BUPA Care Services NZ Limited
(trading as Hayman Care Home)

A Report by the
Deputy Health and Disability Commissioner

(Case 19HDC00370)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns the care provided to an elderly woman at Bupa's Hayman Care Home on 5 and 6 January 2019, in particular the care provided by staff when ants were discovered in her room and bed.

2. On 5 January 2019, a few ants were noticed in the woman's room, and staff sprayed insecticide and cleaned the area. Bupa staff did not locate the source of the ants or document and report the ants in the Maintenance Book on this date.

3. The woman's niece told HDC that on 6 January 2019 she visited her aunt and found several dozen ants crawling on her face and neck. The niece said that when staff arrived to attend to the issue, none of them acknowledged the woman in any way, and ignored her and focused on their search for the source of the ants. The nurse told HDC that he did not see ants on the woman but he did see ants on her sheets. Bupa considers that staff did acknowledge the woman in a non-formal verbal manner, but said that the staff involved acknowledge that they focused on the source of the ants over the immediate provision of care for the woman.

Findings

4. The Deputy Commissioner considered that on 5 January 2019, Bupa staff took insufficient action to investigate the extent of the ant problem and ensure that the source was managed appropriately, and that this showed a lack of critical thinking and proactive management. The Deputy Commissioner was also critical of the documentation by staff on 5 January and in the morning of 6 January. The Deputy Commissioner found Bupa in breach of Right 4(1) of the Code.

5. The Deputy Commissioner also considered that in prioritising the source of the ants rather than providing immediate care to the woman on 6 January, Bupa staff failed to respect the woman's dignity, and, accordingly, that Bupa breached Right 3 of the Code.

Recommendations

6. The Deputy Commissioner recommended that Bupa provide HDC with an update on the changes made since these events, undertake a random audit of 15 patients regarding documentation, and provide a written apology to the woman's family.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her aunt, Ms A, by Bupa Care Services NZ Limited (trading as Hayman Care Home). The following issue was identified for investigation:

- *Whether Bupa Care Services NZ Limited (Hayman Care Home) provided Ms A with an appropriate standard of care on 5 January 2019 and 6 January 2019.*

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

9. The parties directly involved in the investigation were:

Ms B	Complainant
Bupa Care Services NZ Limited (Bupa)	Provider

10. Also mentioned in this report:

RN C	Registered nurse
Ms D	Caregiver
Ms E	Caregiver

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

Information gathered during investigation

Introduction

12. This report concerns the care provided to Ms A by Bupa at Hayman Care Home[1] on 5 and 6 January 2019 following the discovery of ants in her room and bed, and her hygiene care.

13. Ms A, aged 95 years at the time of the incident, was admitted to Hayman Care Home on 6 September 2017 for hospital-level care. At the time of her admission, her medical history included cerebrovascular disease, [2] cognitive impairment, [3] Parkinson's disease, [4] hypertension,[5] hyperlipidaemia,[6] and a history of falls. As a result of her co-morbidities, Ms A was incapacitated and was reliant on others for all aspects of her care.

14. The bed in Ms A's room was placed against a wall, with the head of the bed beside a window that looked out to the garden. Beside the bed was a chest of drawers with a pot plant on it. An additional locker placed near the end of the bed also had a pot plant on it.

[1] Hayman Care Home is one of a number of residential aged-care homes operated by Bupa. It offers both hospital and dementia levels of care.
[2] A group of conditions, diseases, and disorders that affect the blood vessels and blood supply to the brain.
[3] Difficulty remembering, learning new things, concentrating, or making decisions that affect everyday life.
[4] A brain disorder that causes shaking, stiffness, and difficulty with walking, balance, and coordination.
[5] High blood pressure.
[6] Raised lipids (fats, eg, cholesterol) in the blood.

5 January 2019

15. On 5 January 2019, Ms A's clinical record contained only one progress note, documented at 2pm by RN C. The note stated: "Due med[ications] given. Enabler is on. Settled well. [Nil] new concerns."

16. Bupa told HDC that it was established practice for staff to check on Ms A at least every two hours, and confirmed that this practice occurred on this day. Staff interactions with Ms A were not noted in the progress notes, but were recorded in her positioning chart, fluid balance chart, medical administration record, nutritional record, and 24-hour toileting regimen forms.

17. Bupa said that following its discussion with the staff who were working on 5 January 2019, it was identified that a small number of ants were noticed in Ms A's room on this day, and staff felt that they had been removed successfully. Bupa stated:

> "Ants had been seen by caregivers in [Ms A's] bedroom on the 5th January and this was reported to the Household team. The Household team member cleaned the room and also identified at this time that the ants were coming from the pot plants, however they did not remove the pot plants and they didn't report the ants as they should have done through the Maintenance Book."

18. In response to the provisional report, Bupa told HDC that it now considers that the actions taken by staff at the time were appropriate. Bupa also told HDC: "[I]t was not clear at the time that this was an issue that should have been recorded in the Maintenance Book."

19. RN C told HDC:

> "On [5 January 2019], [a caregiver] told me that she noticed that there were ants in [Ms A's] room. I told [the caregiver] to inform the maintenance personnel to clean the room. After lunch, I checked with [a Household staff member] if she already had cleaned the room, which she did and she also mentioned that the ants are coming from potted plants … After a while I saw the Household Manager and asked her about the ants and she said that it is up to [the Maintenance team member] as he got something to address it. After that I thought that the issue has been already addressed properly and during the handover, I also informed the afternoon staff regarding the concerns with the ants. Afternoon staff also mentioned that they noticed some ants on the floor …"

20. On 5 January, a day-shift caregiver supported Ms A to change position and provided her with toileting and hygiene cares from 8am to 12pm, and again at 8.15pm. The caregiver told HDC: "I turned [Ms A] with another caregiver several times … and I did not see any ants in [her] room."

21. Bupa told HDC:

> "After being alerted to a small number of ants being present in [Ms A's] room on 5 January 2019, the household team member cleaned and sprayed insecticide where she had noticed ant activity … following the cleaning of [Ms A's] room, the staff — care and household — considered that the small number of ants … had been successfully removed."

22. The pot plants were not removed on this date. Bupa stated:

> "We have been and are mindful of the risk in implicitly or explicitly creating the expectation that non registered staff feel obligated to remove resident's property, such as a pot plant, whenever even a small number of insect activity is noted."

23. Bupa does not consider that there were grounds for the household team member to remove the property of a resident (the pot plants) immediately when consent to do so could not be provided.

24. In response to the provisional report, Bupa told HDC:

> "Bupa reiterates that the actions taken on 5 January 2019, with only a few ants being noted, were appropriate and in line with expected processes in cleaning … as cleaning staff felt they had correctly rectified the issue with the small number of ants on 5 January [2019], they could not have known that a further intrusion would occur the following day 6 January [2019]."

25. The discovery of ants in Ms A's room was not documented on 5 January, and no further observations or notes about ants were made on this day. The household team did not log the presence of ants in the maintenance book.

Incident on 6 January 2019

Night shift

26. On 6 January, the Positioning Chart noted that Ms A was turned at 2.30am and at 4.50am. No mention of ants is documented.

27. The 24 Hour Toileting Regime documented that at 6am, the night-shift caregiver checked Ms A's pad. Bupa told HDC that staff advised that Ms A's pad was changed at that check, although this was not documented. The caregiver told HDC that she "did not see any ants on either the bed or [Ms A]" at that time.

Breakfast and morning

28. The Medicine Administration Record noted that at 8am Ms A was given her morning medication, and the Positioning Chart noted that at 8am she was turned.

29. The Nutritional Record documented that Ms A was given porridge and Fortisip[7] for breakfast. The time when breakfast was given to Ms A was not recorded, but Bupa told HDC that this was around 8am.

30. Caregiver Ms D told HDC that she assisted Ms A with her breakfast and breakfast hygiene care at around 8.30am. Ms D said that after feeding Ms A, she wiped her mouth and cleaned her with a wet flannel, and "there were no ants on [Ms A's] bed" at that time. Ms D then left Ms A's room and assisted other residents with their meals. In response to the provisional report, Ms B told HDC: "It is difficult to believe that Caregiver [Ms D] wiped my aunt's mouth and cleaned her with a wet flannel. There was no evidence of that on my arrival."

31. RN C noted in a subsequent meeting with Bupa management staff that "[Ms D] said when she fed [Ms A] she saw two ants on [Ms A] and she killed them".

Discovery of ants

32. Ms B visited her aunt at 10am on 6 January. She told HDC:

> "I visited my aunt at 10am, on Sunday 6 January 2019. She was in bed, unwashed, without her teeth, in a dirty nightie with food stains on it. Her face and neck were crawling with several dozen ants. Some ants were on her lips going into her mouth, other ants were coming out. There were dead and live ants on her nightie, her chest and in her bed."

33. RN C said that he saw Ms B checking on Ms A, and that Ms B was very upset and angry. In response to the provisional report, Ms B told HDC:

> "I think most people would be upset and outraged if they arrived to visit an incapacitated [elderly] relative and found her in the state in which I found my aunt. I make no apology for being upset and outraged."

34. In a meeting between RN C and Bupa management staff on 24 January 2019, RN C said that at the time in question, he saw ants and one spider on Ms A's sheets but he did not see any ants on Ms A, or coming from her mouth. In response to the provisional report, Ms B told HDC there were no ants on her aunt's face and mouth as she removed them all as soon as she found her aunt in that humiliating situation. Bupa told HDC that it could not establish to what extent Ms A's clothing or bed linen was dirty or food-stained on the morning of 6 January. Bupa noted that Ms D had cleaned Ms A with a wet facecloth after assisting her with breakfast that morning, and stated that staff had intended to return to complete full morning cares at around 10am, as per Ms A's care plan.

[7] A nutritional supplement.

35. Ms B told HDC that she sought staff assistance. She stated:

> "When a nurse and two caregivers eventually arrived, none of these staff acknowledged [Ms A] in any way. They ignored her completely and instead started on an aimless search for the source of the ants."

36. Bupa told HDC:

> "[RN C] reports that the caregivers did acknowledge [Ms A] on entering her room, albeit in a non-formal verbal manner — such as '… oh [Ms A] — sorry for [Ms A] …"

37. RN C stated:

> "My immediate response was to get [Ms A] cleaned up immediately. I went out of the room and saw [caregivers Ms D and Ms E] … I told them about the concern that we need to do the cares for [Ms A] first … as soon as [Ms D] came, she checked on [Ms A] right away … then the phone rang for another resident so I went to give it to that resident."

38. RN C also told HDC:

> "When I came back to the room, [the caregivers] still haven't started the cares as [Ms B] was still yelling inside. I did not have the courage to ask her to leave … in the meantime, instead of being idle, we started to look for the source of the ants and found that there were clusters of ants underneath the potted plants … as soon as [Ms B] went out [of Ms A's room], [caregivers] started to do her cares."

39. In response to the provisional report, Ms B told HDC that she disagrees with RN C's comment, and stated: "[N]either he nor the caregivers acknowledged my aunt. Their rudeness was appalling." Ms B said that RN C's immediate response was to wander round looking for where the ants were coming from. Ms B also stated:

> "[RN C's] comment that I was still yelling inside is untrue … Given three staff in the room were ignoring my aunt and milling round looking for ants, I certainly gave them a clear instruction to remove my aunt from a bed with ants in it, to get her out of her filthy nightie and to shower her …"

40. In response to the provisional report, Bupa told HDC that the care provided by staff was affected because they were "being yelled at by [Ms B] who was angry", and that it must have been "a situation which they felt was intimidating". Bupa also stated: "[T]here is no evidence that anytime [Ms A] was concerned or distressed."

41. Ms D said that when she was called in by RN C, she saw a few ants in Ms A's bed. Ms D told HDC: "[W]e ask [Ms B] politely if she could wait in the lounge and we could clean [Ms A] and bring her in the lounge."

42. Another caregiver, Ms E, was also called into the room by RN C. Ms E stated: "[W]hat I noticed is there's an ants, on the wall, that is all I can remember."

43. Bupa told HDC:

> "[T]he nurse and caregivers involved acknowledge that they focused on the source of the ants over the immediate provision of care for [Ms A], and are very apologetic that they acted in this way.
>
> …
>
> [T]he [staff] found the situation difficult. We acknowledge that in the heightened situation they focused on looking for the source of the ants and we sincerely apologise that this occurred."

44. In response to the provisional report, Ms B told HDC: "The reaction of the three BUPA staff who eventually arrived in my aunt's room was one of apathy and indifference. They showed no surprise, no disgust, no embarrassment …"

Other allegations by complainant

Removal of Ms A's sheet

45. Ms B told HDC:

> "The male nurse then, without a word to [Ms A], ripped her sheet and blanket down to her feet so she lay there totally exposed from the chest down with four people standing there staring at her … no staff member made any move to improve [Ms A's] situation until I requested that they remove her from a bed crawling with ants, shower her and put her into clean clothes."

46. In the meeting between RN C and Bupa management staff on 24 January 2019, RN C said: "I just wanting to mention that I did not pulled the sheet down as reported by [Ms B]." In response to the provisional report, Ms B stated: "[T]he male nurse on duty on 6 January 2019 was the person who ripped the bed coverings off my aunt."

47. Bupa told HDC:

> "[RN C] does not recall being the staff member who turned [Ms A's] sheet back while looking for ants, and he denies it was ripped back on any account … we are unable to identify which staff member may have turned [Ms A's] sheet down."

Nightie and pad

48. Ms B also told HDC that her aunt's nightie was bunched up around her waist, and it appeared that her incontinence pad had not been attended to since it had been put on the previous night.

49. Bupa stated: "[I]t is not acceptable that [Ms A] was left with her nightie bunched up around her waist, and we sincerely apologise that she was left like this." Bupa noted that

Ms A's pad was checked at 6am on 6 January 2019, and that staff had informed Bupa that the pad was changed at that time.

Subsequent management

50. Bupa stated that after Ms B informed staff about the ants, RN C contacted the Care Home Manager for advice. The Care Home Manager advised staff to move Ms A to another room so that pest eradication measures could be undertaken. Bupa said that at this time, a pot plant in Ms A's room was identified as holding a nest of ants, and once the pot plant was disposed of, Bupa maintenance staff completed a full clean and treatment of Ms A's room.

51. The Care Home Manager said that once RN C rang her, Ms A was then moved to another room until they were able to put down ant bait and have the bedroom sprayed the following day.

52. An afternoon shift caregiver helped to move Ms A to another room. She told HDC that she did not see any ants on the wall or the bed while transferring Ms A to her temporary room.

53. At 3.30pm, RN C documented the incident in Ms A's progress notes as follows:

> "[Ms B] arrived at around [10am], got very upset as she found [Ms A] lying on bed with insects (ants and spiders) crawling all over her. [Ms B] called RN's attention. RN tried to look for an ant-line, found none. Asked [a staff member] to clean and do morning cares for [Ms A]. Meanwhile, RN found cluster of ants on the roots of the potted plants on top of [Ms A's] drawer. Showed it to [Ms B] Rang CHM for advise …"

54. On the same day, RN C also documented the following in Bupa's RiskMan[8] adverse event system:

> "[Ms A's] niece … came to see her and got very upset as she found [Ms A] on bed with ants and spiders crawling all over her. Carestaff said she managed to pick a couple of ants when she was feeding [Ms A] her breakfast, but did not notice any more than that."

55. On 8 January, following the effective eradication of the ants, Ms A was returned to her usual room.

56. Ms B had a meeting with the Care Home Manager on 9 January, and followed this up with a written complaint to Bupa on 10 January. On 26 January, Ms A was moved to another facility. On 9 April, Bupa wrote a letter to Ms B in response to her complaint. The letter stated:

> "We would like to offer our sincerest apologies for the times that care provided to your aunt fell below both your own and Bupa's expected standards, and for the distress caused as a result."

[8] RiskMan is a system used by administrators to monitor near misses, sentinel events, and other incidents.

Further information

57. Bupa said that in March 2018 and August 2019, Hayman Care Home was assessed by an external agency, Health and Disability Auditing New Zealand Limited, and on both occasions Hayman Care Home fully attained the eight standards associated with the provision of a safe and appropriate environment.

58. Bupa told HDC: "We sincerely regret the distress that has been caused as a result of this incident and again offer our sincerest apologies to both [Ms A] and her family."

Responses to provisional opinion

Ms B

59. Ms B was provided with an opportunity to comment on the "information gathered" section of the provisional decision. Where appropriate her comments have been incorporated into this report. Ms B told HDC:

> "If anyone at all found an incapacitated elderly person lying in bed unable to help themselves, with ants crawling in and around their mouth and face, I believe they would have acted as I did — namely by feeling sickened at the sight and by acting immediately to reassure them and then to remove the ants."

Bupa

60. Bupa was provided with an opportunity to comment on the provisional report. Bupa told HDC that it acknowledges the impact of this incident on the whānau of Ms A but disputes the provisional finding. Where appropriate, Bupa's comments have been incorporated into this report. Bupa stated:

> "Bupa has previously acknowledged the impact of this incident on the whānau of [Ms A]. This is acknowledged again here. Bupa is happy to apologise to the whānau of [Ms A]."

61. Bupa said that it sought further advice from its professional pest control expert and was advised that "the presence of a small number of ants as was discovered on 5 January 2019 would not be indicative of an infestation, it would be considered an intrusion. An infestation is likely when hundreds of ants are discovered." Bupa said it was also advised that "the source of the ants is unlikely to have been from the pot plant, nor that a search of the inside [of] the care home would have revealed the source of the ants, as it is likely they would have been outside". Bupa told HDC:

> "There was no clear indication at this time, nor on the 6 January 2019, that the pot plant was the source of the ants, although it is clearly documented that ants were found in the pot plant on 6 January 2019. The assumption that the source of [the ants was] the pot plants was made with the benefit of hindsight."

Changes made since incident

62. Bupa told HDC that as a result of the incident, it addressed issues and made several improvements, including the following:

a) It reinforced with all staff the process for reporting of issues;

b) Pot plants are now checked visually for insects when room checks and cleaning are done;

c) Mealtime/morning hygiene practices were reviewed to ensure that residents receive effective oral, face, and hygiene cares;

d) The Clinical Manager now completes her walk-around to coincide with the residents' end of breakfast;

e) It shared the file review with qualified staff and discussed learnings from the complaint;

f) Etiquette and techniques for assisting residents are to be discussed with all care staff;

g) Hayman Care Home is to consult with Bupa's national Dementia Care Advisor regarding an audit on the resident dining experience;

h) Training on Vulnerable Residents, as per Bupa's education calendar, is to be completed;

i) Monitoring, assessment, and changes in clinical condition are discussed with all care staff; and

j) All care staff are provided with a compulsory education session on dignity.

Relevant standards

63. The Health and Disability Sector Standards NZS 8134.1.4:2008 (NZHDSS)[9] states:

> "Safe and appropriate environment He Taiao Ora, Taiao Pai
>
> Outcome 4: Services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensures physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group, and meets the needs of people with disabilities."

64. The Health and Disability Sector Standards NZS 8134.1.3:2008 (NZHDSS) states:[10]

> "Independence, Personal Privacy Dignity, and Respect Rangatiratanga, Whaiaro, Tumataiti, Mana, Me te Manaaki

[9] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.
[10] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.

Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence."

65. The Health and Disability Sector Standards NZS 8134.1.2:2008 (NZHDSS) states:[11]

"Service Management Te Whakahaere Ratonga

Standard 2.2 The organisation ensures day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers."

Opinion: BUPA Care Services NZ Limited (trading as Hayman Care Home) — breach

Introduction

66. As a provider of healthcare services, Bupa has a duty to comply with the Code of Health and Disability Services Consumers' Rights (the Code). This duty includes a responsibility to operate the facility in a manner that provides its residents with services of an appropriate standard, and a responsibility to ensure that services are provided in a manner that respects the dignity and independence of residents in accordance with Rights 4(1) and 3 of the Code.

67. The NZHDSS requires that rest homes ensure that the operation of their services are managed in an efficient and effective manner to ensure that they provide timely, appropriate, and safe services to consumers.[12] The NZHDSS also requires that rest homes provide a clean, safe environment that is appropriate to the age or needs of the consumer.[13] The NZHDSS also requires that consumers are treated with respect, and receive services in a manner that has regard for their dignity, privacy, and independence.[14]

68. While there is individual accountability for the actions of a number of staff members on 5 and 6 January 2019, in my view the various failures reflect a pattern of poor care provided to Ms A, and indicate a culture at Hayman Care Home that lacked compassion, attention, and concern for Ms A's dignity and independence in relation to the incidents on 5 and 6 January. I consider that Bupa had the ultimate responsibility to ensure that Ms A received care that complied with the NZHDSS and the Code.

69. This opinion concerns the care provided by Bupa at Hayman Care Home on 5 and 6 January 2019 as it relates to the discovery of ants in Ms A's room and bed and Ms A's hygiene care.

[11] https://www.standards.govt.nz/assets/Publication-files/NZS8134.1-2008.pdf.
[12] NZS 8134.1:2008, Standard 2.2.
[13] NZS 3134.1.4:2008, Standard 4.
[14] NZS 8134.1.3:2008, Standard 1.3.

Care on 5 January 2019

70. On 5 January, there is no documentation about ants in Ms A's room. However, subsequent investigation by Bupa found that several care staff noticed ants in Ms A's room on this day. RN C stated that a caregiver noticed the ants, and household and maintenance staff were informed. It was identified that the ants were coming from Ms A's pot plants, and Bupa stated that insecticide was used by the household team on this day to kill the ants.

71. Bupa told HDC that the staff felt that they had removed the ants successfully. The pot plants were not removed from Ms A's room, and the household staff did not report the ants in the maintenance book.

72. Bupa considers that there were no grounds for immediate removal of the pot plants, and said that it is mindful of not creating the expectation that non-registered staff feel obligated to remove a resident's property. In response to my provisional report, Bupa told HDC that it is unlikely that the pot plants would have been the source of the ants, and the actions taken by its staff on 5 January were appropriate.

73. Notwithstanding this, the actions taken by Bupa staff were clearly unsuccessful because ants were found on Ms A's bed and in her room the following day. Ms A was a particularly vulnerable consumer, and was reliant on Bupa staff to provide all her cares.

74. RN Hilda Johnson-Bogaerts advised that the actions of staff on 5 January were a departure from accepted practice, and stated:

> "Good practice requires for routine maintenance schedules to be in place which include planned pest control. Despite the observance of good maintenance and pest control measures, from time to time it is possible that insect infestations occur. For infection control and pest prevention reasons these require an immediate response ie. Cleaning the area, if possible removal of the source, and escalation to the appropriate person or contracted service for eradication. I am concerned that after the cleaners removed the obvious ants and the identification of the source, they did not immediately remove the cause (pot plants) and did not escalate the issue to the maintenance person/team."

75. I accept RN Johnson-Bogaerts' advice. I acknowledge Bupa's comment that it was mindful of not creating the expectation that household staff can remove a resident's property. I also acknowledge that the household team removed the ants obviously visible in Ms A's room. I also acknowledge Bupa's subsequent statement that its professional pest control experts advised that "the presence of a small number of ants as was discovered on 5 January 2019 would not be indicative of an infestation, it would be considered an intrusion. An infestation is likely when hundreds of ants are discovered." Bupa has also subsequently stated that its pest control experts advised that the source of the ants was not from the pot plants. However, the relevant staff told HDC and documented that the source of the ants was the pot plants. In any event, Bupa's staff took no further action to investigate the extent of the problem or ensure that what they thought was the source was managed appropriately, and did not report the issue to the management or

maintenance team. In my opinion, this highlights a lack of critical thinking and proactive management by Bupa staff.

Care on 6 January 2019

Hygiene care

76. Ms B stated that when she visited on 6 January, her aunt was in bed, unwashed, and in a dirty nightie with food stains on it. Ms B also said that her aunt's incontinence pad "look[ed] as though no one had tended to her".

77. Ms D stated that after feeding Ms A, she wiped her mouth and cleaned her with a wet cloth. Documentation indicates that Ms A's pad was checked at 6am on 6 January, and Bupa told HDC that staff said that Ms A's pad was changed at that time.

78. Bupa has been unable to establish to what extent Ms A's clothing or bed linen was dirty or food-stained on 6 January.

79. RN Johnson-Bogaerts advised:

> "[I]n the circumstances as described by the complainant ie '[Ms A] was left in a filthy state with food remains in her mouth, round her mouth and on her nighty' morning cares should have been prioritised and in these circumstances not doing so is a moderate deviation from accepted practice. In this case it would be expected that caregiver [Ms D] who assisted with breakfast would have alerted either a colleague or the registered nurse of the need to prioritise."

80. From the available information I am unable to make a finding on whether appropriate hygiene care was provided to Ms A after she was fed her morning porridge and Fortisip. However, as per RN Johnson-Bogaerts' advice, I would be very critical if Ms A was not cleaned appropriately following her breakfast.

Discovery of ants

81. Ms D stated that when she assisted Ms A with her breakfast around 8am on 6 January, she did not see any ants. However, RN C reported that Ms D told him that when she fed Ms A she saw two ants on Ms A and killed them. On the same day, RN C documented that Ms D told him that she saw some ants when she was feeding Ms A.

82. Ms B stated that when she visited her aunt at 10am, she found a dozen ants on her aunt's bed, face, and neck. She said that "some ants were on [Ms A's] lips going into her mouth and other ants were coming out".

83. RN C stated that he did not see any ants on Ms A or ants coming out her mouth, but did see ants and one spider on Ms A's sheets. Ms D said that she saw ants on Ms A's bed, and Ms E said that she saw ants on the wall.

84. Given the evidence available and the discrepancies between the parties, I am unable to make a factual finding as to the degree and exact location of ants on Ms A's bed and body.

In any event, it is clear that there were ants on Ms A's bed and in her room. I find it more likely than not that Ms D saw ants in Ms A's room when feeding her that morning, as this was documented by RN C.

Management following discovery of ants

85. Ms B stated that when a nurse and two caregivers arrived (RN C and Ms D and Ms E), the staff ignored Ms A and started to search for the source of the ants. Ms B also told HDC that the nurse ripped her aunt's sheet and blanket down to her feet, and Ms A was exposed from her chest down.

86. RN C said that Ms B was very upset and angry, and he did not have the courage to ask her to leave the room so that staff could clean Ms A and provide care to her. RN C stated that he did not pull down the sheet as reported by Ms B.

87. Bupa told HDC that the staff found the situation difficult, and acknowledged that in the heightened situation they focused on looking for the source of the ants rather than providing immediate care to Ms A. Bupa apologised for this, and stated that the staff member who turned down Ms A's sheet could not be identified, and that RN C denied that this occurred.

88. RN Johnson-Bogaerts advised:

> "From the provider's response I understand that in the moment the nurse and caregivers focused in first instance on the ants rather than acknowledging [Ms A]. I don't accept this as a good reason and am critical that the registered nurse rushed and acted reactive without showing concern for [Ms A's] experience. Before removing the sheets of a person lying in bed it is good practice for the carer to check in with the person and say what is going to happen, and preserve a person's modesty if partly undressed. When ripping the sheets off without acknowledgement or talking to the person this can make the person feel exposed, embarrassed and vulnerable. This is especially so if the person is experiencing a degree of Dementia.
>
> In the circumstances the actions taken by the care staff on 6 January 2019 would be seen by my peers as a moderate deviation to accepted practice."

89. It can be difficult to make a factual finding when the parties involved give conflicting accounts of events and there is an absence of other evidence. I have considered all of the information provided by the parties, and I am satisfied that staff focused on identifying the source of the ants before providing immediate care and assistance to Ms A. I am unable to make a factual finding on whether Ms A's sheet and blanket were pulled down. However, I would be very critical if the staff showed no concern for Ms A's dignity.

90. I acknowledge that the staff found the situation difficult, but in any event, I am critical that the staff focused on identifying the source of the ants before providing immediate care and assistance to Ms A.

Documentation

91. I am concerned about the overall standard of documentation by Bupa staff at the time of these events.

92. As discussed above, despite the involvement of the registered nurse, caregivers, and household team, no information about ants was documented on 5 January 2019. Bupa told HDC that the household team should have reported the ants in the maintenance book, but this was not done.

93. RN Johnson-Bogaerts advised:

> "The provided clinical documentation shows that on these two days regular checks were in place as per [Ms A's] care plan. Reviewing the provided observation charts, some minor inconsistencies in completion of the documents were noted. Deviation from accepted practice — nil to minimal."

94. However, I am nonetheless critical of the lack of documentation relating to the ants. I have made a finding that there were ants in Ms A's room on 6 January, and that Ms D saw ants in Ms A's room when feeding her that morning. I am critical that staff did not document information about the ants on 5 January and on the morning of 6 January, and consider that this indicates substandard documentation by numerous Bupa staff. Good documentation ensures continuity of care and treatment by subsequent providers.

Conclusion

95. Ms A had complex care needs owing to her various co-morbidities and limited mobility and communication. She was reliant on Hayman Care Home staff to provide all her cares and, as such, was a particularly vulnerable consumer.

96. Following the discovery of ants on 5 January, no further actions were taken by staff to remove the source of the ants or report this to the management or maintenance team. Subsequently, ants were found on Ms A's bed and in her room on 6 January. No information about the ants was documented on 5 January and in the morning of 6 January. In conclusion, I find that Bupa did not provide appropriate care and services to Ms A and breached Right 4(1)[15] of the Code.

97. Further, I note that Ms A's vulnerability made it critically important that the care provided to her respected her dignity and independence. I am critical that when ants were found on Ms A's bed and in her room on 6 January, Bupa staff prioritised locating the source of the ants over the provision of immediate care to Ms A. Accordingly, I find that Bupa failed to respect Ms A's dignity, and breached Right 3[16] of the Code.

[15] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."
[16] Right 3 states: "Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual."

Recommendations

98. I note that following this incident, Bupa made several changes and improvements. In addition to these changes, I recommend that Bupa:

a) Within three months of the date of this report, provide HDC with an update on all the changes made since these events, as outlined in paragraph 62 of this report, and provide evidence of staff training and discussions, as stated by Hayman Care Home.

b) Undertake a random audit of 15 patients at Hayman Care Home regarding documentation in the progress notes and maintenance books in the preceding month, to assess compliance with applicable policies and professional documentation standards, and report the results of the audit to HDC within three months of the date of this report. Where the audit results do not show 100% compliance, Bupa is to advise what further steps will be taken to address any issues.

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

Follow-up actions

99. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited (trading as Hayman Care Home), will be sent to HealthCERT (Ministry of Health) and the District Health Board.

100. A copy of this report with details identifying the parties removed, except the expert who advised on this case and Bupa Care Services NZ Limited (trading as Hayman Care Home), will be sent to the New Zealand Aged Care Association and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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 from [Ms B] about the care provided by BUPA Hayman Hospital to her aunt [Ms 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 have been asked to comment on the appropriateness of the corrective actions outlined in the letter of response from [Bupa] and propose any further recommendations to address the issues raised by the complainant.

2. Documents reviewed

- Letter from [Ms B] dated 25 February 2019 to the Health and Disability Commissioner
- Letter of response from [the] Care Manager Hayman Care Home dated 1 February 2019
- Hayman Rest Home and Hospital unannounced certification audit results March 2018

3. Complaint

On 6 January 2019 [Ms B] found [Ms A] in a dirty night gown with food stains and ants crawling on her chest, neck and face, and in her mouth. When the registered nurse attended he pulled [Ms A's] sheet down without warning, leaving her lower body exposed as her night gown had bunched around her waist.

[Ms B] is concerned that a number of practices at the rest home contributed to the deterioration in her aunt's condition, given that four weeks after being transferred to another facility she has regained some of her mobility and speech and is back on a solid diet.

4. Provider response(s) and recommendation

The provider letter of response mentions three specific complaints.

a. Incident on 16 December 2018, when a caregiver walked out of the room with an almost full cup and untouched plate of pudding stating [Ms A] wasn't hungry — however when the complainant offered both these [Ms A] finished both. The provider has not responded to this complaint because the Care Home Manager was still to meet with the member of staff.

Recommendation: It is not clear from the response letter what the outcome of the investigation was. If this was a 'one off' situation I would not be concerned. It is

possible that [Ms A] who I understand lives with Dementia changed her mind and was happy to eat her pudding when offered by her niece. It is normal practice that care staff monitor food and fluid intake of their residents ongoing as well as monitor residents for weight loss. If [Ms A] was experiencing unintended weight loss and there is a pattern of not providing support to persons who have difficulty eating without support, this incident would be of concern.

b. Incident on 6 January 2019. [Bupa] apologised for the way staff responded when they came into [Ms A's] room. The corrective actions outlined in the letter staff education via various platforms, addressing the issue of respect for the dignity of their residents in the future. Further the letter describes the actions taken to clear the room from ants and further education of staff on how to deal with an ant infestation in the future.

Recommendation: The corrective actions regarding this incident seem to be appropriate.

c. Issue raised of 'no senior staff' at the care home in the weekends and a concern regarding the standard of care and staff levels during the weekend. This was answered by the Care Home Manager by explaining that '*the weekend cover on the floor is the same as during the week'*. In her letter of response the Care Home Manager states that *'the registered nurse rang me to discuss the incident and …'.*

The receptionist as [Ms B] recalls it said *'that no one was in charge'*. While it is common practice that managers work Monday to Friday, at all times there needs to be a 'senior person on duty' (usually the senior RN), and a Manager or Clinical Manager who is 'on-call'. It is important that all members of staff are able to identify who the 'senior person on duty' is so that they can escalate any issue as appropriate. This 'senior person on duty' is the person who would decide what to further escalate to an 'on call Manager' for any incidents and emergencies that may overwhelm the staff on duty. Reviewing the care home's audit report the absence of 'after hours' clinical and other leadership was not identified as an issue. This brings up the question if this specific member of staff was not aware of the arrangements?

Recommendation: minor deviation from accepted practice.

5. Further issue raised by [Ms B] that in my opinion would warrant further requests for a response by the provider

- Frequency of checks. What is the normal practice for checks on residents and could the provider provide evidence of checks during the night of the incident with the ants (6 January 2019)."

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

"1.Thank you for the request that I provide additional clinical advice in relation to the complaint about the care provided by Hayman Care 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. On 7 March 2019 I provided advice on this complaint and recommended requesting a further response from Bupa on the usual practice for frequency of checks on residents, and evidence of checks on [Ms A] during the night of 5 January 2019 to 6 January 2019. This information was now received and I was asked to comment on the adequacy of the checks on [Ms A] during the night of 5 January 2019 to 6 January 2019.

3. Documents reviewed

a. Provider's letter of response 27 June 2019

b. Clinical records for the period 5 January 2019, 6 January 2019 including documentation that records checks on [Ms A] (Toileting regime, Bowel Record, Nutritional record, Turn Chart, Fluid Balance Chart, Medicine Administration Record)

4. Review of clinical records

In the response the provider included a table with the different times of checks on [Ms A] as can be found back in the clinical documentation and the observation records. This shows that [Ms A] was checked and received attention/care during 5 January and 6 January at least every two hours as evidenced by the documentation of observations and actions noted on the different records of which copies were provided.

On the morning of 6 January 2019 and the two hours leading up to the time where the ants were found at around 10.00 am, [Ms A] was seen by care staff at 8 am when she was provided a Fortisip drink and breakfast, medication was given, she was repositioned at 8 am and at 8.20am.

5. Clinical advice

The provided clinical documentation shows that on these two days regular checks were in place as per [Ms A's] care plan. Reviewing the provided observation charts, some minor inconsistencies in completion of the documents were noted.

Deviation from accepted practice — nil to minimal."

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

"1.Thank you for the request that I provide further clinical advice in relation to the complaint about the care provided by BUPA Hayman Hospital to [Ms 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 comment on:

i. The appropriateness of the actions taken on 5 January 2019 when staff were made aware of an issue with ants.
ii. The appropriateness of the actions taken by various staff members on 6 January 2019.
iii. Any other comments you wish to make.

3. Documents reviewed

- Clinical records for the period 5 January 2019, 6 January 2019
- Bupa Event report [number]
- Provider's letter of response to [Ms B] dated 9 April 2019
- Nutritional record

4. Complaint's background

On 6 January 2019 [Ms B] found [Ms A] around 10 am in a dirty night gown with food stains and ants crawling on her chest, neck and face, and in her mouth. When the registered nurse attended he pulled [Ms A's] sheet down without warning, leaving her lower body exposed as her night gown had bunched around her waist.

5. Review of documentation and clinical advice

i. The appropriateness of the actions taken on 5 January 2019 when staff were made aware of an issue with ants.

5 January 2019, Ants had been seen by caregivers who reported this to the Household team. The Household team cleaned the room and identified that the ants were coming from the pot plants. They did not remove the pot plants and did not report the ants in the Maintenance Book. No further action was taken at that time.

As part of the Health and Disability Services Standard NZ8134.1.4 consumers have a right to receive services in a clean and safe environment appropriate to the needs of the consumer.

Good practice requires for routine maintenance schedules to be in place which include planned pest control. Despite the observance of good maintenance and pest control measures, from time to time it is possible that insect infestations occur. For infection control and pest prevention reasons these require an immediate response ie. Cleaning the area, if possible removal of the source, and escalation to the appropriate person or contracted service for eradication. I am concerned that after the cleaners removed the obvious ants and the identification of the source, they did not immediately remove the cause (pot plants) and did not escalate the issue to the maintenance person/team.

In the circumstances the actions taken by staff on 5 January would be seen by my peers as a mild deviation from accepted practice.

ii. The appropriateness of the actions taken by various staff members on 6 January 2019.

6 January 2019, [Ms A] was found around 10 am in a dirty night gown and bed linen soiled with food stains, ants crawling on her face and neck and mouth. This was after having been assisted with breakfast around 8.30am.

I consider it unacceptable that [Ms A] was left for such a period of time without hygiene cares. Good practice requires for care staff to provide required hygiene cares to mouth, face, clothes and bed linen after assisting a person with meals, even when full hygiene cares are planned for in the coming hour. Care staff should be able to prioritise work and bring forward hygiene cares if the circumstance require this.

When the registered nurse and care staff attended, they ignored the consumer and visitor and started the search for the source of the ants. For this the RN '*ripped*' the bed sheet down resulting in [Ms A] lying exposed. From the provider's response I understand that in the moment the nurse and caregivers focussed in first instance on the ants rather than acknowledging [Ms A]. I don't accept this as a good reason and am critical that the registered nurse rushed and acted reactive without showing concern for [Ms A's] experience. Before removing the sheets of a person lying in bed it is good practice for the carer to check in with the person and say what is going to happen, and preserve a person's modesty if partly undressed. When ripping the sheets off without acknowledgement or talking to the person this can make the person feel exposed, embarrassed and vulnerable. This is especially so if the person is experiencing a degree of Dementia.

In the circumstances the actions taken by the care staff on 6 January 2019 would be seen by my peers as a moderate deviation to accepted practice."

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

"Thank you for the request that I provide further clinical advice in relation to the complaint about the care provided by BUPA Hayman Hospital to [Ms 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.

In particular I was asked to review the new documentation and advise:

- Whether there is cause to amend the conclusions drawn in my initial advice.
- Any further or additional comments in respond to the new information provided from the complainant.
- Whether the error identified was due to systemic issues at the rest home or whether it was more attributable to an individual. The appropriateness of the policies provided by BUPA.

Documents reviewed

- Provider letter of response 15 June 2020 and appendices
- Complainant letter of response 15 May 2020

Provider and complainant response(s)

In response to my previous advice additional information was received from the provider including the hygiene cares provided before 10 am on the morning of 6 January 2019 when ants were discovered. The reported cares included a change of incontinence product at 6.10 hrs, and around 8.00 hrs after assistance was provided with breakfast cares included a wash of face and hands using a wet face cloth. This would be in line with accepted practice.

The provider challenges the statement that clothing was dirty with food stains as reported by the complainant. In the situation that clothing nor bedlinen was stained there might not have been a cause for the prioritisation of the morning cares.

I remain of the opinion that in the circumstances as described by the complainant ie *'[Ms A] was left in a filthy state with food remains in her mouth, round her mouth and on her nighty*' morning cares should have been prioritised and in these circumstances not doing so is a moderate deviation from accepted practice. In this case it would be expected that caregiver [Ms D] who assisted with breakfast would have alerted either a colleague or the registered nurse of the need to prioritise.

Whether the error identified was due to systemic issues

I reviewed the relevant policies and procedures forwarded and relating to: Housekeeping and cleaning, Infection control, Hazard management, After hours on-call and Duty leaders management, Hygiene needs of residents, Care home resident journey relating to personal hygiene. I have found the policies/procedures comprehensive and reflective of accepted and good practice.

I note in addition to the appropriateness of the policies the considerate response to the complaint as well as the follow up with the investigation and implementation of corrective actions, including coaching and refresher education of the staff involved. This would indicate issues are being addressed. I could not identify a systemic issue as contributing factor but any error was more attributed to the individual staff involved."