CHT Healthcare Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 18HDC00859)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report relates to the care provided to a woman at a rest home owned and operated by CHT Healthcare Trust (CHT). The Deputy Commissioner commented on the right of consumers to be treated with respect and dignity, and highlighted the particular importance of this where consumers are vulnerable and less able to advocate for their own interests.

2. The woman had a number of complex medical conditions, including vascular dementia and cognitive impairment. She became wheelchair-bound and bed-bound, and was reliant on staff for cares. In the period May to July 2017, the woman had a number of falls. In April 2018, the woman's granddaughter placed a hidden camera in the woman's room. Video footage recorded by the camera on 2 and 3 April 2018 shows a number of healthcare assistants (HCAs) providing cares to the woman, including showering, toileting, dressing, and feeding her. The granddaughter asserted that the videos showed the HCAs physically and emotionally abusing and neglecting her grandmother.

Findings

3. The Deputy Commissioner considered that the parts of the videos provided to HDC painted a troubling and disappointing picture of the care provided to the woman by the HCAs that fell well below the expected standard. In the Deputy Commissioner's view, the number of HCAs involved suggested that staff did not understand what was expected, as there was a pattern of behaviour that failed to respect the woman's dignity and independence. The Deputy Commissioner considered that CHT failed to provide sufficient oversight, and ultimately was responsible for the issues.

4. CHT was found to have breached Right 1(1) and Right 3 of the Code.

5. The Deputy Commissioner was also critical of some aspects of CHT's management of the woman's falls risk, and that neurological observations were not carried out following all unwitnessed falls.

Recommendations

6. The Deputy Commissioner recommended that CHT provide an apology to the woman's family; review the systems currently in place in CHT facilities for monitoring the interactions between staff and residents; develop a dedicated policy for communicating with residents who have advanced dementia, and provide training to staff on the new policy; undertake a random audit of 20 incident reports for resident falls to ensure that neurological observations are being completed for all unwitnessed falls; and consider amending its moving and handling policy to include guidance on when a resident is rigid or difficult to transfer.

7. The Deputy Commissioner referred CHT to the Director of Proceedings.

Complaint and investigation

8. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her late grandmother, Mrs A, at the rest home. The following issue was identified for investigation:

- *Whether CHT Healthcare Trust provided Mrs A with an appropriate standard of care between May 2017 and April 2018 (inclusive).*

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

10. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's granddaughter
CHT Healthcare Trust	Provider

11. Further information was received from:

Ms C	Healthcare assistant
Ms D	Healthcare assistant
Ms E	Healthcare assistant
Ms F	Healthcare assistant
District health board	
Ministry of Health (HealthCERT)	

12. Also mentioned in this report:

Dr G	General practitioner
RN H	Registered nurse
RN I	Registered nurse
RN J	Registered nurse
Ms K	Healthcare assistant
CNS L	Clinical Nurse Specialist (CNS)

13. In-house clinical advice was obtained from Registered Nurse (RN) Hilda Johnson-Bogaerts (Appendix A).

Information gathered during investigation

Background

Mrs A

14. Mrs A became a full-time resident of the rest home requiring hospital-level care on 2 May 2017. Her medical history included vascular dementia and cognitive impairment (her

RUDAS[1] score was assessed as 6/30[2] in May 2017), pancreatitis, major depressive disorder, benign tremor, and type 2 diabetes. Previously, she had been living at home with her husband.

Rest home

15. The rest home is owned and operated by CHT Healthcare Trust (CHT). CHT has a contract with the district health board (DHB) to provide rest-home and hospital-level care at the rest home.

Complaint

16. Ms B's complaint relates to two key issues. The first issue relates to the management of Mrs A's falls risk in light of her increasing number of falls and the post-fall care provided.

17. The second issue relates to video footage that Ms B obtained by way of a camera she installed in Mrs A's room at the rest home. The video recordings provided to HDC were captured during the period 2–3 April 2018. The recordings show a number of healthcare assistants (HCAs) providing daily cares to Mrs A, including showering, toileting, dressing, and feeding her. Ms B told HDC that she believes that the videos show four HCAs[3] physically and emotionally abusing and neglecting Mrs A.

May 2017 — post-admission assessments

18. On 3 May 2017, Mrs A was reviewed by a physiotherapist. The physiotherapist noted that Mrs A was a high falls risk. The following day, a family meeting was held with Mrs A's husband and daughter. The progress notes record that Mrs A's severe dementia and lack of insight for her safety were discussed at this meeting.

19. On 10 May 2017, General Practitioner (GP) Dr G[4] met with Ms B and Mrs A's sister to discuss Mrs A's diagnosis and outlook. Dr G documented that the physiotherapist's opinion was that Mrs A would not improve. However, it was decided that a second opinion from a geriatrician would be sought.

20. On 15 May 2017, Mrs A's interRAI[5] assessment was completed at the rest home. The assessment recorded that she was at medium risk for falls. The assessment also noted:

> "[Mrs A is] making unsafe decisions with unfamiliar settings, trying to get out of chair or bed, without asking assistance. Does not ring the bell for help. May require supervision at times."

[1] Rowland Universal Dementia Assessment Scale.
[2] A score of 22 or below is considered to signify cognitive impairment. Lower scores indicate greater impairment.
[3] Specifically, Ms C, Ms D, Ms E, and Ms F.
[4] Dr G is a vocationally registered GP.
[5] Resident Assessment Instrument — a standardised instrument for evaluation of the needs, strengths, and preferences of residents in long-term care.

21. Mrs A's long-term care plan was updated the same day. The care plan recorded that Mrs A required a two-person assist for transfers. It was also noted that she would grip staff members' arms or hands when being transferred because she was scared of falling. Her falls risk was recorded as medium as she had an unstable gait and had experienced three falls prior to admission to the rest home. Interventions for Mrs A's falls risk included the use of a sensor mat and fall-out mattress.

22. The care plan also recorded that owing to Mrs A's moderately impaired cognition, HCAs were to explain cares to her before carrying them out, and talk to her slowly and clearly while standing in front of her, and provide encouragement.

May to July 2017 — falls

23. At approximately 2.25pm on 16 May 2017, CHT staff responded to Mrs A's bell ringing and found her sitting on the floor of her room. RN H[6] checked Mrs A's vital signs, commenced neurological observations,[7] and informed Mrs A's husband. RN H noted that Mrs A did not have any new injuries. An incident report for the fall was completed, noting that Mrs A had been trying to get out of bed unassisted.

24. On 24 May 2017, Dr G reviewed Mrs A. He noted that she was stable and making very slow progress with a lot of physiotherapy input. Dr G spoke with Mrs A's husband, and they agreed to continue with Mrs A's slow rehabilitation.

25. At approximately 3.30pm on 25 May 2017, CHT staff responded to Mrs A's bell ringing and found her sitting on her fall-out mattress on the floor. RN I[8] checked Mrs A's vital signs, commenced neurological observations, and informed Mrs A's family. RN I noted that Mrs A did not report any pain, and there were no changes in her neurological status.

26. At approximately 4.35pm on 28 May 2017, CHT staff responded to Mrs A's bell ringing and found her kneeling on the floor with her head resting on a chair. She was checked and found to have no injuries. An incident report for the fall was completed the following day, and recorded that Mrs A's family was notified. Neurological observations were not commenced.

27. At approximately 8.50am on 30 May 2017, CHT staff responded to Mrs A's bell ringing and found her sitting on the floor next to her bed. The progress notes record that Mrs A told staff that she tried to get up to walk. Mrs A denied hitting her head. RN H advised Mrs A to ring her call bell for assistance when she wanted to get up, rather than attempt to do so alone. RN H also checked Mrs A's vital signs and informed Mrs A's husband, but did not commence neurological observations. An incident report for the fall was completed later that morning.

[6] A registered nurse since 2016.
[7] CHT staff recorded neurological observations in a coma record form. Completing the coma record required staff to assess a resident's Glasgow Coma Score (a scoring system used to describe the level of consciousness in a person following an injury to the head), blood pressure, pulse, respiratory rate, pupil size and reaction, and arm and leg strength.
[8] A registered nurse since 2016.

28. On 31 May 2017, Mrs A was reviewed again by Dr G. Dr G noted that Mrs A's mobility and movement had improved with her rehabilitation, but she still required at least a one-person assist.

29. In response to the provisional report, Ms B stated that the family noted that Mrs A was becoming more active as a result of physiotherapy.

30. At approximately 7.30am on 3 June 2017, CHT staff found Mrs A sitting on the floor at the foot of her bed. RN I checked Mrs A's vital signs, noted that Mrs A denied any pain, and informed Mrs A's husband, but did not commence neurological observations. An incident report for the fall was completed that day. In response to the provisional report, Ms B stated that a family meeting was held on this day, in which concerns from the first month of Mrs A's care were addressed.

31. At approximately 7.50am on 17 June 2017, CHT staff found Mrs A lying on the floor next to her chair. RN I checked Mrs A's vital signs, noted that she had no injuries, and commenced neurological observations. RN I also informed Mrs A's husband and completed an incident report for the fall.

32. On 20 June 2017, Mrs A was reviewed by the DHB Clinical Nurse Specialist (CNS) CNS L. CNS L noted in her assessment that Mrs A had fallen six times in the preceding month. CNS L's assessment concluded that Mrs A was at high risk of falls and needed close supervision. However, Mrs A's care plan was not updated to reflect the increased falls risk.

33. At approximately 11.25am on 29 June 2017, CHT staff responded to Mrs A's bell ringing and found her sitting on the floor next to her bed. RN I assessed Mrs A for injury, noting a small scratch on her right cheek. In response to Mrs A reporting some pain, RN I administered paracetamol to her. RN I also checked Mrs A's vital signs, informed Mrs A's daughter of the fall, commenced neurological observations, and completed an incident report.

34. At 10.30pm on 10 July 2017, CHT responded to Mrs A's bell ringing and found her sitting on the floor. Mrs A was noted to be confused and unsettled, stating that she was looking for her daughter. RN J checked Mrs A for injuries, recorded her vital signs, and completed an incident report for the fall, noting that she had notified Mrs A's family about the fall. Neurological observations were not commenced.

35. On 11 July 2017, RN H recorded in the progress notes that she had suggested to Mrs A's family that they consider the use of hip protectors owing to Mrs A's falls risk. On 16 July 2017, RN J discussed with Mrs A's family the benefits and risks of using a lap belt in Mrs A's wheelchair.

16 July 2017 — fall

36. At 9am on 16 July 2017, CHT staff heard a bang and Mrs A's bell ringing. CHT staff found Mrs A lying on the ground in her room with her legs on her chair. A cold compress was applied to the lump that formed on the left side of Mrs A's head. RN J administered

paracetamol to Mrs A when she reported a headache. RN J also completed an incident form, noting that five minutes prior to the fall Mrs A had been sitting on her recliner chair. In response to the provisional report, Ms B noted that there was no mention of why Mrs A had been left unattended while staff went to return Mrs A's breakfast tray. Ms B commented: "They were aware she had become more active. [Since] May she had already had 6–7 falls by this point."

37. Neurological observations were commenced, but were carried out for only two hours, as Mrs A's family decided to take her to an outpatient medical clinic at 11am. The clinic doctor assessed Mrs A, noting that it was difficult to test her gait/power and sensation given her dementia. The doctor advised that Mrs A should continue to ice her head and take pain medication, and go to hospital if she deteriorated.

38. On 17 July 2017, RN J again discussed with Mrs A's family the use of restraints, and head and hip protectors. RN J noted that Mrs A's family were to consider a trial of a lap belt or a bed rail.

39. On 19 July 2017, Mrs A was reviewed by a physiotherapist. The physiotherapist also discussed with Mrs A's family the use of hip protectors. Later that day, Mrs A was also reviewed by Dr G, who noted his opinion that she had a minor head injury from the fall. Dr G documented that Mrs A was to be given pain medication and reviewed if necessary. The same day, Ms B reported to CHT staff that she was concerned that Mrs A's behaviour had changed since the fall. RN J documented in the progress notes a request for staff to continue to monitor Mrs A.

40. Between 19 July and 23 July 2017, the progress notes do not refer to any unusual behaviour from Mrs A, aside from on 22 July 2017, when it was noted that "[Mrs A] didn't walk well when toileting".

41. On 23 July 2017, the ambulance service rang the rest home, reporting that Mrs A's husband had requested that Mrs A be transferred to the public hospital via ambulance. Mrs A's husband was reportedly concerned that Mrs A had pain in her head following her fall on 16 July 2017. The ambulance service requested that RN J assess Mrs A's pain levels. RN J noted that Mrs A was smiling and denying pain. RN J therefore cancelled the ambulance and informed Mrs A's husband, but documented that he was "still concerned about the effects of the fall and wants investigation".

42. On 24 July 2017, Mrs A was reviewed by Dr G. Dr G noted the family's concern about Mrs A's head injury. His assessment was that she did not have a serious injury and there was no indication for an X-ray or CT scan. His documented plan was "wait & see". That evening, the progress notes record that Mrs A was very quiet and drowsy, and that her family was concerned.

25 July 2017 — admission to hospital

43. On 25 July 2017, Ms B took Mrs A to the Emergency Department (ED) at the public hospital. While at ED, Mrs A underwent a CT head scan, which showed:

> "Bilateral subdural collections … The largest overlying the right cerebral hemisphere has appearances consistent with a chronic subdural haemorrhage[9] or a subdural hygroma[10] and causes 5mm of leftward midline shift."

44. ED clinicians spoke with Mrs A's family about the "limited value of neurosurgical and medical input". Mrs A was discharged back to the rest home early on 26 July 2017. The discharge summary recommended the continuation of falls precautions and that Mrs A stop taking aspirin. Dr G reviewed Mrs A that day and noted the cessation of aspirin, and that the CT scan did not indicate any treatment.

October 2017 — use of bed rails

45. Mrs A had another fall, witnessed by her husband, on 18 October 2017. On 25 October 2017, a restraint assessment was completed and Ms B agreed to the use of bed rails to reduce the risk of Mrs A falling from bed. Mrs A did not have any further falls after the bed rails were installed.

April 2018 — video footage

46. On 4 March 2018, Mrs A's interRAI assessment was updated. The updated assessment recorded that Mrs A had deteriorated since the previous interRAI assessment, and noted: "[H]ardly communicate[s] now, may speak 1 word such as hello or okay." Mrs A was noted to be dependent on staff for all cares.

47. In her complaint, Ms B told HDC that there was an infection outbreak in the facility in early 2018. As a result, the family were unable to visit Mrs A for a period of time. Ms B stated that when the facility was reopened for visitors, she became concerned that Mrs A was scared and sensitive to being touched. Ms B decided to place a hidden camera in Mrs A's room.

48. Ms B provided HDC with a number of video clips recorded by the camera on 2 and 3 April 2018. The video clips are summarised below.[11]

2 April 2018

<u>Morning cares</u>

49. This video covers a ten-minute period, from 7.51am to 8.01am. The video shows HCAs Ms F and Ms E providing cares to Mrs A. The video begins with Mrs A undressed and sitting in a chair. She is wiped down fairly rapidly and then dried, again rapidly, with a towel by Ms F, and then Ms F dresses her top half. Ms E then brushes and ties up Mrs A's hair.

50. Throughout the video, Ms E is shown using her mobile phone, both behind and in front of Mrs A. On two occasions, Ms E used her mobile phone in front of Mrs A while Mrs A's

[9] A collection of blood on the surface of the brain.

[10] A collection of cerebrospinal fluid, without blood, on the surface of the brain.

[11] The audio in the videos is of a low quality and it is often not possible to determine what the HCAs are saying. As such, the focus of this report is largely on what can be seen, rather than the specific words of the HCAs.

lower half was nude. Towards the end of the video, Ms E lifts Mrs A to stand by pulling her upper arms. Ms E holds Mrs A standing while Ms F applies an incontinence product and pulls up Mrs A's trousers. While Mrs A is standing, she clutches Ms E's clothing. In response, Ms E loudly says, "Hey!" and pushes Mrs A's hands down. Mrs A is then transferred into her recliner chair. Ms E lowers her and then drops her backwards into the chair from halfway between standing and sitting.

51. HCAs Ms F and Ms E have minimal interaction with Mrs A. There is little indication in the video that cares were explained to Mrs A before they were carried out.

Mid-morning toileting

52. This video covers an eight-minute period, from 10.47am to 10.55am. The video shows HCAs Ms F and Ms E providing cares to Mrs A. The video begins with Mrs A being moved into the room on her recliner chair. Ms F lifts one of Mrs A's legs by her trousers and drops the leg onto the chair's raised footrest. She then checks Mrs A's incontinence pad. It does not appear that Ms F spoke to Mrs A prior to doing so. For approximately six minutes, Mrs A is shown sitting in her chair, facing a wall, while HCAs Ms F and Ms E have a conversation behind her.

53. Towards the end of the video, a person off-screen knocks on the door. The dialogue is unclear, but the person appears to ask whether Mrs A has been toileted, and HCAs Ms F and Ms E appear to confirm that she has, and that she has had a bowel movement.

Afternoon cares

54. This video covers an eight-minute period, from 3.46pm to 3.54pm. The video shows HCAs Ms C and Ms K providing cares to Mrs A. The video begins with Mrs A lying in bed. Ms C moves Mrs A to a sitting position by roughly moving her legs off the bed and pulling her upright by her left hand. Mrs A appears to be distressed by this transfer. Together, HCAs Ms C and Ms K transfer Mrs A onto the commode. Ms K moistens a towel and wipes down Mrs A's face. HCAs Ms C and Ms K then clean Mrs A's lower half, apply an incontinence product, and transfer her to the recliner chair.

55. Ms C brushes and ties up Mrs A's hair. She then holds a drink to Mrs A's mouth for her to drink through a straw. When Mrs A reaches to hold the drink, Ms C roughly pushes her hand back, saying, "You don't hold."

56. There is little indication in the video that cares were explained to Mrs A before they were carried out.

3 April 2018

Morning cares

57. This video covers a 12-minute period, from 7.55am to 8.07am. The video shows HCAs Ms E and Ms D providing cares to Mrs A. The video begins with Mrs A being transferred into a shower chair. Ms D undresses Mrs A with some difficulty, as Mrs A's arms are rigid. Ms D wheels Mrs A into the shower, off-screen. They return after Mrs A's shower two minutes later.

58. Ms D brushes Mrs A's hair, dries her body, and applies moisturiser, while Ms E makes the bed. They then dress Mrs A's upper half. Ms E then lifts Mrs A to stand by pulling her upper arms. Ms E holds Mrs A standing while Ms D dries her lower half, applies an incontinence product, and pulls up Mrs A's trousers. While Mrs A is standing, she clutches Ms E's clothing, and Ms E roughly pushes Mrs A's hands down. HCAs Ms E and Ms D then transfer Mrs A into her recliner chair by lowering her and then letting her fall backwards into the chair from halfway between standing and sitting. The video ends with Ms D tying up Mrs A's hair and asking her if she is all right.

Mid-morning toileting

59. This video covers a 16-minute period, from 9.52am to 10.08am. The video shows HCAs Ms E and Ms D providing cares to Mrs A. The video begins with Mrs A being lowered gently onto the commode by HCAs Ms E and Ms D, and a third person. The third person tells Mrs A that she is on the toilet and then leaves the room. HCAs Ms E and Ms D have a conversation while Mrs A remains on the commode. They do not appear to interact with Mrs A except for when Ms E ties up her hair. About halfway through the video, HCAs Ms E and Ms D lift Mrs A off the commode, apply an incontinence product, and transfer her to the chair. They continue their conversation throughout the transfer and until the end of the video. Neither HCA appears to speak to Mrs A.

Afternoon cares

60. This video covers a 22-minute period, from 12.52pm to 1.14pm. The video shows HCAs Ms E and Ms D providing cares to Mrs A. The video begins with Mrs A sitting in her recliner chair. Ms D is standing next to her, between the chair and Mrs A's bed, while Ms E is standing behind Mrs A. HCAs Ms E and Ms D are having a conversation. At approximately 12.52pm, Ms D puts her foot on Mrs A's bed for approximately ten seconds to readjust her shoe. Her bent knee rests on Mrs A's forearm, which is on the arm rest of the chair adjacent to the bed. It is not clear whether Ms D realises that her knee is on Mrs A's arm.

61. At approximately 1.06pm, HCAs Ms E and Ms D together lift Mrs A from her chair and lower her onto her bed. Ms E then lifts Mrs A's legs onto the bed and rolls her onto her side in one fast and relatively rough movement. HCAs Ms E and Ms D then lift the bed rails. They continue their conversation throughout this transfer and for the remainder of the video. Neither HCA appears to speak to Mrs A.

CHT

Management of falls risk and post-falls assessments

62. CHT told HDC:

> "On [Mrs A's] admission her family arranged a rigorous programme of physiotherapy to improve her movement. This was successful but combined with her worsening dementia led to an increased frequency of falls. Her falls reduced significantly since July 2017 as her mobility decreased."

63. CHT provided copies of the minutes from the Health and Safety and Registered Nurse meetings for the months of June, July, and August 2017. These minutes show that Mrs A's falls were discussed at all the meetings. In June 2017, the minutes note:

> "[A]ll falls caused [by Mrs A trying] to stand up or get up without assistance. Unsafe to leave her alone on wheel chair or lazy boy chair in room, bring to lounge after breakfast, staff can interact and keep an eye on her. Transfer her to her bed and keep bed in low position if no family with [Mrs A] in room."

Internal investigation into videos

64. CHT told HDC that after Ms B informed CHT about the videos, the staff involved were immediately removed from providing care to Mrs A and were suspended while CHT undertook an internal investigation. CHT told Ms B that its investigation concluded that the videos provided evidence of the following actions by HCAs Ms F, Ms E, Ms C, and Ms D:

- A lack of preparation of care or explanation to Mrs A before carrying out cares.
- Rough handling of Mrs A, including when moving, handling, and unclothing her.
- Disrespectful and negligent actions that affected the care and safety of Mrs A.
- The use of personal mobile phones while caring for Mrs A.

65. CHT told HDC that the investigation resulted in a Corrective Action Plan (CAP), and CHT has undertaken a number of actions to address the issues raised. CHT also disciplined HCAs Ms F, Ms E, Ms C, and Ms D. The disciplinary action involved CHT issuing written warnings and putting in place performance improvement plans. CHT agreed with the HCAs that they would no longer work with Mrs A or work together at the rest home. CHT also told HDC that it worked with the DHB to implement the CAP and individual performance improvement plans for the four HCAs.

Policies

66. At the time of events, CHT's Falls Management Programme policy (the Falls Policy) stated that a resident who has been identified as having a medium falls risk or higher must have interventions put in place to manage the falls risk. The interventions must be listed in the long-term care plan. The Falls Policy further provided that falls will be analysed on a monthly basis to identify resident- and site-specific trends.

67. CHT told HDC that at the time of events, not every unwitnessed fall was followed up with neurological observations. It stated: "It was only if these were indicated given the findings of the fall and the circumstances of it." However, CHT stated that neurological observations are now completed for all unwitnessed falls.

68. CHT provided HDC with a copy of its updated Falls Policy, which states:

> "All unwitnessed falls and/or falls where the resident has received a knock to their head will have a [Coma Record] completed. Coma scoring will initially take place every

> 30 minutes for the first four hours and if the resident's scoring remains stable then four hourly for the next 20 hours."

69. CHT also provided HDC with a copy of its Moving & Handling Policy. The Moving & Handling Policy provides: "Staff must avoid hazardous residents' handling and movement practice whenever possible. If unavoidable, assess the risks carefully before proceeding."

70. CHT also provided HDC with a copy of its Employee Code of Conduct & Disciplinary Procedure (the Code of Conduct). The Code of Conduct provides that employees are to "exercise fairness, equity, proper courtesy, consideration and sensitivity in dealing with residents, clients, employees and other stakeholders".

71. CHT told HDC that it does not have a specific policy for communicating with residents who suffer from dementia. It did have an Informed Choice & Consent Policy, which states: "Care Givers are responsible to give explanations to residents before providing cares." CHT further stated that at the end of 2018, it introduced online training for all staff. This online training included modules on communication, privacy and dignity, awareness of mental health, dementia, and learning disabilities. CHT also provided a number of training sessions to staff on incident reporting, CHT's code of conduct, moving and handling, elder abuse, and the Code of Health and Disability Services Consumers' Rights (the Code).

Staff training

72. CHT provided HDC with its staff training schedules for the years 2015 to 2017. In 2017, staff attended training on a number of topics, including manual handling, stress management, the Code, consumer privacy and dignity, challenging behaviour, and abuse and neglect.

Ms B

73. Ms B told HDC:

> "I do not feel that CHT has been very forthcoming in their response to the complaint and the actions taken is a reflection of this, as in my opinion, it does not align with the serious actions of the HCAs."

Responses to provisional opinion

74. Ms B, CHT, and HCAs Ms F, Ms E, Ms C, and Ms D were given the opportunity to respond to the relevant parts of the provisional opinion. HCAs Ms F, Ms E, Ms C, and Ms D provided no comments. Where appropriate, Ms B's and CHT's comments have been incorporated into this report, and further comments are set out below.

Ms B

75. Ms B stated (emphasis in original):

> "Falls aside, this complaint was about the ABUSE and NEGLIGENT CARE provided to my grandmother. I feel as though that should be at the forefront of the investigation and reporting."

CHT

76. CHT submitted that the failures in this case were individual, rather than systemic. It stated: "The case does not involve a deficiency in CHT's policies, nor its management of the situation." CHT further submitted:

> "CHT has always regarded its employees' actions in this case as being inconsistent with CHT's expectations. CHT's view mirrors what is set out at paragraph [85] of [this] report referring to CHT's expectations set out in CHT's code of conduct and CHT's informed choice and consent policy. CHT took its own disciplinary action against the individual staff, where that was warranted."

77. CHT further stated that it sees the recommendations proposed in the provisional report as an opportunity for improvement. It said that it is open to undertaking the audit of incident reports for resident falls, and will give consideration to amending its Moving & Handling Policy.

Relevant standards

78. The Health and Disability Sector Standards NZS 8134.1.2:2008 (the NZHDSS) state:

> "Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence
>
> Criteria The criteria required to achieve this outcome shall include the organization ensuring:
>
> …
>
> 1.3.3 Consumers shall be addressed in a respectful manner by their preferred name.
>
> …
>
> 1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of that consumer."

Opinion: CHT Healthcare Trust — breach

Introduction

79. As a provider of healthcare services, CHT has a duty to comply with the Code. This duty includes a responsibility to operate the rest home in a manner that instils in its staff a culture of treating residents with respect, and to ensure that services are provided in a

manner that respects the dignity and independence of residents in accordance with Rights 1(1) and 3 of the Code.

80. The right to be treated with respect and dignity applies to all consumers universally. However, where a consumer is vulnerable and less able to advocate for their own interests, providers need to be particularly sensitive to the need to treat that consumer with respect and ensure that services are provided in a manner that respects their dignity.

81. As noted by my in-house expert advisor, RN Hilda Johnson-Bogaerts, CHT had adequate policies and procedures in place. However, in my view, and as discussed in more detail below, the actions of CHT's employees as shown in the videos amount to a failure to treat Mrs A with respect, a failure to respect Mrs A's dignity and independence, and a failure to comply with policy. The videos show that these actions were not isolated incidents involving only one or two staff members, but rather were repeated actions involving four staff members. CHT has submitted that the failures in this case were individual, rather than systemic. While there is individual accountability for these actions, in my view the widespread failures reflect a pattern of poor compliance with policy and a widespread culture at the rest home that lacked compassion and concern for Mrs A's dignity and independence, for which ultimately CHT is responsible.

Videos

82. Ms B provided HDC with videos that were recorded by a hidden camera in Mrs A's room. Ms B told HDC that she placed the hidden camera in early 2018 after becoming concerned that Mrs A was scared and sensitive to being touched.

83. The videos provided by Ms B were recorded on 2 April and 3 April 2018. They show five HCAs (Ms F, Ms E, Ms C, Ms D, and Ms K[12]) providing cares to Mrs A, including showering, dressing, feeding, and toileting her, and transferring her to and from her bed.

84. Approximately one month prior to the time the videos were recorded, a routine interRAI assessment had been carried out for Mrs A. The assessment noted that Mrs A's health status had deteriorated and that she was rarely communicating verbally and was dependent on staff for all cares. Mrs A's care plan noted that HCAs were to explain cares to Mrs A before carrying them out, provide encouragement to Mrs A, and to talk slowly and clearly while standing in front of her.

85. CHT's Code of Conduct provides that employees are to "exercise fairness, equity, proper courtesy, consideration and sensitivity in dealing with residents, clients, employees and other stakeholders". CHT's Informed Choice & Consent Policy states that "Care Givers are responsible to give explanations to residents before providing cares". In addition, Standard 1.3 of the NZHDSS requires providers to ensure that consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.

[12] The videos do not show any concerning cares provided by Ms K.

Clinical advice on videos

86. RN Johnson-Bogaerts viewed the videos as part of providing her advice. Her advice on each video clip is set out below.

2 April 2018 — morning cares

87. This video shows Mrs A receiving a wash on her chair. RN Johnson-Bogaerts advised:

> "Receiving a sponge bath on a toilet chair can make a person feel exposed, embarrassed or vulnerable and therefore should always be approached with respect, patience and in a gentle way, never to be rushed. The carer is to allow the person as much independence as possible by way of letting the person do as much for themselves as possible, and by way of gently talking through the steps. A person living with advanced dementia may also need some show and tell, guiding their hands gently.
>
> … I am critical that [Mrs A] was left sitting nude without a towel covering her. Her upper body was washed in one go omitting important parts as for example her hands. She was dried with a towel again in one go starting with her back. Washing her groin area took 2 seconds only. The technique was severely rushed. During this process there was no contact with the consumer. In this case the dignity of the consumer was not preserved."

88. RN Johnson-Bogaerts also commented that the HCA's use of a cell phone would be considered unprofessional by her peers.

89. In RN Johnson-Bogaerts' view, the actions of the HCAs as evidenced by this video amount to a significant departure from accepted practice. I accept this advice and I am critical that the HCAs rushed Mrs A's wash and had no interaction with Mrs A. I also note that the HCA used her cell phone in front of Mrs A, while Mrs A's lower half was nude. I consider that this demonstrates a worrying lack of concern about preserving Mrs A's dignity and privacy.

90. Further, I note that this video shows that Mrs A's hands were pushed away roughly when she clutched an HCA's clothing for support while standing. I note the reference in Mrs A's care plan that she may grip HCAs because of being scared of falling. I consider that the act of roughly pushing Mrs A's hands reflects a lack of appreciation of the fear that Mrs A may have been experiencing.

2 April 2018 — mid-morning toileting

91. This video shows Mrs A's incontinence product being checked. RN Johnson-Bogaerts advised:

> "Good practice requires for the carer to explain to the person what she is going to do and give the consumer the opportunity to agree before removing clothing. In this instance the incontinence pad was checked within the privacy of the bedroom however the carer did not connect with the consumer in a dignified and respectful manner. There was no explanation of what was going to happen. Even if a person is

> affected by advanced dementia explaining what you are going to do is important and part of creating a safe environment."

92. RN Johnson-Bogaerts also noted that the HCAs had a private conversation for approximately five minutes without speaking to Mrs A, which she considered to be unprofessional.

93. In RN Johnson-Bogaerts' view, the actions of the HCAs as evidenced by this video amount to a medium to significant departure from accepted practice. I accept this advice and I am critical of the HCAs' failure to interact with Mrs A. In particular, it is concerning that an HCA checked Mrs A's incontinence product — an act that involves exposing the groin — without speaking to or acknowledging Mrs A. I note that this is also inconsistent with Mrs A's care plan, which requires staff to explain cares before carrying them out.

2 April 2018 — afternoon cares

94. RN Johnson-Bogaerts noted that the HCAs transferred Mrs A from her bed to the commode, and from her commode to her chair, in a "rough manner". RN Johnson-Bogaerts advised:

> "[T]he carer is to explain what she is going to do and ask if that is fine. As the person is moved, the carer should talk them through what is happening. … A person with advanced dementia who might not always understand what is exactly said, would especially benefit from a gentle tone of voice showing care and providing security.
>
> I am critical that the carers performed their task rushed and without making proper contact, dialogue, or showing concern for what [Mrs A] was experiencing. At several points in the video [Mrs A] experienced discomfort without the carers showing concern. When [Mrs A] was lowered in the recliner, this was performed roughly. Due to her body rigidity, this should have been performed slowly."

95. In RN Johnson-Bogaerts' view, the actions of the HCAs as evidenced by this video amount to a significant departure from accepted practice. I accept this advice. The rough manual handling and failure to recognise Mrs A's discomfort is particularly concerning. I also consider that the rough handling represented a failure to comply with CHT's Moving & Handling Policy, which required staff to avoid hazardous handling of residents where possible.

96. In addition, I note that this video shows Mrs A's hand being pushed away several times when she reached to hold her drink. In my view, this action is inconsistent with Mrs A's care plan, which requires staff to provide encouragement to Mrs A.

3 April 2018 — morning cares

97. This video begins with Mrs A being undressed and taken into the shower. RN Johnson-Bogaerts noted that Mrs A was left sitting nude without a towel covering her on the shower chair when she was wheeled into the shower. She advised:

> "Good practice requires for a nurse or carer to cover a person at all times preserving privacy, modesty and dignity of a consumer as well as keeping her warm. During this process there was no talking through the steps of what was going to happen or checking in with the consumer."

98. In RN Johnson-Bogaerts' view, the actions of the HCAs as evidenced by this video amount to a moderate departure from accepted practice. I accept this advice. I am critical that the HCAs again failed to explain to Mrs A the cares that were being carried out, particularly as they involved Mrs A being nude.

3 April 2018 — mid-morning toileting

99. A large part of this video shows two HCAs having a personal conversation in Mrs A's presence, without speaking to Mrs A. RN Johnson-Bogaerts considered this to be unprofessional, and advised that it represents a minimal to moderate departure from accepted practice. I accept this advice, and I am critical that the HCAs again failed to interact with Mrs A.

3 April 2018 — afternoon cares

100. Two HCAs have a personal conversation without speaking to Mrs A for the majority of this video. RN Johnson-Bogaerts advised:

> "During this time they assisted her to bed and did not talk her through the process but ignored her. This would be seen as very unprofessional by my peers. Clearly not a one off situation this begs for the question if there may be a systemic issue."

101. In RN Johnson-Bogaerts' view, the actions of the HCAs as evidenced by this video amount to a moderate to significant departure from accepted practice. I accept this advice. I agree with RN Johnson-Bogaerts' concerns that it appears to be a repeated issue that the HCAs had personal conversations while ignoring Mrs A. In my view, this demonstrates a concerning lack of awareness of Mrs A's experience.

Conclusion

102. Mrs A had complex care needs owing to her advanced dementia, limited mobility, and limited communication ability. She was reliant on CHT staff to provide all her cares. As such, she was a particularly vulnerable consumer. Her vulnerability meant that it was critically important that care was provided to her in a respectful manner.

103. The videos paint a troubling and disappointing picture of the care provided to Mrs A by the HCAs that falls well below the expected standard. I consider that the actions shown in the videos, summarised below, represent a failure to treat Mrs A with respect, or to respect her dignity and independence. Specifically:

- Aside from one occasion on the morning of 3 April 2018 (when an HCA asks Mrs A if she is all right), the HCAs rarely speak to or acknowledge Mrs A. There is little evidence that the HCAs explained cares to Mrs A before carrying them out or provided encouragement to Mrs A.

- The wash Mrs A received on the morning of 2 April 2018 was rushed.
- An HCA's personal cell phone was used multiple times in front of Mrs A on 2 April 2018, including when Mrs A's lower half was nude.
- On two occasions, Mrs A's hands were pushed down roughly when she clutched an HCA's clothing for support when standing.
- Several HCAs had lengthy personal conversations while ignoring Mrs A.
- Mrs A's hand was pushed away several times when she reached to hold a drink that was given to her.
- On two occasions, when being transferred by two HCAs, Mrs A was lowered partway and then dropped into her recliner chair.
- On one occasion, an HCA pulled Mrs A to a sitting position by moving her legs off the bed roughly and pulling her upright by her left hand.

104. In addition, I consider that the HCAs' actions represent repeated failures to comply with CHT's Code of Conduct, the Informed Choice & Consent Policy, Standard 1.3 of the NZDHSS, and the requirements in Mrs A's care plan.

105. Evidence was provided that CHT had given its staff relevant training prior to these events, including on the topics of manual handling, stress management, the Code, consumer privacy and dignity, challenging behaviour, and abuse and neglect. CHT submitted that this case represented individual failures by the caregivers, and did not involve a deficiency in CHT's policies, or its management of the situation. However, I disagree, as the number of HCAs involved in the actions above suggests that the staff did not understand what was expected, as there was a pattern of behaviour that failed to respect Mrs A and that failed to provide services in a manner that respected her dignity and independence, and there was a lack of oversight by CHT. In my view, the widespread and repeated nature of these actions reflects a pattern of poor care and failure to comply with policy, for which ultimately CHT is responsible. Accordingly, I find that CHT failed to treat Mrs A with respect and, therefore, breached Right 1(1) of the Code. Additionally, I find that CHT failed to provide services in a manner that respected Mrs A's dignity and independence, and therefore breached Right 3 of the Code.

106. I acknowledge the comments from RN Johnson-Bogaerts in respect of CHT's response when Ms B first complained to CHT:

> "I note the quick and professional response from CHT management when [Mrs A's] family member made the complaint. Appropriately care staff involved were immediately removed from providing care to [Mrs A] and stood down while the matter was investigated."

Management of falls risk and post-falls care

Updating falls risk in care plan — adverse comment

107. Mrs A was assessed by a physiotherapist on 3 May 2017. The physiotherapist recorded that Mrs A was a high risk for falls. On 15 May 2017, Mrs A's long-term care plan was completed. The care plan recorded, among other things, that she was a medium falls risk. On 20 June 2017, Mrs A was reviewed by the DHB CNS L. CNS L concluded that Mrs A's falls risk was high, in light of Mrs A's six falls in the preceding month. Mrs A's care plan was not updated to reflect the higher falls risk identified by CNS L.

108. I note that RN Johnson-Bogaerts considered that the overall care planning for Mrs A was adequate and updated in a timely manner. However, I consider that CNS L's assessment and conclusion about Mrs A's falls risk should have been a trigger for CHT staff to review Mrs A's care plan to ensure that it aligned with CNS L's assessment, especially in light of the physiotherapist's earlier assessment that Mrs A had a high falls risk. It is disappointing that this did not happen. However, I also note RN Johnson-Bogaerts comment:

> "[CHT's] Falls Prevention Programme requires falls prevention interventions for falls risks medium and high — so the identification of the falls risk to be either medium or high seems of low importance here."

109. Nonetheless, it is important that a consumer's falls risk is considered thoughtfully to ensure that the appropriate level of intervention is put in place. I am critical that there did not appear to be more thought given to the differing assessments of falls risk.

Post-fall observations — adverse comment

110. In the period May to July 2017, Mrs A had nine unwitnessed falls.[13] The majority of these falls appeared to be related to Mrs A attempting to mobilise alone. For example, Mrs A was found several times on the ground next to her bed or her chair, where she had been lying or sitting earlier. CHT told HDC that Mrs A's increasing number of falls related to her improving mobility combined with her advanced dementia.

111. Four of the nine falls were not followed up with neurological observations.[14] CHT told HDC that this was in accordance with the practice at the time, which was that neurological observations were carried out only if they were indicated based on the circumstances of the fall.

112. RN Johnson-Bogaerts advised:

> "While it is good practice to perform neurological observations following all unwitnessed falls involving a person living with advanced dementia, it appears that the nurses used some discretion when assessing the circumstances/extent of injury of the fall. Several of the other falls, Mrs A was found sitting on the floor next to her bed or chair."

[13] On 16 May, 25 May, 28 May, 30 May, 3 June, 17 June, 29 June, 10 July, and 16 July 2017.

[14] Specifically, the falls on 28 May, 30 May, 3 June, and 10 July 2017.

113. In RN Johnson-Bogaerts' view, that neurological observations were not carried out for all of Mrs A's unwitnessed falls was a minor deviation from accepted practice. I acknowledge that management of Mrs A's falls risk was complex, in light of her advanced dementia, frailty, and improving mobility (at the time). I also note that CHT staff did undertake monthly reviews of Mrs A's falls at the Registered Nurse and Health and Safety meetings. However, I consider that CHT should have had a clear requirement for staff to undertake neurological observations following all unwitnessed falls. This is even more important where the consumer has impaired cognition, as this can make it more difficult to ascertain the exact circumstances of the fall. It is pleasing that CHT has since updated its Falls Policy to require neurological observations to be undertaken for all unwitnessed falls.

Recommendations

114. I recommend that CHT:

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

b) Review the systems currently in place in CHT facilities for monitoring the interactions between staff and residents, to ensure that all residents are treated with respect and dignity at all times. CHT is to report back to HDC on any additional measures introduced as a result of this review, within six months of the date of this report.

c) Develop a dedicated policy for communicating with residents who have advanced dementia, and provide learning modules to its staff on the new policy. CHT is to provide evidence of the new policy and the associated training within six months of the date of this report.

d) Undertake an audit of a random sample of 20 incident reports for resident falls over the preceding six months, to ensure that neurological observations are being completed for all unwitnessed falls. CHT is to provide HDC with the results of the audit, and any actions planned to address any issues identified in the audit, within three months of the date of this report.

e) Consider amending its Moving & Handling Policy to include guidance on when a resident is rigid or difficult to transfer. CHT is to report back to HDC on the outcome of its consideration within three months of the date of this report.

Follow-up actions

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

116. A copy of this report with details identifying the parties removed, except CHT and the expert who advised on this case, will be sent to the Ministry of Health's Health of Older People team and the Health Quality & Safety Commission, and they will be asked to report back on any work undertaken in response to the report's findings.

117. A copy of this report with details identifying the parties removed, except CHT and the expert who advised on this case, will be sent to the district health board and the Ministry of Health (HealthCERT), and they will be advised of the name of the rest home. They will be asked to report back on any work undertaken in response to the report's findings.

118. A copy of this report with details identifying the parties removed, except CHT and the expert who advised on this case, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

119. The outcome of the referral to the Director of Proceedings was a restorative settlement by way of negotiated agreement. No formal proceedings were taken by the Director.

Appendix A: Independent advice to the Commissioner

The following expert advice was obtained from in-house aged-care advisor RN Hilda Johnson-Bogaerts:

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

2. I have been asked to comment on the following aspects of [Mrs A's] care between 14 May 2017 and 18 October 2017:

   i. The adequacy of the care plans and timeliness of updating these
   ii. Whether [Mrs A's] falls risk was managed appropriately including interventions
   iii. Whether the assessments undertaken by [rest home] staff following each of [Mrs A's] falls were appropriate and in line with the organisation's falls management programme and established nursing best practice
   iv. Whether further medical attention should have been sought following any of [Mrs A's] falls
   v. The adequacy of the organisation's falls management programme
   vi. Any other matters in this case that you consider warrant comment

3. **Documents reviewed**
   i. Letter of complaint dated […]
   ii. [Rest home's] response dated 27 August 2018
   iii. Clinical records from [the rest home] covering the period 14 May 2017 to 18 October 2017, including:
      - Event reports
      - Progress notes
      - interRAI assessments and care plans
      - Restraint assessment and consent forms
      - Restraint monitoring forms
      - Medication charts
   iv. [The rest home's] Falls Management Programme
   v. Comments from [the DHB] dated 25 June 2018
   vi. Clinical notes from [the DHB] for 25 July 2018
   vii. Clinical notes from [the medical centre] for 25 July 2018

4. **Review of clinical records**

[Mrs A] was [in her seventies] when she was admitted to [the rest home] on 2 May 2017 from [the public hospital] after having been assessed as requiring hospital level care rather than to go back home.

She presented with Significant Functional Decline related to Cerebrovascular Disease with Cognitive Impairment, Advanced Dementia, Mobility issues (2x assist). Besides

this her medical problem list also includes Osteoarthritis Spine, Type 2 Diabetes, Depression and Reflux.

While living at [the rest home] there was a high level of family input. The family visited and participated in her care on a daily basis. They preferred to take a rehabilitative approach before slowly coming to terms with the prognosis of her unavoidable functional decline.

Her clinical file for this period included 10 documented falls. None of these resulted in observable injury except the fall on 16 July 2017 when [Mrs A] presented with a lump located on her left temporal part of her head. A CT scan on showed bleeding on the brain. On 31 July she experienced an episode and presented cold and clammy after which she was transferred to [the public hospital]. She was discharged same day. After [Mrs A's] condition has continued to deteriorate. She had a fall again on 18 October 2017 after which the family consented to the use of restraint to prevent further falls.

2 May 2017
[Mrs A] was admitted by the registered nurses on duty that morning who completed an initial and comprehensive assessment and planning of care. This was continued by the registered nurse on the afternoon duty. Both documented their initial assessment and planning of care in the Progress Notes. Regarding mobility they wrote: '*stand transfer with 2 people'* and in the afternoon '*Family concerned of falls as high history of falls. Explained the pro and cons of cotsides. Discussed to trial sensor mat, fall out [mattress] and bed lowering. Family agreed.'*

3 May 2017
Physio admission: '*High falls risk*' and confirmation of the mobility care as the nurses had identified the day before. Medical admission which includes '*unable to* weight *b[ear] without assistance of 2x assist*'.

4 May 2017
A Family meeting was held led by the RN where [Mrs A's] clinical situation and plan of cares was discussed. The plan included 'avoid falls'. The family decided that they wanted [Mrs A] to have extra physiotherapy in an attempt to improve her mobility. They engaged a physio privately.

14 May 2017
The interRAI assessments were completed. The Progress Notes say that family was present. The interRAI Falls Protocol indicated Medium Falls Risk. The nursing care plan for 'Falls — Clinical Issues CAP' was developed which included comprehensive and appropriate falls risk prevention measures including the use of equipment, assistance and '*Regular rounding while she in her room alone'.* This is in line with CHT Falls Management Program which requires the planning of falls prevention for all residents with a '*medium or higher falls risk'.* Whether the falls risk is scored medium or high is immaterial. Individualised intervention of falls prevention are implemented.

During May 2017 four falls were documented.

16 May 2017 An unwitnessed fall was documented on the VCare Event Report. This report has a comprehensive checklist for interventions. Observations were taken and documented on this form as well as in the progress notes. No injury was found and observations taken were within normal range. Because the fall was unwitnessed, in accordance to CHT Falls Management Programme, the box was marked that Glasgow Coma Scale was commenced. I did not find the results of these neurological observations in the provided documentation. The provided documentation did not include the required completed Coma Record (Ser.29.Frm) that the CHT procedure refers to.

25 May 2017 An unwitnessed fall was documented, observations were taken. No injury, all observations within normal range. On the report the box was marked indicating that Glasgow Coma scale observation was commenced. I could not find results documented in the provided documentation.

28 May 2017 An unwitnessed fall was documented with [Mrs A] found kneeling on the floor. The RN checked for injury however did not take any observation which is not in line with CHT process. Reasoning for not following normal process were not documented by the nurse.

30 May 2017 An unwitnessed fall was documented with [Mrs A] found sitting on the floor with her back to the bed. No injuries were found, all observations taken were within normal range.

On 31 May the Physio entered in the Progress Notes that 'her mobility has improved'.

During June [Mrs A] had 3 more documented falls and her fall on 10 July 2017 all followed the same trend. They were unwitnessed falls on various times of the day where she was found sitting on the floor beside her bed or chair in her room. Staff were alerted to the fall by way of a sensor mat activation. No injury was found, observation within normal range. Neurological observations were not taken. Rounding?

On 16 July 2017 [Mrs A] had again an unwitnessed fall while she was alone in her room. This time she had hit her head. She had pain '*on head where lump located*'. The document indicates that Glasgow Coma scale was commenced however I did not find any evidence of this in the documentation. The box next to Rounding as intervention was also ticked as item for consideration. However I could not find any documentation that this would have been implemented.

Interventions were clinically appropriate and included application of cold compress and pain relief. The family accompanied her to [the] emergency clinic and brought her back late that evening.

On 17 July the nurse documented in the Progress Notes that she had a conversation with the family regarding the risks and benefits of restraint (lap belt and bed rail), use

of hip protectors and use of head padding. The family were going to get back with a decision.

The days after this incident the family showed their concern and asked on several occasions for a further investigation of the head injury. [Mrs A] is seen by the GP on 19 July and 24 July. He concludes that there is no serious injury and wants to wait and see.

The family decide to get a second opinion and a CT scan is organised on 25 July by the family. The results showed a bleeding had occurred since the last scan. It was *'likely that this had occurred due to a fall in the last month'* and *'no further inhospital medical or neurosurgical involvement was required'.* There was a recommendation that [Mrs A] *'would require close supervision to avoid further falls'*.

31 July 2017 [Mrs A] had an episode where she became unresponsive and cold and clammy. She was transferred to hospital as per the family wishes from which she was discharged same day. Nurse documents her concern that the family still have not provided consent for restraint as measure to prevent falls.

In the following months the clinical notes show [Mrs A] participated often in the activities programme, and the family continued to be closely involved with her care. [Mrs A] increases in frailty. She does not appear to attempt to get up which caused falls in the previous months.

9 October 2017 A near miss was documented where [Mrs A] '*slipped from her wheelchair* while *sitting in the lounge waiting for the bus trip'*. Observations were taken and no injury was found.

18 October 2017 [Mrs A's] husband calls the staff to attend to his wife's fall. She was '*found sitting on the floor leaning sideways on her bed*'. The assessment from the nurse did not find any injury. All observation were within normal range.

24 October 2017 Further discussions are documented regarding the use of bedrails to prevent further falls. The family will sign the consent form on 25 October 2017.

5. **Comments and Clinical Advice**

I note that the CHT letter of response to HDC dated 27 August 2018 writes in paragraph 25 that *'a restraint assessment was carried out on 25 July 2017. As a result of this* assessment *CHT obtained consent from [Ms B] to use bed rails … to prevent her falling out'.* I did not find documentation relating to such restraint assessment other than that nurses discussed the use of restraint with members of the family at that time. The family were very hesitant. A restraint assessment document was included in the documentation dated 25 October 2017 and signed by the named family member on the same day. The date might have been misread when formulating the response. No restraint was implemented before 25 October 2017.

It is accepted practice to take neurological observations when an older person with advanced dementia experiences an unwitnessed fall. While this intervention is listed on the VCare Event report and is part of the Falls Management Procedure of the organisation, it is not clear if neurological observations were taken when [Mrs A] experienced unwitnessed falls. No recordings were found and no references to recoding or results were found in the documentation provided.

Deviation from accepted practice — minor to moderate.

I note that the consumer's care plan includes the intervention of '*regular rounding when client alone in* room'. I did not find evidence in the documentation of rounding being implemented. Commonly, documentation of rounding includes the use of a Rounding Observation Sheet. It is my clinical opinion that this intervention would have been appropriate to implement considering the circumstances of [Mrs A's] falls.

Deviation from accepted practice — minor.

When a resident in a care home has a number of falls it is good practice to look at least on a monthly basis for trends and common causes which then can direct interventions of falls prevention. The Falls management policy refers to such reviews. I did not find in the documentation evidence of a review of [Mrs A's] falls looking for trends and causes. This may be a systemic issue.

Deviation from accepted practice — moderate.

i. The adequacy of the care plans and timeliness of updating these

The nurses, GP and physiotherapist all admitted [Mrs A] to the service in the first days. They documented their assessment findings and initial care plan going forward. The interRAI assessments were completed in a timely manner and reassessments occurred when required. Family was also included in the interRAI assessment and care planning. The care plans included items triggered by the interRAI CAPs. The items included in the care plan are comprehensive and include a holistic approach. They were updated when reassessments identified deterioration. A short term care plan was included that addressed the consumer's care while experiencing an acute respiratory infection. I have found the care plans to be adequate and updated in a timely manner. Conversations about the care of [Mrs A] with EPOA and other close family members were documented on an ongoing basis.

Deviation from accepted practice — nil.

ii. Whether [Mrs A's] falls risk was managed appropriately including interventions

The nurse and physio who admitted [Mrs A] into the care home both identified the falls risk as high. The interRAI assessments triggered for falls with a rating of Medium falls Risk. The organisation's Falls Prevention Programme requires falls prevention interventions for falls risks medium and high — so the identification of the falls risk to be either medium or high seems of low importance here. Care planning included a comprehensive and appropriate list of interventions relating to both the use of

equipment and care. I note that [Mrs A's] care plan includes the intervention of '*regular rounding when client alone in room'*. I did not find evidence in the documentation of rounding being implemented. Rounding/checking on the resident when she is alone in her room would in my opinion be a very effective way to prevent falls in [Mrs A's] situation. Typically this would involve documentation of rounding on an observation sheet so that trends can be identified and the need for rounding reassessed on a regular basis.

Deviation from accepted practice — minor to moderate.

iii. Whether the assessments undertaken by [rest home] staff following each of [Mrs A's] falls were appropriate and in line with the organisation's falls management programme and established nursing best practice

In addition to the assessments and observation documented on the Falls Report, it is accepted practice to take neurological observations if and when an older person with advanced dementia experiences an unwitnessed fall. While this intervention is listed on the VCare Event Report and is part of the Falls Management Procedure of the organisation, it seems these neurological observations were not completed as required when [Mrs A] experienced unwitnessed falls. No neurological recordings were found in the provided documentation and no references to such results were found.

Deviation from accepted practice — minor to moderate.

iv. Whether further medical attention should have been sought following any of [Mrs A's] falls

None of the falls except the fall of 16 July 2017 caused obvious injury. The observations taken post these falls were all within normal range. Therefore there was no indication for medical referral. The fall on 16 July was followed by a medical review. In addition the GP also saw [Mrs A] on 19 July and 24 July.

Deviation from accepted practice — nil.

v. The adequacy of the organisation's falls management programme

The Falls Management Programme which is the organisation's policy on falls management is comprehensive and based on good practice. It is my opinion that this policy is a good guide for staff to prevent and manage falls.

Deviation from accepted practice — nil.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

The following further advice was obtained from RN Johnson-Bogaerts:

> "Thank you for the request that I provide additional clinical advice in relation to the care provided by [the rest home] (CHT). In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.
>
> Specifically I was asked to review the response from CHT dated 21 August 2019 and the Neurological observations charts attached to this letter of response, and to advise whether it changes my advice dated 20 January 2019 regarding the management of [Mrs A's] falls risk and post-fall assessments/escalation of care.
>
> **Review of clinical records**
> *Immediate post fall interventions:*
> Neuro Observation charts/Coma Record (Ser.29.Frm) were provided relating to the falls on 16 May 2017, 25 May 2017, 17 June 2017, 16 July 2017 and 18 October 2017. These related to the falls where the post falls report included that neurological observations were commenced. CHT's response explains that not every unwitnessed fall was followed up with neurological observations, only if the findings of the fall pointed to a head injury. The wording on the vCare event report states '*Commence Glasgow Coma Scale if fall unwitnessed and/or there is evidence of head trauma'.* While it is good practice to perform neurological observations following all unwitnessed falls involving a person living with advanced dementia, it appears that the nurses used some discretion when assessing the circumstances/extent of injury of the fall. Several of the other falls, [Mrs A] was found sitting on the floor next to her bed or chair.
>
> It is my opinion that there was a minor deviation from accepted practice relating to [Mrs A's] post falls interventions.
>
> I note that CHT's response included that neurological observations are now completed on every unwitnessed fall.
>
> *Monthly reviews of falls:*
> CHT's response includes the reasoning why no monthly review for trends and common causes was undertaken of [Mrs A's] falls. This was explained by the fact that the cause of falls was obvious at all times. This would not be seen by my peers as a valid reason not to complete the process of monthly reviews. The purpose of the review includes looking for ways to prevent harm from falls. Therefore I maintain my previous advice that this is a moderate deviation from accepted practice.
>
> *Rounding*
> I agree that the term 'rounding' as intervention for falls prevention varies from provider to provider. The response explains that at CHT rounding relates to an '*informal level of increased attention i.e. that a closer eye should be kept on the*

resident than might otherwise be the case'. At CHT this is not systemised and therefore not documented. Deviation from accepted practice — nil.

Addendum 27 February 2020
I was asked to review the response provided by CHT dated 10 February 2020 together with the attached copies of meeting minutes of the RN Meetings and Health and Safety Staff Meetings relating to the months of June 2017, July 2017 and August 2017, and advise if the additional information would change my previous advice.

Both the provided RN Meeting Minutes and the Staff Health and Safety Meeting Minutes include reviews of falls of CHT residents, as well as strategies for care staff how to prevent these falls from reoccurring. This included the review of [Mrs A's] falls relating to these months. She was identified [by her initials] in the minutes.

This shows that the CHT policy was adhered to and managed according to accepted practice. Therefore I am changing my earlier advice to deviation from accepted practice — nil.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

The following further advice was obtained from RN Johnson-Bogaerts:

"1. Thank you for the request that I provide clinical advice in relation the care provided by [CHT]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

2. **Specifically I was asked**
   a. to review the videos and the documentation and advise whether I consider that there has been a departure from the standard of care or accepted practice,
   b. to comment on the appropriateness and adequacies of the policies provided by CHT.

3. **Documents reviewed**
   a. Video recordings from a camera taken during the period 2 April 2018–3 April 2018.
   b. Timeline of events provided by the complainant, which sets out what she believes is happening in the video clips.
   c. Response from CHT Healthcare Trust dated 18 April 2019 and enclosures.

4. **Review of videos, comments and advice**

2018-04-02 07 51 49-P

The consumer sits on her toilet chair without any clothes and without cover. A carer is seen to give [Mrs A's] upper body a wash with a red facecloth in one go starting with her face, going over her hair, right arm, left armpit, and over her back. This is executed in one go, taking in total 16 seconds. It is not clear if any soap was used, the facecloth was not rinsed, there was no second wash or rinse. [Mrs A's] skin was dried starting from her back to her face to stomach area. Again in one go, taking 5 seconds only. A second caregiver is seen handling a garment.

The red facecloth is taken again and [Mrs A's] groin area is washed while still sitting on the toilet chair, taking 2 seconds.

2018-04-02 07 52 49-P

A towel is taken and [Mrs A's] groin area is dried superficially taking 3 seconds.

The caregiver powders the consumer by splashing some powder on her chest and on her back. The yellow garment is taken and the consumer is dressed. Her arms are guided roughly.

2018-04-02 07 53 50-P

[Mrs A] continues being dressed and then pulled forward by her head to guide the garment down. The second caregiver stands in front of the camera seen using her cell phone. The first caregiver continues dressing [Mrs A] and pulls up her pants to her knees. The first caregiver is seen to grab the top clothes and roughly pulling these down while [Mrs A] grabs the carer's arm with her left hand, the caregiver pulls away her arm, [Mrs A's] hand lets go and goes up suddenly as if she got a fright or is in pain.

2018-04-02 07 54 51-P

[Mrs A] is seen sitting by herself, she reaches towards her sheets on her bed. Half a minute later the carer walks in front of the camera with her cell phone in her hand. She puts the phone away and starts combing [Mrs A's] hair.

2018-04-02 07 55 51-P

The carer continues to comb the consumer's hair and leaves the room.

2018-04-02 07 56 51-P

[Mrs A] covers her face with her left hand while sitting on the toilet chair. Her shoes are being put on. A nursing chair is brought within reach of the carers. An incontinence pad is pushed between [Mrs A's] legs while still sitting. One of the carers is seen taking her cell phone from her pocket.

2018-04-02 07 57 51-P

People seem to be talking in the background but it is unclear what they're saying. The carer is standing while [Mrs A] sits in the chair with her face covered. The carer is on her phone and then walks away.

2018-04-02 07 58 52-P
The carer walks back in front of the camera while using her cell phone. She puts the phone away and walks away.

2018-04-02 07 59 53-P
Half a minute passes. A carer comes up to [Mrs A] and grabs her by her R upper arm and left shoulder pulling her up from the chair. There is no prompting. The second carer takes the red facecloth and washes [Mrs A's] lower body.

2018-04-02 08 00 53-P
The carers talk among themselves. One carer dries and dresses [Mrs A] and takes the toilet chair away. The second carer puts the nursing chair behind [Mrs A] and the first caregiver who was assisting [Mrs A] to stand lowers her into the chair. The last part of this she drops [Mrs A] who lands rather hard into the chair. Both carers then lift [Mrs A], pulling her up so she sits higher up in the chair.

2018-04-02 08 01 54-P
[Mrs A] raises her hand and makes some noises. A carer comes back, opens the curtains and moves the consumer's chair behind.

The videos above appear to relate to the morning routine of toileting, bathing and dressing.

Comments and advice Morning cares on 2 April 2018
It is accepted practice to provide a sponge bath or wash while the person is sitting on a toilet chair. To provide dignity, privacy and to keep the person warm, good practice requires for the person to be covered at all times. Usually this would be a warm towel draped over the shoulders and a towel over the lap.

Receiving a sponge bath on a toilet chair can make a person feel exposed, embarrassed or vulnerable and therefore should always be approached with respect, patience and in a gentle way, never to be rushed. The carer is to allow the person as much independence as possible by way of letting the person do as much for themselves as possible, and by way of gently talking through the steps. A person living with advanced dementia may also need some show and tell, guiding their hands gently.

A sponge or wash is commonly divided up starting with washing the face which is then dried before moving to wash the next body part. All skin folds should be carefully washed and dried. It is common to use soap or a body wash liquid in the water which requires rinsing before drying off.

I am critical that [Mrs A] was left sitting nude without a towel covering her. Her upper body was washed in one go omitting important parts as for example her hands. She was dried with a towel again in one go starting with her back. Washing her groin area took 2 seconds only. The technique was severely rushed. During this process there was no contact with the consumer. In this case the dignity of the consumer was not

preserved. While at times on a very busy day a technique may be rushed somewhat that did not seem to be reason in this case.

The use of a cell phone and having private conversations by carers among themselves while providing cares in a resident's room and excluding the residents would be seen as unprofessional by my peers.

Deviation from accepted practice — significant.
2018-04-02 10 47 24-P
A caregiver wheels in the recliner chair with [Mrs A] is sitting in the chair. She lowers the leg rest. She pulls away [Mrs A's] clothing and checks the incontinence pad. A second carer arrives.

2018-04-02 10 48 24-P
[Mrs A] sits in her recliner chair. A carer looks outside the window and talks.

2018-04-02 10 49 24-P – to 2018-04-02 10 54 26-P
The carers talk among themselves standing behind [Mrs A's] chair while she sits in her nursing chair. 5 minutes pass during which there is no interaction between the carers and [Mrs A].

2018-04-02 10 55 27-P
A member of staff comes into the room and asks whether the consumer is toileted. A conversation is held between the carers and another member of staff after which [Mrs A] is wheeled out of the room again.

Comments and advice — Assisting with toileting morning 2 April 2018
The purpose of bringing [Mrs A] to her room is unclear. Most likely this was to check her incontinence product and check if it needed to be refreshed. Good practice requires for the carer to explain to the person what she is going to do and give the consumer the opportunity to agree before removing clothing. In this instance the incontinence pad was checked within the privacy of the bedroom however the carer did not connect with the consumer in a dignified and respectful manner. There was no explanation of what was going to happen. Even if a person is affected by advanced dementia explaining what you are going to do is important and part of creating a safe environment.

It is not clear what the purpose was for the two carers to remain in the bedroom having a continued conversation with each other for a further 5 minutes?

Carers having private conversations among themselves in a resident's room while ignoring the resident would be seen as unprofessional by my peers.

Deviation from accepted practice — medium to significant.

2018-04-02 15 46 56-P
[Mrs A] is seen lying in bed under the blankets. A carer pulls the sheets off [Mrs A] and grabs her feet pulling her sideways and her legs off the bed in a rough manner. [Mrs A] shows distress and body rigidity. The carer grabs the arms and pulls [Mrs A] to sitting on the side of the bed. [Mrs A] shows distress and holds up her hand. The carer grabs the hand while looking away. The carer does not check in with [Mrs A]. A second carer comes along and each of the carers take one side to lift [Mrs A] up who meanwhile looks distressed. The toilet chair is pulled close, [Mrs A's] pants are pulled down and she is made to sit down on the toilet chair roughly. There is no consideration of her body rigidity. The carer puts on gloves and starts undressing [Mrs A].

2018-04-02 15 47 57-P
The carer removes [Mrs A's] top. A white facecloth is used to give [Mrs A] a quick wash, face only, the second carer dries with the towel.

2018-04-02 15 48 58-P
[Mrs A] is dressed with a fresh top by one carer who guides her hands through the sleeves, [Mrs A] is rigid. A new pair of pants is also put on up to her knees.

2018-04-02 15 49 58-P
One carer washes [Mrs A's] lower body and applies a new incontinence pad, her pants are pulled up while the other carer holds her up to stand.

The nursing chair is placed behind [Mrs A] and held up high while the other carer pushes her into the chair. When the chair is put down [Mrs A] looks like she got a fright from this. The first carer makes the bed while the second carer combs [Mrs A's] hair.

2018-04-02 15 52 00-P
[Mrs A] is offered a drink by a carer who holds the drink and assists by holding it up to her mouth. When [Mrs A] reaches for the drink her arms are pulled away.

2018-04-02 15 53 01-P
The carer again pushes away the arms while continuing to assist [Mrs A] to drink. At the same time she grabs the remote control and turns on the TV.

2018-04-02 15 54 01-P
The carers talk among each other while supporting [Mrs A] to drink. Once [Mrs A] has finished the drink, the carer turns her chair around towards the TV to watch it.

Comments and advice — Assisting with getting up from the bed in afternoon 2 April 2018
Before removing the sheets of a person lying in bed it is good practice for the carer to check in with the person, say what time it is and what is proposed that is going to happen next. In this case this was getting up, going to the toilet, freshen up, have a

drink and then watch TV. Ask if that is fine. When removing the sheets this should be done gently and considered of modesty of the person.

When manual handling is required to support the person to get up from the bed, the carer is to explain what she is going to do and ask if that is fine. As the person is moved, the carer should talk them through what is happening. After the person then sits up or stands up the carer should check in and ask how they are feeling. When a person is insecure or gets a fright as was the case here, concern is to be shown and a moment be taken before continuing. A person with advanced dementia who might not always understand what is exactly said, would especially benefit from a gentle tone of voice showing care and providing security.

I am critical that the carers performed their task rushed and without making proper contact, dialogue, or showing concern for what [Mrs A] was experiencing. At several points in the video [Mrs A] experienced discomfort without the carers showing concern. When [Mrs A] was lowered in the recliner, this was performed roughly. Due to her body rigidity, this should have been performed slowly.

Deviation from accepted practice — significant.

2018-04-03 07 55 29-P
Two carers help [Mrs A] up, remove her undergarments before letting her sit on a shower chair. They do not cover her thighs with a towel preserving modesty.

2018-04-03 07 56 29-P
[Mrs A's] clothes are removed by the carer while sitting on the shower chair and then wheels the chair out of site presumably to the shower. She then returns to the room and takes a sheet or towel and looks for the shampoo.

2018-04-03 07 57 30-P
In the background one can hear the shower running and someone talking at times.

2018-04-03 07 58 33-P
[Mrs A] is returned back to the room sitting on the shower chair and covered by two large towels. [Mrs A] starts drying her face while the carer leaves the room.

2018-04-03 07 59 33-P – 2018-04-03 08 00 33-P
The carer returns and dries [Mrs A's] hair with a hairdryer.

2018-04-03 08 01 33-P
The towels are removed and [Mrs A] is dried, moisturiser is applied. The second carer makes the bed. [Mrs A] sits uncovered on the toilet chair. There is no dialogue.

2018-04-03 08 02 33-P – 2018-04-03 08 03 33
The second carer helps [Mrs A] getting dressed guiding the arms through the sleeves. [Mrs A] is pulled forward by her head to pull down her clothes. There is no talking, pants are pulled up to her knees.

2018-04-03 08 04 33-P
[Mrs A] is assisted to stand, her pants are pulled up. The shower chair is removed and the recliner is put behind [Mrs A] who is lowered into the chair.

2018-04-03 08 05 35-P
The carers talk among themselves — the conversation seems emotive.

2018-04-03 08 06 36-P
The carers continue to talk among themselves while one carer combs [Mrs A's] hair. At times she pushes the chair around without telling the consumer.

2018-04-03 08 07 36-P
The carer asks the consumer if she is alright after tying her hair and then wheels her out of the room.

Comments and advice — Shower morning of 3 April 2018
I am concerned that [Mrs A] was left sitting nude without a towel covering her on the shower chair while being wheeled out of the room into the shower. Good practice requires for a nurse or carer to cover a person at all times preserving privacy, modesty and dignity of a consumer as well as keeping her warm. During this process there was no talking through the steps of what was going to happen or checking in with the consumer.

Further the caregivers were having an animated and emotive conversation among themselves. For [Mrs A] this would have been stressful.

Deviation from accepted practice — medium.

2018-04-03 09 52 31-P
The carer and physio/nurse are in the room. They are helping the consumer sit down on the toilet chair. They say 'sit down [Mrs A]' and 'slowly', 'slowly', 'slowly'. [Mrs A] is lowered slowly onto her chair. The physio/nurse removes a belt from her waist and put it away.

2018-04-03 09 53 31-P – 2018-04-03 10 00 36
[Mrs A] sits on the toilet chair and with a rather stressed look on her face while the two carers are having an emotive and animated conversation. [Mrs A] seems to relax when one of the carers starts combing her hair. The discussion among the two carers continues for 8 minutes until they help [Mrs A] up from the toilet chair, dress her and lower her into the recliner chair. The conversation is unclear.

2018-04-03 10 01 37-P – 2018-04-03 10 08
[Mrs A] sits in her recliner chair, the back of her chair facing the camera while the carers continue to talk among themselves.

Comments and advice — Assisting with toileting morning 3 April 2018
The physio/nurse followed good practice using a belt and guiding [Mrs A] when lowering her onto the toilet chair slowly. I am concerned that once this person left and for a substantial time the caregivers were having an animated and emotive conversation among themselves in [Mrs A's] presence and who showed a stressed expression on her face. Due to her advanced dementia it would have been difficult for her to understand what was going on but she would be able to pick up on the general negative sentiment possibly causing distress. The discussion among the carers went on for a significant period of time. This would be seen as unprofessional by my peers.

Deviation from accepted practice — minimal to medium.

2018-04-03 12 52 01-P to – 2018-04-03 13 14 17-P
The carers talk amongst themselves and over the head of [Mrs A] while she is sitting in the recliner apparently ready to go to bed for an afternoon rest. This continues for 7 minutes before they assist [Mrs A] to bed. The conversation among each other continues while they are assisting [Mrs A] from the chair to her bed never checking in with [Mrs A] or talking her through what they are doing and what is going to happen. [Mrs A] is covered by blankets, bedrails are put up as well as covers for the bedrails. All the time the two carers keep conversing with each other — it is not clear what the conversation is about, at times there is some laughter. This continues for another 8 minutes.

Comments and advice — Assisting with going to bed midday 3 April 2018
I am concerned that again the caregivers were having a conversation among themselves in [Mrs A's] presence without acknowledging her for a significant period of time (in total 15 minutes). During this time they assisted her to bed and did not talk her through the process but ignored her. This would be seen as very unprofessional by my peers. Clearly not a one off situation this begs for the question if there may be a systemic issue.

Deviation from accepted practice — medium to significant.

2. Appropriateness and adequacies of the policies provided by CHT
The following policies were reviewed: Moving and Handling Policy; Informed Choice & Consent Policy.

The policies are high level and include principles by which the organisation will conduct services. For this purpose they are adequate. The moving and handling policy includes a reference to CHT's moving and handling guidelines which presumably include the techniques/how to for moving and handling which the care staff could refer to for specifics. The Informed choice & consent policy similarly is comprehensive and includes sound principles.

For carers to understand what this means for their daily practice it is important that the organisation translates the policy principles in effective learning modules. CHT

provides employee learning through Altura Aged care Channel an international provider of mandatory learning. The content of the modules is sound and based on good practice.

Deviation from accepted practice — nil.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"

The following further advice was obtained from RN Johnson-Bogaerts:

"Thank you for the request that I provide additional clinical advice in relation to the complaint about the care provided by CHT to [Mrs A]. In preparing the advice on this case to the best of my knowledge I have no personal or professional conflict of interest. I agree to follow the Commissioner's Guidelines for Independent Advisors.

Specifically I was asked to review the additional information received from CHT and advise whether any of the additional information causes me to amend any of the conclusions in my previous advice.

The following documents were reviewed

- Letter from CHT's [lawyer] dated 21 August 2019 (and enclosures)
- Statements from four individual caregivers
- Further letter from [the lawyer] dated 11 October 2019 (and enclosures)

1. Review of documentation
12 June 2018 Residents' Meeting Minutes. The Area Manager checks with people present if staff '*are pleasant and polite'*. The minutes include that [Mrs A's] granddaughter mentions '*staff are caring and respectful*'. She makes some requests which are noted.

The Complaints Register provided includes an entry on 16 April 2018 regarding the care provided to [Mrs A] and the video evidence provided. The Actions as a result of this complaint included the immediate removal of staff involved in the complaint from providing care to [Mrs A] and the suspension of the staff on 24 April 2018. On 30 June there was another complaint relating to the care of [Mrs A] and one more on 17 March 2019 regarding a near miss medication error. Immediate and appropriate action was documented in the complaints register.

The forwarded Performance Improvement Plans for the individual care staff included with this complaint. The document includes the Policies or Rules Violated followed by the Description of Expected Performance and the sign off of Standard Achieved. The items identified include '*Moving and Handling*', '*CHT Standard of Care Policy*' including

'*Dignity*', '*Abuse and Neglect', 'Personal mobile is not used while working'.* These were all signed off during June 2018 when the plans were reviewed by their Manager.

The email response of 7 June 2019 from CHT to the family included an apology and the statement that CHT wants to work with the family to make sure that they have responded fully to all concerns. And a second letter of apology from CHT dated 11 June 2018 which included the results of CHT's investigation into the concerns raised and the actions taken.

The four care staff responses included are reflective of what happened and include an apology to [Mrs A's] family and agreement with the comments made in my previous advice regarding the way care was provided. The letters also include the comprehensive lists of additional education they attended.

2. Conclusions

Reviewing the provided responses I remain critical of the way care was provided by the care staff as per my previous advice.

In addition I note the quick and professional response from CHT management when [Mrs A's] family member made the complaint. Appropriately care staff involved were immediately removed from providing care to [Mrs A] and stood down while the matter was investigated. The issue was taken seriously and CHT provided an apology and assurance of working with the family in his email. Corrective action included appropriate disciplinary action against the involved care staff as well as providing them with additional education and the completion of an individual and very specific Performance Improvement Plan. The family was provided with the results of the investigation, the actions taken and again with an apology from CHT. This is in line with accepted practice and shows a professional response from Management in line with good practice.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Aged Care Advisor
Health and Disability Commissioner"