Decision 22HDC01813
24 June 2025

HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Care provided to vulnerable resident in care home

Introduction

1. At the outset, I would like to express my sympathy and heartfelt condolences to the family and friends of Mrs A, for their loss. I hope this report brings some closure for Mrs A's family.

Complaint background

2. On 27 July 2022 this Office received a complaint from Ms A about the care provided to her elderly mother, Mrs A at Bainlea House (2013) Limited (trading as Bainswood on Victoria).[1] The complainant raised concerns regarding the care and treatment her mother received between March and August 2022 (inclusive).

3. Mrs A received hospital-level care from Bainlea House (2013) Limited due to her hemiplegia[2] and dysphagia[3] as a result of a stroke. Ms A was Mrs A's welfare guardian.[4]

4. Ms A's main concern is an allegation that her mother had been sexually assaulted. Ms A stated that on a couple of occasions her mother's incontinence product had been found open and ripped, and on one occasion her vulva was noted to be red. According to the progress notes, concerns of sexual assault were raised on 5 July 2022 and 24 July 2022. Ms A stated that her father had been 'falsely accused' and, as a result, for a time Bainlea House (2013) Limited prohibited him from visiting his wife.

5. At the time of her complaint (27 July 2022) Ms A was concerned that an internal investigation had not been initiated by Bainlea House (2013) Limited, but according to documents received, an investigation was initiated on 1 August 2022.

6. On 10 August 2022 Police were contacted by Bainlea House (2013) Limited, and the following day they interviewed Mrs A. The Police concluded that there was no clear disclosure of sexual offending, and the Police file was closed.

7. In addition, Ms A expressed concerns about the management of her mother's sacral[5] pressure injury wounds, and her mother's weight loss.

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[1] Please note, all references to Bainlea House (2013) Limited refer to Bainlea House (2013) Limited (trading as Bainswood on Victoria).
[2] One-sided paralysis of the body.
[3] Difficulty swallowing.
[4] A person appointed by a Family Court judge to make decisions on behalf of someone else, including their day-to-day care and welfare.
[5] Lower back.

Names (except the advisor on this case and Bainlea House (2013) Limited (trading as Bainswood on Victoria)) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Scope of investigation

8. The following issue arising from the complaint was investigated by HDC:

- *Whether Bainlea House (2013) Limited (trading as Bainswood on Victoria) provided [Mrs A] with an appropriate standard of care between March 2022 to August 2022 (inclusive).*

HDC investigation findings

9. HDC gathered information from Bainlea House (2013) Limited, including clinical records, documents from the internal investigation, staff statements, and policy documents. Following review of this information, the following conclusions were reached.

Concerns regarding alleged sexual assault, including photos taken by staff of Mrs A's vaginal area

- The Abuse and Neglect policy (issued 2021) was inadequate to guide staff actions when encountering potential/alleged sexual abuse.
- Staff did not escalate their concerns in accordance with the seriousness of the concerns, as required by the organisation's policy.
- There was no assessment of Mrs A's capacity to give consent to have sexual relations with her husband, Mr A.
- Staff did not engage Mr A in a confidential conversation before they decided to contact Mrs A's welfare guardian, Ms A.
- Mrs A's care plan had insufficient information to guide staff should they observe any further signs of abuse, and did not note what was discussed and agreed upon with Mrs A's welfare guardian.
- It was not appropriate to communicate with the daughter who was not the welfare guardian for Mrs A.
- The emailing of photos taken was considered insensitive and a breach of confidentiality and consent for Mrs A.

Management of Mrs A's pressure injury

- No monitoring charts/repositioning schedules were completed for Mrs A to monitor how often she was turned, and on to which side.
- Progress notes included repositioning in general terms only and lacked detail such as what side Mrs A was turned to, and how often.

Management of Mrs A's weight loss and dietary needs

- Mrs A's progress notes contain very few entries documenting her food and fluid intake.
- A referral to a dietitian should have been initiated at an earlier time (such as when her pressure injuries were identified on 17 May 2022. The referral to the dietitian was made on 27 July 2022).

In-house advice

In-house aged-care advice was sought from registered nurse (RN) Hilda Johnson-Bogaerts (Appendix A), who identified the following deviations from the accepted standard of care provided by Bainlea House (2013) Limited:

- Concerns regarding alleged sexual assault, including photos taken by staff of Mrs A's vaginal area — **medium to significant deviation.**
- Management of Mrs A's pressure injury — **minimal deviation.**
- Management of Mrs A's weight loss and dietary needs — **minimal deviation.**

Response to provisional opinion

Bainlea House (2013) Limited

10. Bainlea House (2013) Limited was given a copy of RN Johnson-Bogaerts' advice. Bainlea House (2013) Limited apologised for any breach of Mrs A's privacy and said that the staff always had her welfare and best interests at heart throughout the time she was a resident at Bainlea House (2013) Limited.

11. Bainlea House (2013) Limited acknowledged that some errors were made concerning the management of Mrs A's incontinence wrap, including the taking of photographs and sending these to Mrs A's daughter who was not the welfare guardian. However, Bainlea House (2013) Limited does not agree that it amounted to a medium to significant deviation from the accepted standard of care, as identified by RN Johnson-Bogaerts, because consent was provided by Mrs A for photos to be taken. RN Johnson-Bogaerts reviewed her advice and acknowledged that it was a delicate and difficult situation for all involved, but she remained concerned about the management of the issue at the time, and therefore the medium to significant deviation remained.

12. Bainlea House (2013) Limited acknowledged that Mrs A was not asked by staff whether she had consented to sexual relations with Mr A. However, Bainlea House (2013) Limited stated that Mrs A's distressed behaviour made them believe she did not consent. It acknowledged that this was an error on its part and said that it addressed this via a Corrective Action Plan that was developed following the incident.

Ms A

13. Ms A was given the opportunity to respond to the provisional opinion, including the proposed findings and recommendations.

14. Ms A told HDC:

> '[Bainlea House (2013) Limited] tried to tarnish my father's reputation by painting a picture of him being a sexual offender, this being a man's worst nightmare! … The only thing Dad was guilty of was taking an active interest in his wife's wellbeing, caring for her and … There were certainly no sexual overtures from him to my mother.'

15. Ms A stated: '[Bainlea House (2013) Limited] brought absolute shame on my family for no reason at all and caused us all so much unnecessary stress.'

Decision

16. The issue in this matter is whether Bainlea House (2013) Limited (trading as Bainswood on Victoria) provided Mrs A with an appropriate standard of care between March 2022 and August 2022 (inclusive). RN Johnson-Bogaerts identified issues in three areas of Mrs A's care and advised that in all three areas, the care provided by Bainswood fell below the accepted standard. I accept RN Johnson-Bogaerts' advice.

17. Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code)[6] requires that services are provided with reasonable care and skill. In the circumstances, having reviewed all the information available, I consider that Bainlea House (2013) Limited (trading as Bainswood on Victoria) did not provide services to Mrs A with reasonable care and skill and breached Right 4(1) of the Code.

Changes made since events

18. Bainlea House (2013) Limited told HDC that additional education was provided for all staff in August 2022 and repeated throughout 2023 and 2024, and included the following:

- Sexuality and intimacy
- Abuse and neglect
- Privacy
- Communication
- Critical thinking

19. An escalation policy was developed and implemented in July 2022 and updated in July 2024.

Recommendations

20. RN Johnson-Bogaerts noted that the corrective actions undertaken by Bainlea House (2013) Limited were comprehensive and of good quality, with an emphasis on staff education. I acknowledge the changes made by Bainlea House (2013) Limited and consider these to be appropriate in the circumstances.

21. In the provisional report, I recommended that Bainlea House (2013) Limited apologise in writing to Mrs A's family for the breach of the Code identified in the report. Bainlea House (2013) Limited has provided the apology, and it will be forwarded to Mrs A's family.

22. In the provisional report, I recommended that Bainlea House (2013) Limited provide HDC with a copy of the escalation policy that was developed in July 2022 (and updated in July 2024). Bainlea House (2013) Limited has provided this policy and therefore I consider that this recommendation has been met.

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

23. In the provisional report, I recommended that Bainlea House (2013) Limited provide HDC with evidence of education/training in the areas of sexuality and intimacy; abuse and neglect; privacy; communication; and critical thinking, in the form of education/training material. Bainlea House (2013) Limited has provided evidence of education/training in the above areas, and therefore I consider that this recommendation has been met.

Follow-up actions

24. A copy of this report with details identifying the parties removed, except the advisor on this case and Bainlea House (2013) Limited (trading as Bainswood on Victoria), will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Carolyn Cooper
Aged Care Commissioner

Appendix A: In-house clinical advice to Commissioner

The following advice was obtained from 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 Bainlea House (2013) Limited 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.

2. In particular I was asked to review the provided clinical documentation and advise on:

a. Steps taken following concerns about [Mrs A's] continence wrap/pads being ripped, and whether these were appropriate (including the taking of photographs).
b. Pressure injury cares, including the quality of monitoring and positioning.
c. The management of the consumer's weight loss and dietary needs.
d. Any other issues you consider warrant comment.

3. Documents reviewed

- Provider letter of response to HDC dated 21 September 2022
- Timeline log for events and complaints
- Staff statements and other documentation in support of the timeline
- Policies and procedures
- Long term care plan dated 1 August 2022
- Interviews of staff as part of the internal review 4 September 2022

4. Review of clinical records and clinical advice

At the time [Mrs A] was a resident of Bainlea House (2013) Limited where she received hospital level care. Her medical history includes hemiplegia and dysphagia as a result of a CVA. Her long term nursing care plan developed 29 July 2022 includes that she needed full assistance with mobilising using a wheelchair and transferring with a full hoist. She required full assistance with her ADL. Due to incontinence she depended on incontinence products documented by staff as a "wrap". She developed a stage 3 pressure injury in the gluteal fold for which the care home's nurses received input from the district nursing service … [Mrs A] was on a high protein diet with thickened fluids and needed assistance with eating and drinking. On 1 August 2022 her BMI was reported to be 24. Due to aphasia (a condition that typically occurs in adults as a result from damage to the left side of the brain and effects language expression and/or language comprehension) [Mrs A] had difficulty expressing herself with staff needing to understand the sounds and gestures she makes when communicating. The care plan includes that her short term memory seemed to be intact with no evidence of confusion in time or place. She was well supported by her family with her husband visiting daily and often taking her out in his car for long periods of time. Her two daughters were also very involved with one of them acting as welfare guardian.

a. Steps taken following concerns about [Mrs A's] continence wrap/ incontinence product being ripped, and whether these were appropriate (including the taking of photographs).

The clinical progress notes of 5 July 2022 include a record of [Nurse B] about a conversation with daughter [Ms A] (welfare guardian) raising her concern regarding the frequent and long outings (at times lasted 5 hours) of [Mrs A] with her husband impacting on the development/healing of pressure injuries. She proposed to arrange for outings using … transport in a wheelchair and for up to 2 hours a day. This was also recommended by the [nurse] from [a district nursing service] because of the grade 3 pressure injury which was identified as caused by poor and prolonged seating positioning. [Nurse B] also notes that she pointed out that [Mrs A] frequently cries and does not seem to want to go out with her husband and "*it seems she goes under duress*".

A further entry of [Nurse B] about meeting with the husband and [Mrs A's] other daughter … reads: "*serious concerns about the length and time that [Mr A] takes her out and the condition that she comes back in, there has been some evidence of her wrap being tampered with and the caregiver found sticky substance on [Mrs A's] vagina. [Mrs A's] often cries and states that she does not want to go home with [Mr A]…"*

The notes include it was decided and agreed that for the next month [Mr A] would visit in the care home rather, giving the pressure injury time to heal. Further it was decided that next time there would be concerning findings a swab was to be taken by the nurse and sent to the lab for analysis.

The documentation did not include an adverse event report regarding the reported concerns of that day. I did not find instructions in a short term care plan regarding the need to take a swab or instructions for escalation of this finding.

The notes of 18 July 2022, 20 July 2022 include an entry regarding [Mrs A] calling out when visited by her husband in her room. When staff went to check she indicated she was okay.

On 24 July 2022 it was noted that on the last round of the day the caregivers found that her wrap was ripped on the right side and her vagina was red and swollen on that side. [A caregiver] … contacted a senior [staff member]. Together they proceeded to take photographs after asking [Mrs A] for consent, which they state she gave by moving her head and saying "yes". Photos were taken of the ripped wrap and the swollen perineum. This senior [staff member] informed [Mrs A] that she would only show the photos to [a nurse]. There is no evidence or report that at the time [the nurse] on duty was notified nor [the management]. The issue was picked up by [a nurse] the next day who completed an adverse event report flagged as "suspected sexual abuse". Both daughters were advised separately by phone. As a result the welfare guardian would contact her father [Mr A] that he would be unable to visit till further notice, the photographs were emailed to daughter … at her request. Following an email dated 26 July 2022 from the welfare guardian in which she expressed her concerns regarding the allegations made about her father and the potential impact of this on both her father

and mother, the visiting block was reassessed and [Mr A] could visit again at allocated times with the bedroom door open.

[Management] picked up the issue conducting staff interviews. The long term care plan regarding sexuality and intimacy was updated and included now for staff to "monitor for signs of sexual overture that are unwelcome". The care plan does not include the specific arrangement that the door was to remain open when the husband is visiting in her room nor what to do when signs of sexual overture are observed.

The provider's response includes that [a caregiver] … during the interview reported that in the last months [Mrs A] expressed distress while her husband was visiting and that this was since over a year. This [caregiver] described an incident that occurred over a year ago where the [nurse] was informed and Dr … assessed [Mrs A]. The clinical documentation did not include any incident report from that incident or notes made by the GP. According to the provider [Mrs A] indicated to the GP that [Mr A] was the cause of a groin trauma however [Mrs A] did not want the GP to talk to her husband. According to the [caregiver] [Mrs A] didn't seem worried and "as they are husband and wife, we left it".

On 7 August 2022 the welfare guardian emails that it had come to her attention that staff again found "so called evidence of alleged sexual abuse" — she states that staff should follow due process and involve the police. The care home contacted the police on 10 August 2022 and a police investigation followed. The report from this investigation is inconclusive and included learnings for the care home including that if in the future incidents of this nature should occur they are to call 111. Police have forensic specialists available to properly examine victims of suspected sexual abuse.

Clinical advice

It is not uncommon for a couple of which one person is living in residential aged care to want to continue to have sexual relations and be intimate. Living in residential aged care does not mean people cannot continue to be intimate if they want. It is recommended for a care home to have a sexuality policy which includes what the care home's view is on consent and capacity including the monitoring of mental capacity in residents who are sexually active. Further the policy is to include how they ensure the safety of their residents in terms of sexual activity and how they ensure privacy and respect for the people involved[1]. Staff education on the policy and topic is imperative. It may be difficult for staff to make sure residents have the privacy they need especially when for example a person needs assistance with washing and bathing after sex. Staff should always respect the confidentiality of relationships.

It is accepted practice to have interventions relating to the topic of sexuality in the Long term care plan. In their response the provider did not refer to a sexuality policy or staff education provided.

[1] https://www.torontomu.ca/content/dam/crncc/knowledge/eventsandpresentations/2012/SexualityPracticeGuidelinesLLGDraft_17.pdf

An aged care provider has the obligation to have an abuse free environment. According to Family Violence Intervention Guidelines: Elder Abuse and Neglect (2007)[2] best practice will be achieved when dealing with suspected elder abuse by way of sufficient organisational support for addressing abuse as a critical health care issue; having a multi-agency/multidisciplinary approach, ensuring there is informed consent prior to assessment from the person or their welfare guardian; maintaining confidentiality and protecting information in accordance to Health Information Privacy Code including the legal and ethical obligation to take action if serious harm is likely to arise through not doing so. Staff training and a clear policy and procedures/protocols is paramount in achieving this. The assessment of and response to any elder abuse is described in the guidelines as the following six steps approach: Identify, provide emotional support, assess risk, plan safety, document, and refer.

The provider's Abuse and Neglect Policy is informative and sets the standard of zero tolerance and that appropriate measures will be taken where there is suspected or identified abuse, that measures are to be taken to minimise the risk including staff orientation/ongoing training. The policy includes a good definition of sexual abuse and that other agencies may be contacted for advice and support to resolve any possible problems. The [management] is to usually carry out the referral to outside agency. The policy further includes the signs and symptoms of abuse including specific ones relating to sexual abuse. The policy is clear on the process that all instances of suspected abuse need to be discussed with [the senior staff] and referred onto the Doctor or Advocacy Service as appropriate and that it may be appropriate to involve the Police. All incidents need to be reported and recorded for investigation on an Adverse Event form. The policy however is not clear on specific protocols to be followed by staff when observing or suspecting abuse and taking into account the delicacy of such situation for the person and their family including the observance of confidentiality. It is recommended that the policy be updated with specific protocols and with clear instructions on when to immediately refer to the Police and call 111.

Reviewing the documentation I did not find evidence of an immediate escalation to a [nurse] (in the progress notes) of the concerns on 5 July 2022 and 24 July 2022. In the absence of a Sexuality policy and because staff were concerned this involved abuse their non-escalation was in breach of the organisation's Abuse and Neglect Policy. Further, the [nurse] who was made aware of the suspected abuse the next day (25 July 2022) did not follow due investigation and escalation processes to … I am concerned that the incident report was closed two days later without due assessment or due conclusion that the situation involved consensual relationships.

On 1 August the [management] started a further investigation assessing the situation. The nursing care plan was updated asking monitoring for signs of abuse. In my opinion this action taken by the [management] was appropriate however the care plan was insufficient to guide staff on actions should they observe a potential new issue, and the

[2] https://www.health.govt.nz/system/files/documents/publications/family-violence-guideliens-elder-abuse-neglect.pdf

care plan did not include what was agreed with the family/Welfare guardian. I would have expected further action taken to establish [Mrs A's] capacity to give consent, and a conversation with the husband. I note that the care plans don't seem to have been updated as the situation changed and when agreements were made with the family.

I am critical that staff sent the photos taken on 24 July 2022 to [Mrs A's] daughter (not Welfare guardian) while staff obtained consent to take a photo on 24 July 2022 to show the [nurse] only.

In conclusion:

In the circumstances I consider the actions taken following concerns about [Mrs A's] continence wrap/incontinence product being ripped to have been a medium to significant deviation from accepted practice. I have come to this conclusion because:

- I consider the Abuse and Neglect policy while informative, to be inadequate to guide staff actions when encountering potential/alleged sexual abuse.
- I am concerned that care staff as well as [the nurses] did not escalate their concerns in accordance with the seriousness of such concerns and as required by the organisation's policy and NZ Best practice guidelines[1];
- There was no establishment by the provider of [Mrs A's] capacity to give consent to have sexual relations or having a confidential conversation with the husband in the first place before talking to the welfare guardian;
- The care plan did not provide staff with due guidance and was not updated to include agreements with the welfare guardian;
- Communication of the concern with the daughter who was not the welfare guardian was not appropriate in the circumstances;
- The emailing of photos taken via email is considered by my peers as having been insensitive and was breaching due confidentiality and the consent given by the consumer.

I recommend that the organisation updates its Abuse and Neglect Policy and develops a Sexuality Policy using the Intimacy and Sexuality Practice Guidelines[2] referenced earlier and provides staff education on the topic and new policy.

b. Pressure injury cares, including the quality of monitoring and positioning.
[Mrs A] was assessed as being at high risk for developing pressure injuries by the nurses as documented in her care plan.

17 May 2022 a new pressure injury was reported on the right gluteal fold and a wound care plan was developed. The wound was described as moisture associated skin damage which had evolved to a grade 3 pressure injury. A wound care plan was developed describing the wound care regime and was reviewed regularly. Pictures were included in the clinical documentation showing how the wound progressed over time. On 3 June 2022 it was recorded that there were signs of infection present. This was referred to GP and antibiotics prescribed. The infection was reported as healed on 22 June 2022. However the wound continued to deteriorate and deepen. On 30 June 2022 there was

another review by a [nurse] and a new wound care plan implemented. It was identified that the cause of wound could have been from sitting in the car seat supplied by the family. She would sit in that chair daily for up to 5 hours when taken out by her husband. It was recommended by [the district nursing service] that [Mrs A] would only sit up to 2 hours in her wheelchair and reposition her regularly while in bed. The clinical notes include a conversation about this with the welfare guardian and with the husband.

The wound remained difficult to heal. On 12 July 2022 the progress note include the observation of early signs of pressure injury on [Mrs A's] left heel also, which resolved later. On 17 July 2022 [the nursing service] reviewed the pressure injury again recommending to continue with current wound care plan. Because the wound was reported not to respond to treatment a medical review was requested. The GP changed the wound care regime to a change of dressing every 3 days only. [The nursing service] was again involved 25 July 2022. The [nurse] included now for a dietician and physio to be involved to help heal the wound. A new care plan was developed including a pressure relief regime. Due to pain, analgesics were prescribed to be administered prior to wound dressing changes. It is reported that the pain relief given had at times minimal effect. 8 August 2022 the wound was seen by [the nurse] and a referral made for plastic surgery. 19 August the wound care was reviewed by [a senior staff] — minimal pain was reported at the time. The wound care plan and documentation continues to report a deterioration. On 26 August 2022 there was a family meeting to discuss the care in general and specific that it was recommended that [Mrs A] would remain in bed to receive wound care involving a vacuum over the pressure injury.

Clinical advice

In the circumstances I consider the pressure injury care, including quality of monitoring and positioning to have been a mild deviation from accepted practice. I have come to this conclusion because:

- The clinical notes show that nurses were regularly assessing the skin and attuned to finding early signs of pressure injuries as for example on her left heel and toes and were taking appropriate measures to prevent further deterioration.
- The care plan and clinical notes include considerations for positioning and for regular repositioning to avoid pressure on bony prominences as well as the use of special cushions and other supportive cushioning.
- I did however not find any monitoring charts/repositioning schedules completed to document times and position when [Mrs A] would have been repositioned. The progress notes included repositioning in general terms only.
- Deterioration of the pressure injury was escalated appropriately as well as the need for analgesia. The [district nursing service] and the GP/[nurse] were appropriately involved.
- Documentation of the changing wound care instructions was documented including regular assessments of progress.
- There is documentation of family communication (husband and welfare guardian) keeping them informed and updated.

- The involvement of a dietician to include nutritional and hydration support for wound healing could have been at an earlier stage and when difficult wound healing was established end of June 2022.

c. The management of the consumer's weight loss and dietary needs.
The provider response gave an overview of [Mrs A's] changes in weight with a significant weight loss between March 2022 (66 Kg) and June (62.2 Kg) and July 2022 (57.3 Kg) possibly explained because she had been unwell with COVID in April 2022 and was not eating and drinking well which gradually improved.

Due to her continued weight loss and difficulty with wound healing of her pressure injury a referral was made to the dietician. For this a Food and Fluid intake chart was completed for 5 days (6–10 August 2022) and forwarded to the dietician who visited on 11 August 2022 prescribed Ensure supplement, protein snacks, protein fortification of meals and encouraging of fluid intake. By the end of August [Mrs A's] weight had increased by 2 Kg.

Reading the Progress notes I found that very few of the entries relate to [Mrs A's] food and fluid intake.

In conclusion I found the management of the consumer's weight loss and dietary needs to have been minimally deviating from accepted practice. It is my recommendation that care staff document more regularly/daily observations relating to food and fluid intake and for a dietician review to be instigated at an earlier time when pressure injuries are identified.

Addendum to advice 16 October 2024
Thank you for the opportunity to review my advice after receiving the feedback response from the provider dated 24 September 2024.

The provider pointed out that the Incident report relating to the 24 July 2022 incident was closed off on 26 August 2022, one month after the incident. And not two days after the event as per my advice above. Reviewing the forwarded Major Event Report this report indeed includes that the incident was closed on 26 August 2022 and after the investigation by [the management].

Acknowledging that this was a delicate and difficult situation for all involved I continue to be concerned about how the issue was managed at the time as per my advice.

Reviewing the forwarded evidence of corrective action taken by the provider including the reviewed and new policies as well as their emphasis on staff education I consider these actions to have been comprehensive and of good quality.

Hilda Johnson-Bogaerts, BNurs RN MHSc PGDipBus
Nurse Advisor (Aged Care)
Health and Disability Commissioner'