospital (Villa Gardens). The following issues were subsequently identified for investigation:

Whether Villa Gardens Home & Hospital Facility Manager, registered nurse Mrs B, provided Mrs A with reasonable treatment and care in 2007, and responded appropriately to complaints about her care.

Whether registered nurse Ms C provided Mrs A with reasonable treatment and care in 2007.

Whether Oceania Care Company (No 1) Ltd[1] *[trading as] Villa Gardens Home & Hospital provided Mrs A with reasonable treatment and care in 2007.*

An investigation was commenced on 21 October 2008.

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

[1] During the period under investigation Villa Gardens was owned by Eldercare Green Valley Services Ltd. On 30 May 2008, Eldercare Green Valley Services Ltd changed its name to Oceania Care Company (No 1) Ltd.

The parties directly involved in the investigation were:

Mrs A	Consumer
Mrs B	Provider/Registered nurse/Villa Gardens Facility Manager
Ms C	Provider/registered nurse

Information was reviewed from:

Mrs D	Complainant/consumer's daughter
Mrs E	Consumer's daughter
Ms F	Consumer's daughter
Mrs G	Consumer's daughter
Mrs B	Provider/Villa Gardens Facility Manager
Ms C	Provider/registered nurse
Ms H	Oceania Care Company South Island Operations Manager
Ms I	Oceania Care Company Group Quality & Risk Manager
Ms J	DHB Funding & Planning Advisor
The public hospital	

Others mentioned in this report:

Ms K	Nurse Manager/Villa Gardens
Ms L	Eldercare South Island Operations Manager
Mr M	Registered nurse
Dr N	Medical practitioner
Dr O	Consultant psychiatrist
Dr P	Consultant psychiatrist
Ms Q	Dietitian
Dr R	Clinical Director for Older Persons Health, the DHB
Ms T	Eldercare Director of Nursing
Ms S	Registered nurse, Acting facility manager
Ms U	Registered nurse, Facility manager

Independent expert advice obtained from registered nurse Dr Stephen Neville is attached as **Appendix A**.

Information gathered during investigation

Villa Gardens Home and Hospital

Villa Gardens Home and Hospital (Villa Gardens) provides hospital, rest home and dementia care. Villa Gardens has 40 hospital level beds, 28 dementia care beds and 26 rest home beds. Eldercare Green Valley Services Ltd (Eldercare) purchased Villa Gardens on 9 September 2005. Eldercare merged with another company, and was rebranded as Oceania Care Company, on 30 May 2008.

Villa Gardens' management
In 2005 registered nurse Ms C was working as a charge nurse in the hospital wing of Villa Gardens. She was appointed as the Care Manager in 2006 with overall responsibility for clinical care. Ms K was the Nurse Manager at Villa Gardens. The date that Ms K resigned as manager is not known, but while Eldercare was in the process of appointing a replacement, Ms C had a dual role as Care Manager and Acting Nurse Manager.

Mrs B was appointed by Eldercare as the Facility Manager in June 2007. Mrs B had previously worked in Auckland in aged care management positions. At Villa Gardens she was responsible for maintaining occupancy, staff appointments, and ensuring that expenditure was within budget. She also had overall responsibility for ensuring a quality service was provided.

After Mrs B's appointment, Ms C continued in her position as Care Manager. From June 2007 until January 2008, Mrs B was supported in her role by Eldercare South Island Operations Manager Ms L. The Operations Manager has oversight of business and quality. In January 2008, Ms H replaced Ms L.

Mrs A

Background
Mrs A had ischaemic heart disease, high blood pressure, and vascular and Alzheimer's type dementia. Two of her daughters, Mrs E and Ms F, had been jointly appointed as having enduring power of attorney (EPA)[2] for her care. Mrs E was the nominated first contact for any decisions.

2006 — increasing dementia
In July 2006, Registered nurse Mr M[3] initially completed a Lifestyle Plan for Mrs A. This focussed on her socialisation and managing her behaviour. The plan was updated at six-monthly intervals.

[2] Despite the restriction in section 98(2) of the Protection of Personal and Property Rights (PPPR) Act 1988, which provides that only one individual can act as an attorney, no steps were taken to resolve who was the attorney.
[3] Mr M was employed by the previous owners of Villa Gardens, to work 20 hours per week to write care plans for the dementia and rest home residents. The remaining 20 hours per week he was engaged in maintenance at the facility.

Mrs A had lived in the rest home section of Villa Gardens, with her husband, since June 2002. Care Manager Ms C stated that Mrs A's dementia became more evident over time. Mrs A was unwilling to take medication, to shower or wash, and she refused to allow staff to care for her husband. Staff had to distract her and remove her from the room so that they could attend to her husband. He died in May 2004.

On 10 August 2006, a Diversional Therapist devised a plan to manage Mrs A's challenging behaviours. The plan instructed staff to approach Mrs A in a "calm, friendly manner and tell her who you are and the task you want her to do. If she becomes angry, walk away and try again later." Care Manager Ms C recalls that the therapist recommended that Mrs A might be better suited to a smaller family-type environment, but the family would not agree to transfer Mrs A to another facility.

Mrs D advised that she obtained a list of suitable dementia facilities from the Alzheimer's Society and, with Mrs E, contacted and visited all the suitable facilities. At the time there was a shortage of dementia beds in the area and no vacancies. Mrs A's name was added to the waiting list of a number of facilities. Mrs D stated, "It was a case of not having anywhere to move our mother to, **not** that we would not agree to move our mother."

On 25 August 2006, the Villa Gardens resident medical practitioner, Dr N, recorded that Mrs A had "increasing dementia and behavioural problems", and proposed that she be referred for reassessment with a view to transfer to a dementia care unit. Mrs A's daughter, Mrs D, stated that she and her sisters had problems coming to terms with their mother's dementia.

On 31 August a family meeting was held to discuss Mrs A's ongoing treatment and management. Mr M and Ms C met with Mrs A's daughters, Mrs E, Mrs D and Ms G. Mr M and Ms C discussed the difficulties in getting Mrs A to bathe, caused by her fear of water, and suggested that a pre-run bath plus medication, such as Oxazepam, to reduce her anxiety and stress, might be the answer to the hygiene problems. Mrs A's Lifestyle Plan was also discussed and it was noted that when she had been last weighed in July, she was 61kg. Ms C advised that Mrs A had twice refused to be weighed in August.

Mrs D stated that at this meeting Villa Gardens "insisted" that the family sign an advance directive form. It included, "not for resus". Mrs D recalls being reluctant to sign the "nil fluids" section of the form to be enacted if her mother was dying, because of the circumstances of her father's death and the family's philosophy regarding the benefit of intravenous fluids in the final stages of life.

Mrs D said that she would weigh her mother when she took her home at the weekend. Mrs A's food intake was also discussed, and the family were advised that a food chart would be started. The family agreed that Mrs A would be reassessed by the public hospital's Psychiatric Services for the Elderly team with a view to transferring her to the dementia unit; that she would be gradually introduced to the dementia unit, and

that medication would be tried before stress-inducing activities, "only after notifying [Mrs E] first".

A written record of the 31 August meeting was provided by Villa Gardens. However, the Care Plans, medication administration forms and nursing progress notes for this period were not provided to HDC. The frequency of administration of anti-anxiety medication to Mrs A, and the efficacy of the medication, is not known.

On 16 October, the public hospital's Psychiatric Services for the Elderly assessor assessed Mrs A, noting that she needed 24-hour rest home care in a facility with "specialised dementia knowledge and secure boundaries".

On 25 October, Dr N noted, "Major management problem associated with nocturnal restlessness and increasing inappropriate behaviour". He prescribed the sedatives haloperidol and oxazepam (as required) for Mrs A.

On 29 November, Mrs E gave written permission for her mother to be trialled on a mild dose of haloperidol to manage her agitation. Mrs E stated that although she consented to the trial after discussing the issues with Villa Gardens Manager Ms K, Ms C and Dr N, she wanted to be consulted before the frequency or strength of dosage was increased.

On 20 December, Ms C made an urgent referral to the public hospital's Psychiatric Services for the Elderly team noting the October assessment, and that consultant psychiatrist Dr O had suggested that Mrs A be given risperidone and lorazepam 45 minutes before attempting to transfer her from the rest home to the dementia unit. In that letter, Ms C stated:

> "We have had no success with the Lorazepam as it has caused over sedation, and the Risperidone required to be halved again due to side effects. Today the family have stated that all meds are to be stopped and we are now left with a resistant resident due to be transferred into the Dementia Unit on 28 December and no plan of action to achieve this successfully. Our GP needs your assistance in this matter urgently."

On 21 December, another consultant psychiatrist, Dr P, wrote to Ms C suggesting key strategies for managing the transfer: moving familiar belongings such as photos rapidly to the new room to help orientate Mrs A, familiarising her to new key staff, and enhancing the family input to smooth the transition. Dr P also recommended that Mrs A be given a two-week course of haloperidol, 0.5–1mg per day, to "take the edge off aggression and suspiciousness". He advised that if this was given for only one to two weeks, it would be "unlikely to cause significant side effects". He also recommended short-acting oxazepam (which is less potent than lorazepam) to settle her distress when reassurance by staff and family failed.

Dr P stated:

> "Medication may well help, it is just a question of what dose and what medicine. If medicines were not to be used at the advice of family, then family really need to make themselves available as the key non-pharmacological strategy to make this move successful."

Mrs D stated that Mrs A's family were not privy to the consultations regarding moving her to the dementia wing, or Dr P's involvement and recommendations. She recalls speaking to Ms K to ask what action plan was in place for the move and was told there was no plan. Mrs D said that she made some suggestions, which were subsequently followed. She recalls that the family was told not to visit Mrs A for a week, in contrast to Dr P's recommendations.

Transfer to dementia care

On 27 December 2006, Mrs A was transferred to the Villa Gardens dementia unit. The Lifestyle Plan, updated on 18 December 2006, instructed staff to document the type of behaviours encountered and how the issues were resolved. Staff were instructed to remove food trays from her room after all meals, and to check drawers and under the bed for discarded food. On 12 December, Ms C added, "Check [Mrs A's] room on Wednesday after she goes out with her sister."

The plan also noted:

> "Staff will follow a plan to direct [Mrs A] to the small lounge to eat with two other residents. Staff will encourage [Mrs A] to the small lounge before putting other residents up to the dining room tables, so this enables staff to have the time to assist [Mrs A] to her meal."

Initially Mrs A appeared to settle in the unit, but she later became verbally aggressive and suspicious of any physical contact. Mrs A would not allow cleaners in her room, and was hiding dirty dishes in her dressing table drawers. If unsupervised, she would wear the same clothes for days on end, and would secrete soiled clothing in her room. Mrs A's daughters visited frequently to assist the Villa Gardens staff to feed her and attend to her personal needs, including laundry and cleaning her room.

The records show that there were regular discussions and meetings with the family. During February there were three recorded discussions with Mrs A's daughters, Ms F, Mrs D and Mrs E, about their mother's dietary requirements.

Referral to dietitian

On 16 February 2007, Ms C conducted a mini-nutrition assessment on Mrs A, noting her weight to be 60kg, with a body mass index of 26, which equated to her being at medium risk of malnutrition. Ms C made a referral to dietitian Ms Q for a review of Mrs A's nutritional requirements.

On 11 March, Ms Q reported her assessment of Mrs A to the public hospital's Psychiatric Services for the Elderly consultant psychiatrist Dr O. Ms Q noted that Mrs A ate very little, and preferred to have her meals in her room where she hid food in

her drawers or disposed of it down the toilet. Ms Q recorded in her report that Mrs A had had a "significant" weight loss from 60kg to 54kg, over six months. She stated that she would meet with the family to discuss management strategies for when Mrs A absolutely refused to eat. Although Mrs A's family told Ms Q that their mother would not accept nutritional supplements, she asked Dr O to make an application for a specialist nutritional supplement for Mrs A and to advise her when this was done.

Mrs D stated that the meeting with the dietitian was an "affront" to the family because the dietitian suggested that the family "would want an input" into Mrs A's care. At that time the family were providing their mother with food and ensuring that she was eating.

There is no record in the documentation provided to HDC that Dr O made the application for the nutritional supplement.[4]

Medication

Ms C advised that during the early months of 2007 Mrs A's behaviour became unmanageable. She was "cheeking"[5] her medication and then hiding it in her room. Mrs A was refusing to wash and change her clothes, or to be weighed or have her blood pressure taken. She would push staff out of her room. Ms C recalled one occasion when Mrs A became aggressive and chased her down the corridor when she collected the cups and saucers from the room.

Ms C recalled one occasion where Mrs E handed her tablets wrapped in a tissue, which she had found in Mrs A's room. Ms C stated that the tablets were "well sucked and it was difficult to discern what medications they were". She discussed this matter with the dementia unit team leader. Ms C stated that when Mrs A refused her medication this was documented and reported to Dr N.

On 19 March, Dr N recorded that Mrs A was to start a trial of the antipsychotic quetiapine. (The medication prescription and administration sheets, and progress notes for this period have not been provided; therefore the date and frequency that the medication was given cannot be verified.)

On 20 March 2007, Ms F wrote to Ms K about Dr N's decision to trial her mother on a daily dose of the antipsychotic quetiapine. (Mrs E had consented to the trial.) Ms F advised Ms K that she had discussed the issue with her sisters, Mrs G and Mrs D, and they were not comfortable with the decision, stating that they had not been given the opportunity to discuss this matter before the decision was made.

Consent

On 21 March, Mrs E wrote to Ms K advising that after talking to someone from the dementia unit she would agree to her mother being given "carefully monitored" mild medication if this would help her to be more responsive to eating and personal cares.

[4] It is assumed that he did so as the progress notes provided refer to Mrs A being given the nutritional supplement Fortsip from 15 July.
[5] Hiding medication in her cheek and later spitting it out.

She noted that if the rest of the family disagreed with this decision, she would abide by their decision, "on the basis that they take full responsibility for the outcome".

There is no evidence that Villa Gardens' staff considered administering the quetiapine using subterfuge, which is common practice in these circumstances,[6] or that they were aware that as the medication was intended to prevent serious damage to health, Mrs E could not refuse consent. When the consent she gave was conditional and inconclusive, no steps were taken to clarify the decision-making authority.[7]

On 30 March, Dr N noted that Mrs A was exhibiting "some" improvement on quetiapine and that she was leaving her room more, but was still resistant to cares. He instructed staff to continue with the regular quetiapine in the meantime.

On 11 April, Ms F again wrote to Ms K, noting that her mother had started a "week trial of quetiapine at a daily dose of 12.5 milligrams from 23 March 2007". Ms F stated that she had discussed her mother's reaction to the quetiapine with the dementia unit registered nurse on 30 March, and had been advised that her mother had been given a further week of the drug. Ms F said that she had not seen "any improvement" in her mother's eating habits and she requested a written report on the steps taken, "other than the Quetiapine to ensure [Mrs A's] daily nutrition is maintained and further weight loss avoided".

Mrs D advised that she talked to Dr N about her mother's care and lack of hygiene. He prescribed a sedative, which Mrs D was to give her mother half an hour before attempting to wash her hair. Mrs D recalls that around this time the dementia wing team leader told her that Mrs A had already been charted this medication. Mrs D stated, "There was obviously a lack of communication and also a potentially dangerous situation with the risk of double dosing. I was not privy to Mum's medical information even though [Mrs E] had signed a directive that all sisters could view records."

Ms C advised that a further family meeting was arranged and agreement was reached that Mrs A could be medicated 30 to 40 minutes prior to any intervention, provided the family were advised beforehand. A week later, Mrs A's family requested that the medication be stopped because Mrs A was becoming drowsy. Ms C had explained to the family that this was a short-term effect. She recalls that once the medication was stopped Mrs A's aggression increased. Mrs D stated that Ms C had made an assumption that the family opposed medication. They did not oppose it but wished to be informed before a decision was made to increase the dosage.

Ms C stated that after Mrs A attacked Mrs E, throwing her across the room, Mrs E agreed to her mother being given a regular dose of quetiapine. The "Doctor's Prescribed Medication" sheet records that the dosage of the antipsychotic quetiapine,

[6] This is what was subsequently done with success at the public hospital.
[7] An EPA cannot refuse permission for standard medical treatment intended to prevent serious damage to health (PPPR Act s18).

which had been prescribed for Mrs A, was reviewed a number of times from June 2007. On 11 July 2007, the quetiapine 25mg was increased from half a tablet in the morning to half a tablet three times daily at breakfast, lunch and dinner. On 13 July, this was increased to a whole tablet at breakfast and lunch, and a half tablet at dinner on trial for a week. Mrs A's reaction to the medication was then to be reviewed. The PRN (as required) drug sheet shows that Mrs A was also prescribed the sedative haloperidol 0.5mg.

Mrs B stated that she and Ms C discussed their concerns about Mrs A's behaviour with Dr N, who decided to increase her quetiapine.

On 14 July, a registered nurse recorded on the "Communication with Families/Friends/Agents" form that Mrs D asked if Mrs A could be given her oxazepam[8] prior to being taken for a haircut. The registered nurse recorded that he advised Mrs D that her mother's quetiapine had recently been increased and he would need to assess the effect of this before giving her the medication.

On 20 July, the progress notes record that a visiting medical practitioner had increased Mrs A's quetiapine dosage. Staff were instructed to document any mood changes.

On 16 August the nursing progress notes record that when a staff member tried to remove a "few cups" from Mrs A's room that morning, Mrs A hit her over the head. Ms C telephoned the duty assessor at the public hospital's Psychiatric Services for the Elderly (PSE) to discuss options for managing Mrs A's behaviour. A few days later she telephoned Dr O, who recommended that Mrs A be given antipsychotic medication. Ms C advised him that the family had insisted that Mrs A was not to be medicated.

Mrs A's quetiapine was further reviewed and increased on 12 September to two 25mg tablets at breakfast and lunch and one at dinner, and on 14 December to a 100mg tablet at breakfast and again at dinner.

On 7 January 2008, Mrs E wrote to express her concern that Dr O had increased the sedation dose without her consent, and reiterated that her instruction of 21 March 2007 regarding sedation dosage still stood.

Family concerns

Throughout this period, Mrs A's family continued to be concerned that the care being provided to their mother in the Villa Gardens dementia unit was not meeting her needs. They wrote to the Villa Gardens nurse managers frequently and met with senior staff to discuss their concerns.

On 11 April 2007, Ms F wrote to Ms K to remind her that at the meeting on 22 March (which Mrs D also attended) she had agreed to arrange for a social worker and

[8] The medication prescription form shows that the PRN oxazepam was discontinued on 20 July 2007.

diversional therapist to see her mother. Ms F wanted to know what progress had been made on these arrangements.

There is no record that Ms K replied to the five letters received from Ms F and Mrs E between February and April 2007.

On 12 July 2007, Mrs D and Ms F wrote to the newly appointed Villa Gardens Facility Manager, Mrs B, outlining their concerns about their mother's care. The letter provided Mrs B with background, stating that a mouse was seen in their mother's room on 9 June 2007 and caught by the family a few days later. Staff had also reported seeing the rest home cat bringing a mouse in the window. On 2 July and 11 July the family had found Mrs A's appearance "unkempt and unclean" and her room in a dirty state. Badly soiled underwear and towels had been found in her dressing table drawers. Mrs D said that on one occasion she found 23 cups, saucers and plates, some containing whole meals that were obviously days old, in drawers and cupboards in her mother's room.

Mrs D stated that on 2 July she asked the staff to clean the room while she took her mother for an outing. When she arrived back with her mother, Mrs D found that her mother's bathroom walls, floor and vanity were still smeared in faeces. She said she had to clean her mother's rooms herself.

Mrs D wrote that she was also concerned about her mother's weight loss. She said that when Mrs A was admitted to the Villa Gardens dementia wing she weighed 61kg. Mrs D wrote:

> "She is now 53.9kg. Mum is being fed 3 times a week during the day & a couple of evenings a week by family as staff say that Mum will not eat for them & is not drinking her Fortsip. This is evident by bottles of Fortsip being left full or coagulated."

Mrs B stated that when she started as the Villa Gardens Facility Manager at the beginning of June 2007, she knew little about the dementia unit. She said:

> "Sometime in July, about 5 o'clock, I had a phone call from [Mrs D], asking if she could come and talk to me. I said of course she could. She came with her sister [Ms F] and they sat in my office and talked and said that they didn't feel that their mother was being cared for properly, that she hadn't had a shower for a year, the room was dirty, all those things. I said that I didn't know but that I would look into it. We talked until nearly seven and I said I'd get back to her.
>
> So the next day I called … the team leader in the Dementia Unit. … I was told, 'Oh, you don't want to deal with that family'. … I said, 'Well tell me about [Mrs A]'. [The team leader] and [Ms C] said that she had a water phobia. She hadn't had a shower any of the time she had been at Villa Gardens. … [was] very aggressive, unmanageable, often wouldn't let staff near her, was violent. I

> said to them, 'Well we can't just leave that, we need to get her reassessed.' And all they said was 'No, she had a reassessment in January and there's nothing more to be done.'"

On 18 July, Mrs B wrote to Ms F including a copy of her mother's medication charts and Dr N's clinical records, which she had requested at a meeting earlier that week.

On 22 July, the progress notes record that Mrs A was confused and incoherent. Mrs D visited at 1pm and found that her mother had a swollen tongue and that her left eye was black. She discussed her concerns about her mother's condition with a nurse. Ms C, who checked Mrs A at 3pm, recorded that she had assessed the state of Mrs A's eye and tongue and found nothing seriously wrong.

Mrs B said that she spoke to the staff again about Mrs A at the end of the month and asked for an update. She was told that Mrs A was "much better than she was".

On 27 July, Mrs B wrote to Ms F and Mrs D to update them, as she had undertaken to do. Mrs B noted that she had spoken to them both over the previous two weeks about their concerns regarding their mother's care. She stated:

> "As you are aware your mother has presented some challenging behaviours over the last months which have prevented the staff carrying out her personal cares and cleaning her room to an acceptable standard. Staff attempted to manage these behaviours with a number of strategies but have been unsuccessful in achieving an acceptable standard of hygiene and cleanliness.
>
> We have also had concerns regarding the safety of [Mrs A] and staff and fellow residents due to these behaviours, and as you are aware following consultation with both yourselves and the GP, have commenced a medication regime.
>
> Re the mouse in [Mrs A's] room, once we have solved the problem of food being left in the room I am hopeful this will resolve, I have however contacted a pest control company for advice re an ongoing pest control programme.
>
> While [Mrs A's] lack of appetite has been of concern it is good to note since being on the current medication her appetite has improved."

Mrs B advised HDC that the Eldercare policy was that all complaints were to be notified to the Operations Manager, and all response letters had to be approved by her before being sent. Mrs B discussed her concerns about Mrs A with Operations Manager Ms L. She stated that Ms L told her to leave the clinical care to the Care Manager, Ms C, and concentrate on the business. Mrs B said that Ms C was responsible for sending reassessment referrals. She resented Mrs B becoming involved in the clinical management of residents.

Reassessment

In November, Mrs B called a meeting with the dementia unit team leader and Ms C to discuss Mrs A. Ms C told Mrs B that Mrs A's behaviour was "still no different"; she was not showering or allowing staff to clean the room. Mrs B recalls that she told Ms C, "We have to put a referral through for reassessment. We have to pass this one to someone else, we can't just leave it." Mrs B completed the referral to Dr O, and advised Mrs E of her decision to have Mrs A reassessed.

On 12 December, Mrs A's Lifestyle Plan was updated with a supplementary page completed by Mr M, noting the steps staff needed to take to ensure that Mrs A took her medications. He noted that if Mrs A refused to take her medications, staff were to document this on the drug sheet and behaviour monitoring form.

Mrs D recalls that she, Ms F and Mrs G met Dr N on 13 December to ask for their mother to be reassessed. She said, "at no time did [Dr N] inform us that a reassessment has already been instigated four weeks previously."

Mrs B recalls Dr O telephoning her at about 3pm on 18 December to say that he could see Mrs A that afternoon. Shortly afterwards, Dr N called at Villa Gardens and told Mrs B that he had had Mrs A's two daughters, Ms F and Mrs G, in his office saying that they wanted their mother reassessed, and that they wanted to be present for the assessment. Mrs B telephoned Dr O to advise him of this request. Dr O stated that he would prefer the family not to be present because this was an emotional situation. Mrs B told him that she would talk to Mrs E and ask her if she agreed to him assessing Mrs A without the family. Mrs E agreed to this. Mrs B left a message for Mrs D that Dr O was conducting the assessment that afternoon.

Dr O reassessed Mrs A. In his assessment report (copied to the family), he noted:

> "Taking care of [Mrs A's] hygiene needs has become very difficult. I was told that she has not showered for over a year although she continues to carry out some washing herself (staff suspect this is mainly just sprinkling herself with talcum powder). She brushes her hair, feeds herself, toilets herself and dresses/undresses herself, but the quality of this self-care has declined. She has occasional faecal incontinence, but it is very difficult to assist with this or to ensure regular changes of underwear. Cutting her nails poses an extreme challenge, and is frankly dangerous."

He also considered Mrs A's medication and noted:

> "She has been prescribed quetiapine 50mg 0800 & 1200hrs [8am and midday] and 25mg 1700hrs [5pm] for the last several months (along with several other medications), but her adherence is poor, especially in the mornings. At best she actually takes about 75% of her quetiapine. The staff feel quetiapine helps a little if [Mrs A] takes it, but resistiveness and (?paranoid) anger persist nonetheless."

Dr O advised Dr N and Mrs B of the result of his assessment, noting that Mrs A's "dementia-related disabilities (both physical and behavioural) sadly have progressed somewhat". Dr O noted that her daughters "remain attentive and concerned for their mother's care and welfare, and are naturally very stressed about the difficult situation. They do what they can to help in a practical sense with care tasks, although I have to question the wisdom and safety of this." Dr O noted that this situation had led to stress and tension within the family. He stated:

> "I think [Mrs A] cannot be safely managed within a dementia rest-home care environment as things stand. … I have discussed this case with my specialist colleagues at [the public hospital] and all are agreed to this."

Dr O went on to say that there was a 25 percent chance that more assertive medication might allow Mrs A's placement at Villa Gardens to continue in the short term. He noted that he had explained the side effects of this medication to Mrs E and Ms F and advised them that if the more assertive medication plan combined with ongoing "creative ways to assist [Mrs A] with personal cares" did not work, then there would be no choice but to make arrangements to move Mrs A. They were agreeable to this plan. Dr O noted that should replacement be required, it would need to be done via a planned admission to the mental health unit at the public hospital, so that a comprehensive overview of care needs and specialist management options could be undertaken. Dr O stated that he would make a final decision about these matters on 9 January 2008.

On 21 December, Mrs B wrote to Mrs D in response to her letter about the assessment process. Mrs B apologised to Mrs D for distress that the short notice might have caused and explained that she had been advised only at 2.30pm that Dr O could be available to visit at 5pm. Mrs B advised that she had talked to Dr O about Mrs D's wish to be present for the reassessment, but he would not be available again until mid-January 2008. Mrs B stated, "Given [Mrs A's] difficult behaviours and the concern this has been causing I did not believe it was in anyone's best interest to wait until mid January 2008." Mrs B noted that she had had permission from Mrs E to go ahead with the reassessment.

Mrs D stated that Mrs B had telephoned her at 4.09pm to advise her about the reassessment, one hour after the assessment had taken place. Mrs D was unaware that Mrs E had given permission for the assessment to go ahead, but both Mrs B and Dr N were aware that she had wanted to be present. Mrs D stated, "A breakdown in family communication [was] made worse by [Mrs B's] involvement."

On 7 January 2008, Mrs E wrote to Mrs B to complain that when she had visited her mother at lunchtime that day (7 January) she was upset to find her in bed fully clothed and deeply asleep. Her lunch was on the dresser untouched. Mrs E observed that her mother did not appear to be eating or drinking.

On 7 January 2008, a Villa Gardens Dementia Unit enrolled nurse faxed Dr O a timeline of care issues relating to Mrs A's behaviour. She summarised her report stating:

> "[Mrs A's] condition appears to be more frail. She is eating less. She has been spending a large amount of time in her bed fully clothed, refusing any help with cares. She had in the past ventured out of her room down the corridor. She has mouth ulcers, only on two occasions since 28th December [and she has] taken Nilstatin for this. Since 25/12/2007 [Mrs A] has only refused her medications two times."

On 8 January, Dr O advised Mrs E and Mrs D that he had arranged for their mother to be transferred to the public hospital under the Mental Health (Compulsory Assessment and Treatment) Act 1992. Mrs E said that the way he described the process was very worrying. Mrs D was also upset by her conversation with Dr O.

Mrs B stated that when Dr O decided that Mrs A needed to be moved to the mental health unit, the family were very distressed, angry, and resistant to this decision. Mrs B recalls that Mrs D believed her mother had only mild dementia and that her behaviour was caused by the way she was treated.

Mrs D stated that the family was not in a position to make an informed decision about moving Mrs A to the Mental Health Unit, as they were never given the opportunity to discuss what that entailed. She said she was fully aware of the degree of her mother's dementia, as she had read extensively about the subject, joined the Alzheimer's Society and attended a monthly support group. However, she believes that some of her mother's behaviours were caused by the way she was treated at Villa Gardens.

Transfer to the public hospital

When Mrs B arrived at Villa Gardens at 8.20am on 9 January, her administrator advised her that Dr O and Mrs A's family were in her office. Mrs B recalls that Dr O spent a long time with the family trying to talk them into agreeing to transfer Mrs A to the public hospital mental health unit. They finally agreed to the transfer and, at 9.45am, Dr O gave Mrs A 200mg of quetiapine.

Mrs D stated that Mrs B's comments about the discussion that took place during this meeting between Dr O and the family are incorrect. Mrs D says that the family did not disagree with Mrs A being admitted to the mental health unit at the public hospital. However, they did not agree that she should be transported under restraint, by the Police if necessary. Mrs D wanted to take her mother in her car, but initially Dr O would not agree to that plan. However, after the family took legal advice it was agreed "by all concerned" that she should transport her mother with two mental health unit staff sitting in the back seat. Dr O gave Mrs A a quetiapine tablet (which Mrs D recalls was later found on Mrs A's dressing table) and Mrs D took her mother out of Villa Gardens and to the public hospital.

Mrs D stated: "Within 24 hours she [Mrs A] was medicated successfully, showered, clean and her dignity restored."

Complaint investigation
On 4 February Mrs B wrote to Mrs D to apologise for the delay in advising her of the outcome of her investigation of her complaints about her mother's care. Mrs B detailed the outcome of her investigation under the headings Medication, Room cleaning, Communication with team leader, dementia unit, Communication with family, Staff attitude, Personal cares and Complaint about a staff member. Mrs B summarised her investigation as follows:

> "Over the four months from July 2007 to referral for reassessment in November 2007 staff were concerned with [Mrs A's] increasing resistance in permitting staff to assist with her personal cares and cleaning of her room. This was discussed with medical staff and following consultation with [Mrs E] an increase in medication was trialled. When this did not result in a change of behaviour and following further consultation with [Mrs E] a referral for reassessment was sent. At all times staff attempted to do their very best for [Mrs A] in very difficult circumstances. I am pleased to hear she is now ready to leave PMH and wish her well in her new home."

Additional information

In July 2008, two HDC staff members met with Villa Gardens staff about concerns raised about the care provided to residents and patients at Villa Gardens Home and Hospital. The issues raised by Mrs A's family in their complaint were discussed. Caregivers who had cared for Mrs A advised that:

- Mrs A carried out her own personal hygiene cares
- she resisted any attempts to dress her or clean her room
- the family attended to many of her cares, such as washing her hair
- she rarely left her room and was scared of the other residents
- Mrs A would sometimes agree to take her medications, but often would not
- there was never any suggestion that caregivers would be allowed to conceal medicines in food and drinks.

Mrs B
Mrs B has been a registered nurse for 41 years, the last 14 of these in management roles. During the time she was managing a facility in Auckland she successfully ran both the clinical and business side of the facility for two years before a clinical manager was appointed. Mrs B stated that the position at Villa Gardens was offered to her by the then General Manager of Eldercare, who had been offering her positions in the company for some time.

Mrs B stated that shortly after arriving at Villa Gardens in June 2007, she became aware that there was resentment amongst the staff against the Eldercare takeover of Villa Gardens, and resistance against adopting the Eldercare policies and procedures.

Mrs B believes that this resentment was transferred to her as the new Facility Manager.

She found the clinical care at Villa Gardens "old fashioned", and that the care plans and clinical documentation were not up to standard. Mrs B stated that Villa Gardens was a difficult site with "deep rooted issues".

Mrs B said that from the time of her appointment, she encountered problems in establishing a harmonious team. The relationship between the Care Manager, Ms C, and the other registered nurses was dysfunctional. Mrs B said she was given little support from management in addressing these problems.

Mrs B discussed the staffing, documentation and care issues, at the weekly meetings, initially with operations manager Ms L and, from January 2008, with Ms H. Mrs B stated that the weekly meetings were documented and management plans were put in place.

She advised Ms L and, after January 2008, Ms H, about problems she was having employing registered nurses. (The minutes for the meeting on 29 January 2008 noted: "RN shortage. No response from advertising. 1 booked with Medcall. [Mrs B] to book another." There were further references about the need to hire more registered nurses in the February and March 2008 meetings.)

Mrs B felt that she "did not always have a lot of say in how things were going to be done", such as taking the Clinical Co-ordinator off clinical duties. Mrs B stated, "I probably should have put my hand up and said, 'Look, the staffing issues here are huge. I need someone to come in you know. I can't just walk in and clean it all up', which seemed to be the expectation."

Mrs B advised that she tried to talk to Ms C about the clinical care, care plans and documentation "not being up to speed", but found she was resistant to change and became abusive if challenged. Ms C told Mrs B that she had never been given any training for her position.

In 2008, as a result of discussion Mrs B had with Ms H, the Eldercare Facility Support Manager spent time at Villa Gardens working with Ms C.

On 20 February 2008, Mrs B and Ms H met with Ms C to discuss performance issues. Mrs B developed a Performance Improvement Programme for Ms C, with input from Ms H. The issues identified for improvement were human resources, service delivery and self management. Review dates were set for two-weekly intervals. Mrs B said that a lot of time was spent with Ms C regarding her performance, but at around the end of May 2008 she decided that she would not participate in the Performance Management Plan, and resigned.

In response to the provisional opinion, Mrs B stated that she "deeply regrets any distress" caused to Mrs A and her family, and said that her apologies to the family in previous correspondence have been "sincere and with great faith". Mrs B stated:

> "I do regret I did not insist on actioning a reassessment for [Mrs A] sooner. However, not only were the senior staff, who had cared for [Mrs A] longer opposing any action which would cause her to transfer out of the facility, but [Mrs E] who I had constant contact with was also against a reassessment and move. Nor at any time did the medical staff caring for [Mrs A] initiate a reassessment.
>
> I recall [Mrs E's] words to me when we discussed it, 'it's a high price to pay for hygiene'. The staff stated that '[Mrs A] was happy in her own little world' and it would be cruel to move her."

Ms C

Ms C stated that when she was appointed as the Care Manager in 2006, she was not given any training or orientation for the role, and was given very little support by senior management.

Ms C said that during the time she was the acting manager at Villa Gardens Home and Hospital, in early 2007, a Ministry of Health audit was conducted. She said that the audit report recommended increasing the number of registered nurse hours in the dementia unit, but she had no authority to implement the recommendation. (A copy of the audit report was not provided.)

Ms C stated that after Mrs B was appointed, staff who left were not replaced and Villa Gardens began to experience staff shortages. This resulted in senior nursing staff working extra shifts and long hours. Around December 2007, the dementia unit team leader, an enrolled nurse, resigned. The new team leader, also an enrolled nurse, had no experience in dementia care. When the registered nurse working in the dementia unit resigned, these duties were added to Ms C's responsibilities. Ms C stated that she was "on-call" every second weekend, and on her off-duty weekend she would frequently get calls from staff who were unable to contact Mrs B.

Ms C said:

> "I was constantly juggling my time and with the severe staff shortages I had an inability to deliver what I consider to be quality care. I also witnessed on many occasions instances where I felt staff were disrespected by the manager. Staff morale over this period was low and staff [resigned] from key positions prior to my own resignation and continued following it."

Ms C felt unsupported by Mrs B and said that communication between them deteriorated. Ms C said that Mrs B's answer to the need to increase registered nursing hours in the dementia unit was to add this to her role. She felt "physically and mentally exhausted" and found her position "impossible". She resigned in April 2008.

Ms H

Ms H advised that Mrs B inherited significant staff/human resource difficulties, which had been exacerbated by Villa Gardens' transition to being part of the Eldercare

organisation. She was aware of the "very dysfunctional relationship" between Mrs B and Ms C, and [after January 2008] discussed this with Mrs B frequently. She said that some of the Villa Gardens staff (and this included Ms C) were resistant to the corporate model and the new policies and procedures. Mrs B was seen by staff to represent the new changed corporate model. Ms H stated, "There was not enough work from Eldercare in relation to this transition."

Ms H advised HDC that she visited Villa Gardens every seven to ten days, to discuss the business and management. The meetings would usually involve discussion about outstanding issues from the previous meeting and any new issues, such as complaints, and a walk through the facility.

Ms H stated that Ms C's responsibilities as Care Manager were not unreasonable. She had been in a position of responsibility before Mrs B was appointed. Ms H was of the opinion that the problems were related to time management and "asking for help when needed".

In July 2008, the Clinical Director for Older Persons Health at the DHB, Dr R, advised that it is unusual for staff not to conceal medication in food. He stated that a dementia unit must try various strategies to ensure a resident takes his or her medication. If a resident is refusing to take medications voluntarily, the usual practice is to:

- discuss the issue with the EPA and to try to conceal medication in food; if that is not effective, the dementia unit would usually seek expert advice from the needs assessment team or a psychiatrist specialising in geriatric care
- the dementia unit should then try the strategies that have been suggested by those experts for an agreed amount of time, then review the situation.

Dr R advised that Villa Gardens did not follow standard practice for a resident who is refusing medication and noted that Mrs A settled down very quickly at the public hospital as soon as she was taking regular medication, concealed in a marshmallow.

Eldercare

Eldercare Director of Nursing Ms T stated: "It is clear that Villa Gardens could have done better in providing for [Mrs A] and there are lessons to be learnt from the experience." She advised that from March to September 2008, Villa Gardens had worked closely with the DHB to remedy the issues raised. She said:

> "[Mrs D] has asked for an apology, and we certainly reiterate our regret that we were not able to meet their expectations and that this caused them so much upset. We apologise unreservedly to [Mrs A's] family."

Mrs D

Mrs D stated that it was pleasing to read that Ms T acknowledged that Villa Gardens could have done better in caring for their mother and that lessons have been learnt. She said, "It is unacceptable that Eldercare could not meet our expectations of a

reasonable standard of care." They looked forward to receiving a formal letter of apology.

Mrs D stated that the journey of making a complaint had been very stressful on the family. However, they "take comfort in knowing that the final years of [their] mother's life will be lived in a caring, loving environment". Mrs D stated:

> "If my complaint has helped in even some small way, to improve the standard of care received by residents in Dementia care then the journey has been worthwhile."

Follow-up actions

The DHB audit
After receiving multiple complaints (following publicity about care at Villa Gardens), the DHB commissioned an issues-based audit. A site visit was conducted on 28 and 29 July 2008. The audit found a number of service areas where high priority action was required, which included providing adequate staffing, in particular minimum staffing levels for the hospital, and risk management. Moderate priority actions were required to be taken in areas of care planning, strategies for managing behaviours, and resident assessments.

Oceania's investigation
Mrs B stated that her last working day at Villa Gardens was 28 July 2008 when she went on leave. She had been on sick leave during the week of 21 July but returned on 28 July to assist with an audit. She did not return after that.

On 23 July the DHB appointed a temporary manager to Villa Gardens. Oceania's Christchurch Operations Manager, RN Ms S, was seconded to the role of Acting Facility Manager. Ms S was replaced by RN Ms U on 31 July when Ms S subsequently stepped into the Clinical Co-ordinator role (acting).

Ms U and Ms S were tasked with investigating the situation at Villa Gardens. Their report of July/August 2008 identified multiple issues to be addressed by the Oceania team to remedy inferior systems and processes, which included: complaints, management of challenging behaviour, use of bureau staff, care plans, medication management, personal grooming/hygiene, and restraint. Ms U and Ms S's report summary stated:

> "Our initial impressions are that insufficient vigour in monitoring this facility's care delivery has significantly contributed to deficiencies at Villa Gardens. This was compounded by the Manager (RN) and the Clinical Manager's failure to manage inputs into quality clinical outcomes and the failure of Regional Managers to review adequately and pick up early on issues."

Ongoing monitoring
Since these events, Oceania Care Company Group Quality and Risk Manager, Ms I, has commissioned additional spot audits, and the DHB has required a series of unannounced audits for a period of 12 months.

A January 2009 audit of Villa Gardens, conducted by the temporary manager found that there had been a number of improvements in the areas of clinical recording, eating and hydration needs, weight monitoring and maintenance, and staffing and management had been stabilised. There was still work to be done on reviewing and updating policies and procedures.

The DHB Funding & Planning Advisor Ms J advised that the DHB is satisfied with the progress being made by Villa Gardens, but continues to keep a close watch on progress. Policy and procedure development is now the focus. Ms J stated that the present leadership at Oceania Care Company is "turning things around" at Villa Gardens.

In January 2009, Ms I stated that while the situation at Villa Gardens has been difficult for residents, their families, staff and the business, Oceania has taken this opportunity to review all systems and establish the contributing factors to the situation. She advised that significant effort has been made to address the issues at Villa Gardens through review of clinical systems at both a local and national level, recruitment of staff and sound clinical guidance, mentorship and monitoring. She stated, "We envisage continuing to work in partnership with [the] DHB to ensure that the quality of care and safety of residents at Villa Gardens reflects quality and satisfaction for all parties."

Opinion

Discussion
Villa Gardens and its staff had a duty of care to Mrs A. When her husband died in 2004 she was demonstrating symptoms of dementia. On 16 October 2006, a Psychiatric Services for the Elderly assessor assessed Mrs A, noting that she needed 24-hour rest home care in a facility with "specialised dementia knowledge and secure boundaries". Mrs A was reassessed and transferred to the dementia unit at the end of 2006 where she continued to deteriorate. During 2007 she was frightened and aggressive at times. She was "cheeking" her medication and refused to shower or change her clothes. Villa Gardens' staff did not shower her for 12 months. She also lost a substantial amount of weight. She refused to allow staff into her room and it became unhygienic, with uneaten meals, pills, and soiled clothing hidden in the room. Yet it was not until November 2007 that she was referred for reassessment. In January 2008 she was transferred to the psycho geriatric ward at the public hospital where her cares were able to be managed appropriately.

My expert nurse advisor, Dr Stephen Neville, accepts that Mrs A should have been reassessed earlier, but he is of the view that difficulties with the family involvement and workforce issues influenced the care. He has advised that the care was reasonable under the circumstances.

However, I take a somewhat different view. In 1996 in the case *B v Medical Council*[9] Justice Elias stated:

> "The reasonableness of the standards applied must always be for the court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag."

This statement has subsequently been approved by the Court of Appeal.

In my opinion, and taking into account Mrs A's interests and community expectations as well as Dr Neville's advice, Villa Gardens should have explored different strategies and management techniques (such as hiding medication in food) in order to provide appropriate care to Mrs A, or they should have recognised their inability to care for her and made timely arrangements to transfer her to a more suitable institution. It is not acceptable that this took so long to occur. My findings are as follows:

Breach — Mrs B

As Facility Manager, Mrs B was responsible for staff appointments, maintaining facility occupancy, and ensuring that the expenditure was within budget. Although the position did not have specific responsibility for ensuring the provision of appropriate standards of nursing assessment and care (the role of the Care Manager), the Facility Manager had overall responsibility for ensuring a quality service was provided. The Eldercare Quality Policy states: "The responsibilities of management and staff include commitment to ensure: … accurate assessment of resident dependency and needs to ensure appropriate care and support … the provision of appropriate staff numbers and skill mix."

Response to family complaints
By the time Mrs B was appointed as the Facility Manager at Villa Gardens Home and Hospital in June 2007, Mrs A had been displaying increasing signs of dementia for many months. She had started refusing medication, refusing to wash and shower, and at times she was verbally aggressive and suspicious of any physical contact. She was also hoarding dirty crockery in her room and refusing to allow staff into her room to tidy and clean.

Mrs A's four daughters live in the area. They visited her frequently and worked with the Villa Gardens staff to manage their mother and provide her with care.

[9] *B v Medical Council of NZ* 8/7/96 Elias J, HC Auckland HC11/96 at p.14.

In July 2007, Mrs A's daughters wrote to Mrs B complaining about the care being provided to their mother. They were concerned that she was unkempt and unclean, that there was an accumulation of dirty dishes in her room, and that there were tablets hidden in her room or discarded on the floor on a regular basis.

Mrs B was new. She followed up the concerns by promptly meeting Mrs D and Ms F. The next day she talked to the dementia unit leader and Care Manager Ms C.

Mrs B thought Mrs A needed to be reassessed, but she apparently accepted the assurance of staff who told her this was unnecessary because an assessment had been done in January.

Later that month, after further assurance from staff about Mrs A's condition, Mrs B replied in writing to the family concerns noting that, as they were aware, Mrs A had been recently presenting some challenging behaviours. Her behaviour was causing concern for the safety not only of Mrs A, but also of other residents and staff. This was being addressed through a medication regime. Mrs B advised the family that staff had tried a number of strategies to try to manage Mrs A's hygiene and meals with little success.

Mrs B responded in writing to all letters from the family and met with them several times. She also raised the issues with the Operations Manager, who in accordance with the Eldercare and later Oceania Care Company complaints' policy checked all Mrs B's response letters before they were sent. When she discussed her concerns about Mrs A with the former Operations Manager Ms L, Mrs B stated she was advised to leave the clinical care to Ms C.

Mrs B also expressed to her manager her wider concerns about the delivery of care at Villa Gardens, in particular care planning and documentation, but felt that she was not adequately supported in her efforts to effect change.

Reassessment

As stated previously, in July 2007, Mrs B met with Ms C and the dementia unit team leader to discuss the family's concerns about Mrs A. Mrs B was told that reassessment was not necessary. She had also been advised by her manager to leave the clinical care to the registered nurses and Ms C. Furthermore, Mrs B felt that Ms C resented her being involved in clinical issues.

It was more than four months before Mrs B acted on her initial instinct, which had been to have Mrs A reassessed. In November, after being advised that Mrs A was "still no different", she advised Ms C that a referral to a geriatrician for reassessment was needed, stating, "We can't just leave it." Mrs B made the referral to the public hospital herself.

Consultant psychiatrist Dr O reviewed Mrs A on 18 December and advised Mrs A's family and GP that her "dementia related disabilities … sadly have progressed somewhat". He decided to review her again at the beginning of January 2008 to make a final decision about her ongoing placement.

Mrs A was transferred to the mental health unit at the public hospital on 9 January 2008 after Dr O met with Mrs A's family. They were upset and angry about the proposed procedures for the transfer but after a lengthy meeting with Dr O agreement was reached about how the transfer would be facilitated. Mrs B regrets not insisting that Mrs A be reassessed earlier.

Summary

I accept that Mrs B responded promptly to complaints from the family. As a newcomer, she appropriately followed up by seeking information from senior staff who were more familiar with Mrs A. I also understand the reasons why Mrs B did not challenge the advice she received at that time. She was finding her way as the Facility Manager and conscious that the nursing team resented the change in management of the facility and the introduction of new policies and procedures. She had been discouraged from being involved in clinical issues by her line manager, and she was not directly responsible for clinical care.

Nonetheless, Mrs B had overall responsibility for ensuring a quality service was provided to Mrs A. When the family approached her with their concerns just after she was appointed, she brought fresh eyes to the problems and immediately identified the right question — whether Mrs A needed to be reassessed. Mrs A was entitled to care that was consistent with her needs, minimised harm and optimised her quality of life. However, it was not until November that Mrs B decided that referring Mrs A for reassessment for transfer to a facility more suited to providing the specialised care she needed could not be left. Although she had been previously discouraged from being involved in clinical issues, she made the referral. While I acknowledge that there were a number of complicating factors (discussed later) it is not good enough that it took more than four months for this referral to be made.

In my view, Mrs B needed to respond more quickly and do more to satisfy herself that Villa Gardens, the facility for which she was responsible, and its staff, were able to provide Mrs A with quality care. By July the family's concerns were longstanding and well documented, as were the growing difficulties for staff in managing Mrs A's care. These issues were unresolved.

Mrs A was not provided with quality care and Mrs B, as Facility Manager, must bear some responsibility for this. In my opinion, Mrs B did not provide Mrs A with a service consistent with her needs, and that minimised harm and optimised her quality of life, and therefore she breached Rights 4(3) and 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code).[10]

[10] The relevant Rights of the Code of Health and Disability Services Consumers' Rights are attached as Appendix B.

Breach — Ms C

As Care Manager from 2006, Ms C was responsible for the oversight of care provided to residents and patients at Villa Gardens, as well as orientation of new staff, in-service training, and infection control and monitoring of accidents and incidents. This means she had overall responsibility for Mrs A's clinical care. She was also the on-call registered nurse every second weekend.

Ms C was clearly actively involved in the management of Mrs A. For instance, she took part in a meeting with the family at the end of 2006 to discuss the need to have Mrs A reassessed with a view to transferring her to the dementia care unit where it was felt she could be better managed.

I also note that when it became apparent in March 2007, three months after her transfer to the dementia unit, that Mrs A was not eating and was losing weight, Ms C appropriately made a referral to a dietitian, who started Mrs A on the nutritional supplement Fortsip. Ms C also monitored Mrs A's behaviour and liaised with her GP about options for the management of her aggression, which included the introduction of a trial of the antipsychotic quetiapine on 19 March 2007.

Medication
In March 2007 Dr N recommended that quetiapine be trialled because Mrs A's behaviour was deteriorating. She had become verbally aggressive and suspicious of any physical contact, was not eating, was hiding uneaten meals in her room, and was refusing to allow staff to remove dirty plates. Ms C recalls being chased down the corridor when she tried to collect dirty crockery from the room. She also recalls being handed discarded, "well sucked" tablets by Mrs A's daughter, Mrs E.

Ms C has stated that when the family brought to her attention that there was discarded medication in various places in Mrs A's room, she instructed staff to supervise Mrs A closely to ensure she took her medications.

Ms C advised that medication refusals were well documented in the case notes and reported to Dr N and the Villa Gardens Manager. Mrs A's habit of "cheeking" her medications made it difficult for staff to see whether she took the medication, and because she would not allow staff in her room, checking for discarded medications was difficult.

My decision
Dr Neville accepted that the monitoring of whether Mrs A took her medication was extremely difficult because of her aggressive and uncooperative behaviour. Nonetheless, he noted that the Villa Gardens Medication Administration Procedure protocol states that staff "must ensure that oral medications are swallowed" and clearly this did not occur on all occasions. He advised that this oversight was "mild in terms of severity" in the circumstances.

Dr Neville advised that the effectiveness of antipsychotic medication in addressing some of the behaviours exhibited by Mrs A, such as aggression and refusing to eat, is well documented. He noted that when Mrs A was subsequently admitted to the public hospital under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the provisions of her admission meant that she could be forced to have her hygiene needs attended to and to take her mediation and, as a consequence, her behaviour improved. Dr Neville stated that when Mrs A was at Villa Gardens she could not be forced to undertake these activities.

I accept that force is not appropriate; however, I note that the public hospital has used techniques such as concealing the medication in a marshmallow with considerable success. Dr R, the Clinical Director for Older Persons Health at the DHB, advised HDC that a dementia unit must try other strategies for ensuring that residents take their medications, including the concealing of medicines in food, and that these strategies should be tried and then reviewed.

There is no evidence that strategies such as this were considered or tried by the care team at Villa Gardens. Caregivers spoken to by HDC said there was never any suggestion this should be done. Ms C was aware that Mrs A was "cheeking" her medication and hiding it in her room, and this was a risk to her and others. In my opinion, Ms C could and should have taken greater steps to ensure that Mrs A took her medication, so that the effects of the treatment could be evaluated effectively and her care managed appropriately. It also would have assisted with managing the hygiene issues.

Informed consent

Mrs A had dementia and her condition was clearly deteriorating. Informed consent was needed for her treatment plan, including the administration of medication, but there was a lack of clarity about who was legally entitled to give consent on Mrs A's behalf and when consent was needed.

Two of Mrs A's daughters, Mrs E and Ms F, were recorded as holding enduring power of attorney (EPA) allowing them to give consent on her behalf if she was not competent to do so. Mrs E was the nominated first contact but all four sisters were actively involved in their mother's care and, at times, expressed differing views on what should be done. This is not unusual in aged care. Families often have different views on what needs to be done for their loved ones. While this can be difficult to manage, rest homes and dementia units need clear strategies for dealing with it. In this case, appropriate steps were not taken to address the situation.

Mrs A had initially been prescribed oxazepam to control her aggression. When Dr N recommended that quetiapine be trialled in March 2007, the Nurse Manager at that time, Ms K, wrote to Mrs E to inform her about the medication and obtain her permission to start the trial.

On 21 March, Mrs E replied to Ms K agreeing to Mrs A being given the minimum dose, "if that was the best solution". However, Mrs E's sisters were not comfortable

with this because they had not had the opportunity to discuss it before the decision was made. Mrs E advised that if the rest of the family disagreed, she would abide by their decision on the basis that they took full responsibility for the outcome. This is not adequate informed consent and there was a missed opportunity here to clarify the situation.

On 11 April, another of Mrs A's daughters, Ms F, wrote to Ms K wanting to know whether the quetiapine had been effective and noting that the one week trial had been extended. She asked for a written report on steps being taken to manage Mrs A "other than quetiapine". There is no record of Ms K complying with this request but Ms C has advised that she met with the family to discuss their concerns. Ms C recalls that the family subsequently asked that the medication be stopped, but after Mrs E was attacked by her mother she agreed to a regular dose of quetiapine.

On 11 and 13 July Mrs A's quetiapine was increased with instruction to staff to monitor her reaction to the medication. Further increases followed on 20 July and in September and December. It appears that the family were aware that Mrs A was being given medication so that personal cares could be undertaken, as there are a number of records of the family asking for her to be given "as required" sedation prior to them arriving to take her out for trips such as to the hairdresser. However, there is no indication that the family were advised of the dosage changes. On 7 January 2008, Mrs E wrote to Mrs B to complain that she had not given her consent for psycho geriatrician Dr O to increase the quetiapine dosage. She reiterated that her instructions of 21 March 2007 still stood.

The Eldercare "Policy for Resident Admission & Orientation" states that "The resident's family/next of kin is kept up to date, depending on the resident's wishes, and, where appropriate, involved in decisions that affect treatment and care during and after the admission process." This is good practice. Ideally there should be dialogue with all interested parties and a plan of treatment agreed, but in this case there was clear failure by the care team to recognise where this was appropriate, and to properly manage the ongoing consent process, particularly once difficulties occurred.

I acknowledge that there was a wider responsibility by Villa Gardens in relation to this issue (discussed later). Other staff were involved. Ms K, as the Villa Gardens Nurse Manager, was initially a primary contact. Nonetheless, Ms C was the Care Manager throughout 2007, she had regular contact with the family, and had direct responsibility for the day-to-day management of Mrs A's care. She was liaising with the doctors about strategies to manage Mrs A's behaviour and was aware that disagreements between Mrs A's daughters about medication were impacting on the effective management of Mrs A's needs. As Care Manager, Ms C should have known that the Protection of Personal and Property Rights Act 1988 (PPPR Act) provides that an EPA may not appoint more than one person as attorney.[11] Furthermore, an

[11] Section 98(2).

EPA cannot refuse permission for standard medical treatment intended to prevent serious damage to health (section 18 of the PPPR Act 1988). If she did not know the legal situation, Ms C should have sought advice on this once it became clear that there were difficulties gaining consent to treatment. It was not good enough simply to allow the situation to continue.

Ms C knew the family's wishes regarding their mother's medication and had a responsibility to ensure that they were kept informed of any proposed changes and consulted where reasonably practicable before decisions were made, and before changes to the treatment plan. When she encountered difficulties with this, she needed to clarify who held EPA and the extent of the EPA's authority in the first instance. Rather than allowing the input from various family members to impede the provision of good care to Mrs A, she should have sought consent from one EPA alone. The EPA holder needed to be made aware that although they should be informed and consulted as far as practicable in the circumstances, they cannot refuse consent to standard medical treatment.

Behaviour management
In August 2006, Ms C asked a diversional therapist to assess Mrs A with a view to managing her behaviour and eating. The therapist recommended that Mrs A might be better suited to a smaller family-type environment, but the family were not able to find a bed for Mrs A in a suitable facility because of a shortage of dementia beds in the area. The alternative was to provide Mrs A with exclusive access to a small lounge for meals to reduce external stimuli. However, when Mrs A became more reclusive she stopped using the lounge.

As previously noted, when the family raised concerns about Mrs A's care with Mrs B in July 2007 she met with Ms C and the dementia unit team leader to discuss Mrs A. Ms C assured Mrs B that Mrs A had been reassessed at the beginning of 2007 and there was nothing more to be done.

When concern about Mrs A's increasingly aggressive behaviour was raised in August, Ms C then contacted the duty assessor at the public hospital's Psychiatric services for the Elderly to discuss management options, and a few days later she spoke with consultant psychiatrist Dr O about the difficulties staff were having managing Mrs A. Dr O recommended that Mrs A be given quetiapine. Initially the family agreed to Mrs A being given medication 30 to 40 minutes prior to any intervention provided they were advised beforehand, but a week later requested that Mrs A's medication be stopped. As previously mentioned, once the medication was stopped, Mrs A's behaviour deteriorated and when she assaulted one of her daughters, permission was given to restart the medication.

In November, Mrs B called a meeting with the dementia unit team leader and Ms C to again discuss Mrs A. Ms C advised that there was no change in Mrs A's behaviour. Mrs B stated that this situation could not be left as it was, and she herself made the referral to the public hospital for a reassessment for Mrs A.

Dr Neville noted that there were reported issues with Ms C's communication style and whether appropriate information relating to Mrs A's care was communicated to the other members of the health care team. He advised that following a review of the clinical documents, it is his opinion that Ms C provided an "appropriate standard of nursing assessment and care to Mrs A in relation to her care planning, personal needs and nutrition".

I respect Dr Neville's advice. However, in my view, while staff attempted under difficult circumstances to deliver an appropriate standard of care to Mrs A, without the assistance of her daughters they would have achieved very little. For a substantial period of time staff were mostly unable to attend to Mrs A's hygiene, struggled to manage her aggression, and their attempts to get her to take food and her medication were not always successful. Insufficient action was taken to address these issues.

Summary
In my opinion, Ms C should have recognised sooner that Villa Gardens was not able to provide the specialised level of care Mrs A required. Mrs A was showing signs of moderate dementia in 2006 when she was reassessed as requiring dementia level care. At that time she was water phobic and becoming reclusive. Over the next 12 months she became verbally and physically aggressive, was not eating and was refusing to bathe and take medication. Although various antipsychotic and sedation regimes were trialled, these had a limited effect in controlling her behaviour. I appreciate that Ms C was sympathetic to the family's reluctance to accept their mother's dementia, and was trying to accommodate their wish that she stay at Villa Gardens. However, as Care Manager she was responsible for the oversight of clinical care, and was therefore the person who should have advocated for Mrs A to be transferred to a specialised unit much earlier than was done. When behavioural and consent issues arose, it was her responsibility to ensure that all reasonable strategies had been tried to enable appropriate clinical care to be provided. This was not done.

For all of the reasons outlined above, in my opinion Ms C breached Right 4(1) of the Code.

Breach — Oceania Care Company (trading as Villa Gardens)

Systemic issues
Eldercare, who had owned Villa Gardens Home and Hospital from 2005, merged with another company and was rebranded as Oceania Care Company on 30 May 2008.

There is significant information, backed up by subsequent reviews, that Mrs B and Ms C were not alone in their failure to deliver services of an appropriate standard to Mrs A. Clearly there were wider systemic issues at Villa Gardens at the time of these events.

Dr Neville advised that there were clinical governance and quality structures in place at Villa Gardens, but they were not being implemented effectively. He advised that clear support structures for senior staff should have been put in place, and said, "I rate this issue as moderate in severity." However, Dr Neville opined that the issues relating to clinical governance and quality structures at Villa Gardens did not on their own affect the quality of care provided to Mrs A, and that an appropriate standard of nursing assessment and care was provided.

I am not bound to accept expert opinions uncritically and, in a case such as this, where a simple strategy should be undertaken to manage a patient's condition (such as concealing medication in food) and there was an obvious risk if this is not done, I have taken into account patient interests and social good when evaluating Dr Neville's opinions about accepted practice.[12] It was not acceptable for the difficulties with Mrs A's behaviour and treatment to continue for as long as they did. Again, I note the view of Dr R, the Clinical Director for Older Persons Health at the DHB, who advised HDC that a dementia unit must try other strategies for ensuring that residents take their medications, including the concealing of medicines in food, and that these strategies need to be reviewed.

In July and August 2008, a review by the then Interim Manager, Ms U, and the Acting Clinical Co-ordinator, Ms S, identified multiple deficiencies at Villa Gardens. They reported that there had been "insufficient vigour in monitoring" the delivery of care, compounded by the failure of the Facility Manager, the Clinical Co-ordinator and the regional managers to "review adequately and pick up early on issues".

In July 2008, the DHB commissioned an issues-based audit of Villa Gardens. The audit, conducted on 28 and 29 July 2008, found a number of service areas where high priority action was required, which included risk management, and providing adequate staffing levels for the hospital. Moderate priority actions were required to be taken in areas of care planning, strategies for managing challenging behaviours, and resident assessments.

In my view, Eldercare (now Oceania) must bear overall responsibility for this. As I noted in an earlier recent opinion which involved another rest home,[13] "The inaction and failure to follow policies … demonstrates a culture of non-compliance, systemic failings, and an environment that did not sufficiently support and assist staff to do what was required of them. The Home must take responsibility for this."

Legal issues

As noted previously, there were clear difficulties surrounding Mrs A's EPA. Informed consent was needed for her treatment plan including the administration of medication. The medication issues contributed to significant difficulties with hygiene and nutrition and risked her health and safety as it was not possible to accurately assess an appropriate dosage.

[12] *B v Medical Council* 8/9/97 Elias J HC Auckland HC 11/96 at p14.
[13] Opinion 07HDC16959.

Villa Gardens has a dementia unit and deals with many mentally impaired patients, so it should and must know the requirements of the Protection of Personal and Property Rights Act 1988 (PPPR Act). Staff should have communicated better with the family about requirements, such as the need to have only one EPA, and that it was not appropriate to refuse standard medical treatment. Although it is not ideal and should be seen as a last resort, Villa Gardens could have sought the direction of the court under s102(2)(a) of the PPPR Act when Mrs A's daughters disagreed about the proposed treatment options, particularly as this conflict was affecting the provision of care. There was a failure to proactively deal with this issue.

I am aware that there have been significant changes in staffing and management at Villa Gardens since these events, and that the unannounced audits undertaken by the District Health Board reveal that there have been a number of improvements in clinical recording and the aspects of patient care that had been identified as being deficient. Staffing and management structures have been stabilised, but there is still work required to update policies and procedures. Eldercare Director of Nursing Ms T stated: "It is clear that Villa Gardens could have done better in providing for [Mrs A] and there were lessons learned from the experience."[14] She noted that Villa Gardens continues to work closely with the DHB to remedy the issues raised.

This is encouraging. However, the fact remains that Villa Gardens Home and Hospital did not provide services to Mrs A with reasonable care and skill and that were consistent with her needs and minimised potential harm and optimised the quality of her life. Accordingly, Villa Gardens Home and Hospital (and its owners, Eldercare, now Oceania Care Company (No 1) Ltd) therefore breached Rights 4(3) and 4(4) of the Code.

Vicarious liability

Under section 72(2) of the Health and Disability Commissioner Act 1994, employing authorities are vicariously liable for any act or omission of an employee unless they can show that reasonable steps were taken to prevent the act or omission in question.

Mrs B advised that when she became Facility Manager in mid-2007, she found the clinical care at Villa Gardens was "old fashioned", and the documentation was not up to standard. There was resistance to the adoption of the Eldercare policies and procedures, and an inharmonious relationship between the Care Manager, Ms C, and the registered nurses.

Mrs B discussed the staffing, documentation and care issues at weekly meetings throughout 2007 with the company's South Island Operations Manager Ms L (and, later, Ms H). These meetings were documented, and recorded continuing staffing and recruitment difficulties.

Mrs B stated that she was having particular problems with Ms C, who did not react well to receiving support or instruction from senior management. At the weekly

[14] Ms T's letter to HDC of 3 September 2008.

meetings, Mrs B talked to the operations managers about her problems in establishing a harmonious nursing team and the resistance she was encountering from some of the registered nurses. Mrs B felt that she did not always have a "lot of say". She stated, "I probably should have put my hand up and said, 'Look staffing issues here are huge. I need someone to come in you know. I can't just walk in and clean it all up', which seemed to be the expectation."

The Oceania Operations Manager from January 2008, Ms H, has apparently supported this. She advised that Mrs B inherited significant staffing difficulties which had been exacerbated by Villa Gardens' transition to being part of the Eldercare organisation back in 2005. Ms H acknowledged that some of the staff were resistant to the corporate model and policies and procedures that had been introduced. Ms H stated, "There was not enough work from Eldercare in relation to this transition."

For her part, Ms C advised that when she was appointed as the Care Manager at Villa Gardens in 2006, she was not given any training or orientation for this new role. She believed that the scope and responsibilities of the role were unrealistic, and she was provided with very little support in this role by senior management.

Ms C advised that a number of staff left and were not replaced in 2007 and she had to take on additional duties. She felt unsupported by Mrs B and was "physically and mentally exhausted". She has also indicated that her relationship with Mrs B was not good and deteriorated.

Dr Neville stated that orientation programmes for all staff should be available and be made mandatory. Ms C should have insisted that she be given the opportunity to participate in an orientation programme. If her request was not acted upon by the management, then she could have sought support from her professional body or union representative.

However, Dr Neville noted that at the time of the events complained about, Villa Gardens was experiencing inadequate staffing, difficulties in attracting, recruiting and retaining staff, poor or inadequate lines of communication, and a lack of organisational leadership. He noted that the challenges associated with the recruitment and retention of qualified staff in the residential care sector are not new, and Villa Gardens should have had the necessary contingency plans in place to address any staffing crisis.

Dr Neville also advised that given the tension that existed between Mrs B and Ms C, another senior person should have stepped in to mediate the issues. I agree with this view. In particular, I note that it appears it was not until January 2008 that this issue was directly addressed, although even then, as Dr Neville noted, it appears the process may have been "derailed" by the dysfunctional relationship between Mrs B and Ms C.

Dr Neville noted that this case is surrounded by "a complicated set of extraneous but potentially influencing factors that need to be acknowledged" — the family tensions around Mrs A's diagnosis and treatment options, and the significant workforce related

issues at Villa Gardens. Dr Neville also advised that the initiatives that have been undertaken to improve services at Villa Gardens since these events appear appropriate. He commented:

> "Recommendations are only as good as the people who instigate them. The key to improving services at Villa Gardens will be reliant on a competent, stable, well qualified and unified senior management team."

Summary
It is a fundamental requirement that a dementia unit will be able to provide appropriate care to dementia patients and to promptly recognise when they are no longer able to do so. Villa Gardens did not have adequate systems available in 2007 to ensure that this requirement was met. Neither did it sufficiently support Mrs B and Ms C to enable them to do this. Accordingly I find Villa Gardens Home and Hospital (and its owners, Eldercare, now Oceania Care Company (No 1) Ltd) vicariously liable for Mrs B and Ms C's breaches of the Code.

Naming

I have discretion to name group providers in the final version of any breach reports that are published on the HDC website and sent to relevant agencies. However, each case is considered on it own merits. In this case, Oceania Care Company (No 1) Ltd submitted that it would be inappropriate to publish its name in my report because it was not in existence at the time the breaches occurred. I have carefully considered this issue and decided that, on balance, the public interest favours publication. Accordingly, Oceania Care Company (No 1) Ltd will be named along with Eldercare, and Villa Gardens, in the version of this report published on the HDC website and sent to relevant agencies.

Recommendations

Mrs B
I recommend that Mrs B:

- provide a written apology to Mrs A's family for her breach of the Code. The apology is to be forwarded to HDC by **30 September 2009** for sending to the family.

Ms C
Ms C has provided a written apology for Mrs A's family. I recommend that she:

- review her practice in light of this report, and advise me by **30 September 2009** of any changes she has since implemented.

Oceania Care Company
Oceania Care Company (No1) has provided a written apology for Mrs A's family. I recommend that Oceania Care Company (No 1) Ltd, trading as Villa Gardens Home and Hospital:

- review the progress made in updating its policies and procedures and restructuring the staffing and management structures at Villa Gardens and advise HDC by **30 September 2009** of steps being taken to advance issues highlighted by this report

- upskill management and staff about their legal duties with regard to the consent for treatment of incompetent patients and advance directives, and report back by **30 September 2009** on steps to be taken to address the issues highlighted by this report.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Ministry of Health (HealthCERT), and the District Health Board.

- A copy of this report, with details identifying the parties removed except the names of Villa Gardens Home and Hospital, Eldercare, and Oceania Care Company (No 1) Ltd, and the expert who advised on this case, will be sent to HealthCare Providers New Zealand and the Association of Residential Care Homes and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert advice from registered nurse Dr Stephen Neville

"The aim of the contents of this report to the Health and Disability Commissioner is to provide advice, as to whether in my professional opinion:

Oceania Care Company (No 1) Ltd t/a Villa Gardens Home and Hospital, Facility Manager registered nurse [Mrs B] and registered nurse [Ms C], provided an appropriate standard of care to [Mrs A].

Complaint

- Whether Villa Gardens Home & Hospital Facility Manager, registered nurse [Mrs B], provided [Mrs A] with reasonable treatment and care in 2007, and responded appropriately to complaints about her care.
- Whether registered nurse [Ms C] provided [Mrs A] with reasonable treatment and care in 2007.
- Whether Oceania Care Company (No 1) Ltd t/a Villa Gardens Home and Hospital provided [Mrs A] with reasonable treatment and care in 2007.

This report will begin with an overview of my professional qualifications and clinical experience, followed by a timeline outlining the events surrounding this complaint. Finally, my professional opinion on the case will be provided. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, my own professional clinical and research experience of working with older adults and their families/significant others, my extensive experience working as a nurse at all levels of the health care environment, and after reviewing the relevant literature related to the ethical and legal obligations of nurses in providing a nursing service to vulnerable older people and their families.

Personal and professional profile

I am a registered nurse, who has a doctoral degree in nursing, is a Fellow of the College of Nurses Aotearoa (NZ) and has been nursing for 31 years. I am currently working as a senior lecturer and postgraduate programme coordinator in the School of Health and Social Services, Massey University, Albany Campus, Auckland. I teach in postgraduate nursing programmes and my doctoral research focused on delirium in people over the age of 65 years and the impact this had on families/significant others. My clinical experiences include working with people who have disabilities, acute care, operating theatre and health care of the older person. I am currently on the Management Board of Nursing Praxis in New Zealand and am an Honorary Research Consultant at the University of Queensland, School of Nursing. My research experience and publications are in men's health and well-being, nursing and older people, the social aspects of ageing, health assessment, vulnerable populations and health workforce issues. Finally, I have extensive experience in providing independent advice to the Health and Disability Commissioner related to ensuring consumers of health services receive safe and appropriate standards of care.

Background

Mr and [Mrs A] first came to live at Villa Gardens Home and Hospital in 2001 where they lived in the residential care section of the organisation. They had four daughters who visited regularly. [Mrs A's] husband died in 2006 by which time [Mrs A] had begun to show signs of experiencing dementia. These signs manifested as being unwilling to take her medication, not washing or showering, not letting Villa Gardens staff come into her room, keeping dirty cups and plates in her clothing drawers, being verbally aggressive and suspicious of any physical contact. At this stage [Mrs A's] daughters worked with the staff to provide care and manage [Mrs A].

Around this time [Mrs A's] general practitioner intimated that dementia level care might be appropriate as [Mrs A] was increasingly exhibiting behaviours that were commensurate with someone who had dementia. These included nocturnal restlessness, aggression, suspicious/paranoid behaviours, refusing to shower and not taking her medication. Consequently in the November of that year [Mrs A] was reassessed as needing specialist dementia care and was consequently moved to the Dementia Care Unit of the Villa Gardens in January 2007. The family's concerns centred on a perceived lack of needs assessment and care planning for [Mrs A] around the time of her transfer to the dementia unit. For example, staff leaving meals and medications with their mother and not supervising and/or checking that she had accepted them.

Around July 2007, the family expressed further their concerns about the physical, psychological and emotional well-being of their mother. These concerns arose out of claims by the family that [Mrs A] was wearing the same clothes for several days without changing, as well as the presence of dirty dishes and faecal covered clothing in her dressing table drawers. At this stage the family were providing approximately 90% of their mother's daily care needs including feeding, attending to personal hygiene needs, the cleaning of [Mrs A's] room as well as her washing and ironing. The family also claimed to have found on several occasions medication that had not been taken either on the floor or in their mother's drawers.

Surrounding this case is a complicated set of extraneous but potentially influencing factors which need to be acknowledged. Firstly, there appeared to be significant family tensions. One of the daughters, [Mrs E], had Enduring Power of Attorney in relation to [Mrs A]. However, frequently other family members had differing views to [her] which were difficult to resolve and resulted in significant disagreements. For example, some members of the family were reluctant to accept that their mother required dementia level care which may have resulted in a delay to [Mrs A] receiving appropriate levels of care. Also there was disagreement regarding commencing [Mrs A] on a week trial of the drug Quetiapine. [Mrs E] had agreed to the trial of Quetiapine which [the other daughters] did not support (see document B, 00143). The presence of intra-family issues was recognised by other health professionals outside of Villa Gardens, for example the consultant geriatrician [Dr O] states '… Sadly, the stressful situation has now led to a falling out among the daughters as well as ongoing tension between family carers and professional carers' [B, 00077]. Secondly, there

were also significant workforce related issues at Villa Gardens. These included difficulties in attracting and retaining a stable registered nurse workforce, as well as personality issues within the staff. Finally, Villa Gardens received a significant amount of negative media attention which may have resulted in a level of hypersensitivity by consumers of their services, their families/significant others, the Oceania Group and funding agencies. Therefore impartiality is pivotal to ensure whatever decision is made about this case is based on solid supporting evidence relating directly to the complaint made by [Mrs A's] family.

Professional advice

I have been asked to advise the Commissioner on whether, in my opinion, Oceania Care Company/Villa Gardens Home and Hospital, [Mrs B] and [Ms C] provided services to [Mrs A] of an appropriate standard during the period of 2007.

1. Were the services provided to [Mrs A] appropriate?
2. What standards apply in this case?
3. Were those standards complied with?

Finally, as required, I will comment on any other aspects of the care that I deem necessary. The following professional advice is presented as it relates to the above points. I conclude my advice with my opinion on the level of severity associated with the complaint made against Oceania Care Company/Villa Gardens Home and Hospital, [Mrs B] and [Ms C], documented as mild, moderate or severe.

[Mrs B]

1. *Did [Mrs B] take appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mrs A]?*

During the period of 2007, it is my professional opinion that [Mrs B] took the appropriate steps to ensure a suitable level of care was provided to [Mrs A]. This is evidenced by the type and quality of the documentation provided to me as an expert advisor. For example, even though [Mrs B] was not directly involved in [Mrs A's] care her knowledge of the care provided by staff in the facility was evident and is supported by the detailed letters written to [Mrs A's] family outlining their mother's care in response to their complaints.

2. *Is there anything else [Mrs B] should have done in the circumstances?*

From the documentation provided to me it is clear that [Mrs B] in her role as Facility Manager of Villa Gardens Home & Hospital did all she could to ensure appropriate levels of care were provided to consumers. It is important to remember that the focus of the Facility Manager role is not on providing clinical care but on running the business side of the company which included tasks such as maintenance, bed occupancy, managing the budget and dealing with staff as well as family related issues.

[Ms C]

1. *Did [Ms C] provide an appropriate standard of nursing assessment and care to [Mrs A]?*

After reviewing the clinical care documentation provided to me my expert opinion is that [Ms C] provided an appropriate standard of nursing assessment and care to [Mrs A] particularly in relation to care planning, personal care needs and nutrition. However, point 1.3 (B, 00207) of the 'Medications Administration Procedure' protocol/guidelines states 'The staff member must ensure oral medicines are swallowed …' This obviously did not occur. Consequently, the complaint relating to the safety of leaving untaken medication lying around in [Mrs A's] room is valid. However, due to [Mrs A's] aggressive and uncooperative behaviours toward staff the monitoring of whether this person had taken her medication or not would have been extremely difficult. I therefore rate this particular oversight in care as mild in terms of severity.

2. *Did [Ms C] communicate appropriately with other providers involved in [Mrs A's] care?*

After reviewing the documentation provided it is my opinion that although there might have been issues with [Ms C's] communication style, the appropriate information relating to [Mrs A's] care was conveyed to other members of the health care team as evidenced by the entries in the clinical documents.

3. *Did [Ms C] appropriately document her care?*

There is an appropriate and moderately detailed set of documents pertaining to the care provided to [Mrs A] during 2007.

4. *Were there any systemic factors impacting on [Ms C's] ability to provide appropriate care?*

I have already determined that an appropriate standard of care has been provided by [Ms C] in this case. However, issues such as difficulties in attracting and retaining staff, organisational tensions within the health care team and intra family tensions, all of which plagued Villa Gardens, did have the potential to influence the delivery of nursing care.

5. *What else, if anything, should [Ms C] have done in the circumstances?*

In [Ms C's] statement (D, 00268 -> 00275) she identifies that the opportunity to participate in an orientation programme was not offered to her. It is my belief that [Ms C] should have insisted, with or without the assistance of her union representative, on some form of orientation programme.

Oceania Care Company/Villa Gardens

1. *Were there adequate clinical governance and quality structures in place at Villa Gardens?*

While the clinical governance and quality structures in place at Villa Gardens were adequate [Ms T] (Director of Nursing) identified in her correspondence (C, 00237 -> 00240) that further improvement was needed. It is my opinion that the issues related to the clinical governance and quality structures at this facility did not on their own affect the quality of care provided to [Mrs A].

2. *Was RN [Ms C] adequately supervised and supported?*

It appears from RN [Ms C's] statement that she did not receive an adequate orientation programme. However, [Mrs B]'s statement intimates that [Ms C] was difficult to deal with and did not react to receiving suggestions or support from Senior Management particularly well. This behaviour required [Ms C] to participate in a performance review programme. However, the success of this performance review programme may have been derailed by the apparent dysfunctional relationship between [Mrs B] and [Ms C] (see G, 00308).

3. *What else, if anything, should Eldercare/Oceania have done in the circumstances?*

Orientation programmes for all staff should be made available and be mandatory for all staff at Villa Gardens. Clear support structures for senior staff should have been put in place. In the case of the tensions that existed between [Mrs B] and [Ms C] another senior person should have stepped in to mediate the issues.

4. *Please comment on the initiatives designed to improve services at Villa Gardens since these events*

The initiatives provided to me appear appropriate. However, recommendations are only as good as the people who instigate them. The key to improving services at Villa Gardens will be reliant on a competent, stable, well qualified and unified senior management team.

5. *Please provide any further recommendations for improvement.*

I have no further recommendations to suggest.

Conclusion

Having a family member who lives with dementia is stressful. The resulting changes to a person's personality and cognitive functioning can be extremely distressing. Families frequently struggle with having to make decisions that are in the best interest of their significant other. In the present case, the family struggled with issues such as commencing and/or increasing the type and amount of antipsychotic medication

offered to their mother resulting in delayed interventions. It is my professional opinion that delays such as these were not necessarily in the best interests of [Mrs A]. The appropriate use of antipsychotic medication has been well documented to address some of the behaviours exhibited by their mother. For example, aggression, refusing to eat, grooming and taking medication. There were also issues with staffing and the clinical governance structures at Villa Gardens that this organisation is now attending to. Section A of the documentation provided compares the standard of care provided by Villa Gardens, [the mental health unit at the public hospital] and [a] Dementia Hospital. It is important to remember that [Mrs A] was admitted to [the mental health unit] under the Mental Health Act. This means that she had no option but to take her medication and have her hygiene needs attended to. While she was a resident at Villa Gardens she could not be forced to undertake these activities. The resulting change in behaviour when transferred to [the] Dementia Hospital is a result of having been forced to take her medication over a period of time resulting in a desired therapeutic effect being achieved. I am interested to note that the family was extremely critical of the care provided at Villa Gardens but yet saw nothing wrong with their mother being forced to have a shower. [The family] outlines in section A, page 0003, that their mother was showered within twenty four hours of entering [the mental health unit] with the aid of four staff!! Some critics would argue that this was a breach of an individual person's rights. Finally, I conclude with the point that [the family] did acknowledge that '… there had been some very good care and staff at VG [Villa Gardens]' (H, 00311).

Yours faithfully,

Dr Stephen Neville, RN, PhD, FCNA (NZ).

Additional advice

Dr Neville reflected further on these issues and advised that [Mrs A] should have been reassessed and referred earlier than she was, but there was resistance from the family to a lot of the strategies the staff suggested to control her behavior.

He said that the key issues that contributed to these events were the organisational structure at Villa Gardens, and that [Mrs B] was not supported by the Eldercare/Oceania managers, in particular the South Island Operations Manager.

Dr Neville believes that the care provided to [Mrs A] was reasonable in the circumstances, and that the staff had a difficult job. He stated that when [Mrs A] was sectioned and transferred to [the public hospital], the staff there had the ability to require her to take her medication and shower her. Staff at Villa Gardens did not have this ability.

Appendix B — Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill. …

…

(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.