Wilding International Limited
(trading as Armourdene Rest Home)

A Report by the
Deputy Health and Disability Commissioner

(Case 18HDC01769)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

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Executive summary

1. This report concerns the care provided to a resident at Armourdene Rest Home (Armourdene), and Armourdene's failure to provide information during an HDC investigation. The report highlights the vulnerability of elderly consumers, and the obligations of providers to facilitate the resolution of complaints about the care provided.

2. A man aged in his seventies, had a complex medical history including brain injury, stroke, and prostate cancer. At approximately 7am the man had an unwitnessed fall in his room. A caregiver called the on-call registered nurse and monitored the man. At 11am, another caregiver called the on-call registered nurse and the man was transferred to hospital. He was diagnosed with a fractured hip, and he died a few days later.

3. The man's sister-in-law was concerned about many aspects of the care he received at Armourdene, including the management of his fall, and made a complaint to HDC.

4. HDC asked Armourdene to provide its policies and procedures, statements from staff, and the man's clinical records. This was a routine request, and the information was requested on multiple occasions. However, Armourdene did not provide the information, and did not provide a reasonable explanation for failing to do so.

Findings

5. The Deputy Commissioner considered that the concerns raised by the man's sister-in-law were serious and appeared to be in breach of the Code. However, because Armourdene did not provide information that was crucial to the investigation, the Deputy Commissioner was unable to determine whether or not Armourdene had provided appropriate care.

6. The Deputy Commissioner found that Armourdene had undermined and frustrated the investigation process, and that as a result, Armourdene breached Right 10(3) of the Code. Right 10(3) provides that every provider must facilitate the fair, simple, speedy, and efficient resolution of a complaint.

Complaint and investigation

7. The Health and Disability Commissioner (HDC) received a complaint from Mrs B about the services provided by Armourdene Rest Home to her brother-in-law, Mr A. The following issue was identified for investigation:

- *Whether Wilding International Limited (trading as Armourdene Rest Home) provided Mr A with an appropriate standard of care in 2018.*

8. 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.

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9. The parties directly involved in the investigation were:

Mrs B	Complainant/Mr A's sister-in-law
Mr C	Mr A's son
Ms D	Mr A's daughter
Armourdene Rest Home	Provider
Mr E	Sole director of Wilding International (which owned and operated Armourdene)

10. Also mentioned in this report:

RN F	Registered nurse
Ms G	Caregiver

11. Further information was received from:

The Coroner
District health board
HealthCERT

Information gathered during investigation

Introduction

12. This report concerns the care provided to Mr A while he was a resident at Armourdene. The first part of the report summarises the information that HDC was able to obtain about Mr A's care at Armourdene. The majority of the information about Mr A contained in the report has been obtained from the complainant, Mrs B (his sister-in-law), and is based on her understanding of his health issues, and her observation of the care provided to him. However, HDC was not provided with all the information relevant to the investigation of this complaint.

13. The second part of the report outlines HDC's requests for information from Armourdene, and Armourdene's responses to the requests.

14. Because not all the relevant information has been provided, it is not possible to determine whether the care provided to Mr A at Armourdene was appropriate. As a result, the focus of this report is on Armourdene's limited participation and lack of cooperation with HDC's investigation process.

Background

15. In 2010, Mr A, then aged in his sixties, was admitted to Armourdene. Mr A had a history of a brain injury, stroke and hypertension, and a diagnosis of schizoaffective disorder.[1] In

[1] A combination of symptoms of schizophrenia, such as hallucinations or delusions, and mood disorder, such as depression or bipolar disorder.

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2012, he was diagnosed with prostate cancer, for which he received ongoing treatment. As a result of the cancer, Mr A's right leg was swollen, he suffered severe pain, and his mobility was further restricted. He had an indwelling urinary catheter, and, according to Mrs B, was prone to faecal incontinence at times. At the time of these events, Mr A was in his seventies.

16. It is reasonable to surmise from Mr A's complex medical history that he was unable to function independently and required increasing levels of support as his health deteriorated. It is highly likely that while a resident at Armourdene he needed considerable assistance with most aspects of daily living on account of his paralysis and limited mobility. It is also reasonable to assume that he would have needed careful monitoring with appropriate interventions from nursing and support staff as his health deteriorated further and he began to experience more pain and discomfort.

17. Armourdene is a 28-bed facility that offers rest-home-level care. Armourdene is owned and operated by Wilding International Limited. Its sole director is Mr E.

Enquiries regarding reassessment of needs

18. Mr A's family was concerned about whether Armourdene could continue to provide the level of care that Mr A required. In early 2018, Mrs B and Ms D attended a meeting with Mr E and RN F at Armourdene to discuss Mr A's ongoing care. Mr C was present by speaker phone. Ms D and Mr C told HDC that Mr E assured them that Armourdene could continue to provide Mr A with appropriate care.

19. Mr C told HDC that following the meeting, he called Hospice for advice and was told that Armourdene was not a suitable place for Mr A. Mr C said that Hospice offered to assess Mr A, but he was admitted to hospital before that could occur.

20. Mrs B told HDC that in 2018 she lodged a complaint with Age Concern.[2] She said that she was referred to Disability Support[3] to assess the ongoing suitability of Armourdene for Mr A's needs. Mrs B said that Mr E was furious that she had made a complaint, and accused her of trying to remove Mr A from Armourdene.

21. Ms D said that she was contacted by Mr E, who was not happy with the request for an assessment by Disability Support. Mr E told her that Mr A's doctor was away, and that it would be better to wait for his return. Ms D agreed to postpone the assessment until Mr A's doctor had returned.

Complaint to HDC

22. In her complaint to HDC dated 20 September 2018, Mrs B expressed concern about the care Mr A received at Armourdene. She said that Mr A was not offered assistance to use the toilet, and that as a result sometimes he soiled himself. Mrs B said that Mr A had a

[2] Age Concern is a not-for-profit organisation that provides advice and support for elderly people.

[3] Disability Support Services is a Ministry of Health service responsible for purchasing disability support services for people with a long-term physical, intellectual, and/or sensory impairment that requires ongoing support. The Needs Assessment and Service Co-ordination service works with disabled people to help identify their disability support needs and to outline the supports available.

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permanent indwelling urinary catheter that was not emptied regularly and often overflowed, leaving Mr A in urine-drenched clothes. On one occasion when the catheter overflowed, Mr A was left alone in the lounge partially dressed with no nurse to assist him. The room was cold with no heating running. Mrs B also said that staff insisted that Mr A use a walker despite being paralysed in his right leg, and would not provide him with a wheelchair.

23. Mrs B stated that on Day 1[4], Mr A was found on the floor of his room. This aspect of her complaint is outlined later in the report.

24. Mrs B stated that she had other concerns about Armourdene, which included:

> "[No] form of alarm system in patient's rooms in the event of a fall. No checking that patients got to bed safely. Staffing reduced to two persons at night and weekends. No medical cover for patients over weekend — families are expected to take patients to the Medical Emergency rooms."

25. Mrs B said that she was concerned about the oversight of rest homes generally, and the care provided to Mr A in particular. She stated:

> "[I] believe that vulnerable elderly people deserve to be treated with respect and consideration. This was not evident at Armourdene. Perhaps the question needs to be asked who supervises these so-called 'rest homes' and how often?
>
> …
>
> Like many people with brain injuries when [Mr A] arrived at Armourdene he was difficult and volatile, full of fear and confusion — he had lost everything in his life — his home, his family and his ability to work. For me I remember the shy 13 year old I met when I married his brother, whose smile lit up his face, who made us laugh and deserved better treatment at the hands of those entrusted to care for him."

Armourdene response to complaint

26. Armourdene was provided with a copy of Mrs B's complaint and asked to respond. Armourdene provided multiple responses[5] disputing aspects of the complaint. Information regarding the facilities and the staff at Armourdene was also provided, and is summarised below.

27. Armourdene told HDC that there is one full-time nurse and one part-time nurse at Armourdene. Both nurses are qualified, and at least one registered nurse is on call over the weekends. Two caregivers are on duty at all times, and Armourdene said that its staffing levels exceed its contractual obligations. Medical care is also provided by a general practitioner, who visits every two weeks.

28. Armourdene said that there are call systems in all of the patients' rooms, and that patients are checked at night.

[4] Relevant dates are referred to as Days 1-5 to protect privacy.
[5] Responses dated 26 October 2018, 27 October 2018, and 14 November 2018.

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29. Armourdene stated that Mr A wanted to remain independent with his walking frame, but that a wheelchair was available for his use when he left the facility. Armourdene said that Mr A's walking frame had a seat, which he used, and that the lounge and Mr A's chair in the lounge were close to his room.

30. Armourdene said that Mr A had been independent with his catheter care, but that his deteriorating cognitive function occasionally resulted in leakage. Mr A was usually continent of stool.

31. Armourdene stated that power of attorney (POA) authorisation is required for a reassessment by Disability Support. Armourdene said that it called Mr A's daughter, Ms D, who was the POA, and they agreed to postpone the reassessment until "further evidence surfaced and [Mr A's] doctor reviewed the situation".

Fall on Day 1

32. Armourdene's response to the complaint also included an account of Mr A's fall at approximately 7am on Day 1.[6]

33. Armourdene said that Mr A was in his bedroom receiving personal care from a caregiver, Ms G, who left the room to obtain supplies. Mr A stood up from his chair and fell to the floor. Armourdene stated: "[Ms G] heard the noise of his fall and returned immediately and actioned a response in line with our protocols."[7]

34. RN F stated[8] that on Day 1 he was the registered nurse on call, and at approximately 7am he received a call from Ms G, who was a night-shift caregiver. He said that Ms G told him that Mr A had fallen in his room, and that she and another caregiver had lifted him into the armchair and he did not appear to have any injuries. RN F said that he instructed Ms G to monitor Mr A's vital signs.

35. RN F stated that at approximately 11am, a day-shift caregiver rang him and advised that Mr A could not get out of his chair, which was a significant change in his behaviour.

36. RN F said that he arrived at Armourdene about 20 minutes later to assess Mr A. On examination, Mr A was unable to lift his right leg, and he complained of severe pain when his right hip was assessed. RN F thought that Mr A might have fractured his hip, and he called an ambulance. The ambulance arrived a few minutes later and transferred Mr A to hospital. RN F said that he then called Mr A's daughter and advised her accordingly.

37. Mr C told HDC that his sister is adamant that when RN F called her, he said that he did not know how long Mr A had been on the floor.

[6] In a letter to HDC dated 14 November 2018. The letter stated that RN F had also provided input into the response.
[7] In a letter to the DHB dated 19 October 2019.
[8] In a letter to the Coroner dated 13 September 2018.

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Transfer to hospital

38. Mr A was transferred to hospital by ambulance. The Ambulance Care Summary stated: "Unwitnessed fall in rest home this morning. Lifted and initially mobile with walking frame but as morning progressed refused to move." The Care Summary also noted: "[Patient] incontinent of faeces enroute, short transport time, nil other problems."

39. Mr A was diagnosed with a hip fracture, and also found to have a UTI[9] and a pressure sore on his sacrum.[10]

40. On Day 3, a registered nurse at the public hospital made a social work referral for Mr A. The Internal Referral Form stated that the reason for the referral was "Aged care concern report done 2/52 by family. Needs [increased level of care]." The referral also documented: "[Mr A] came into the ward [with] existing [pressure injury] on sacrum, very unkempt and malodorous."

41. Mr A remained in the public hospital, and he died on Day 4.

42. The Coronial Postmortem Report stated that the cause of death was acute cardiac failure, and that the underlying contributing conditions were a hip fracture and prostatic carcinoma. It stated: "In summary, no injuries are found on the body. The deceased does not look neglected in any way. The deceased appears relatively well nourished and hydrated."

43. Armourdene stated[11] that RN F called the hospital on Day 5 for an update on Mr A's condition, and was advised of Mr A's death. For that reason, Armourdene did not advise the family of Mr A's death prior to Day 5.

DHB internal clinical review

44. As a result of a complaint from Mr A's family, the DHB conducted an internal clinical review, which was completed on 6 March 2019. The purpose of the review was to verify Mr A's condition on his arrival at the public hospital on Day 1, to examine the process used by Armourdene for Mr A's transfer to hospital, and to check the communication between the DHB and Armourdene about Mr A's death.

45. The internal review stated that on admission to the Emergency Department it was noted that there was a smell of urine and faeces on Mr A, and that the permanent indwelling catheter was not secure, was not draining effectively, and smelled of infected urine. The review also noted "'poor cleaning' around the meatus of the penis and perianal area, which was foul smelling".

46. The DHB asked Armourdene to provide Mr A's clinical notes to assist with the review, but these were not provided. As a result, the DHB was not able to determine when the obstruction of urine occurred, how long the catheter had been in place, or when the pressure sore developed.

[9] Urinary tract infection.
[10] Bone at the base of the spine.
[11] In a letter to the DHB dated 19 October 2018.

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47. The DHB's review stated:

> "At what stage an obstruction to flow of urine had occurred; presence of infection, [what] duration the IDC[12] had been in situ and whether changed in accordance with recommended practice, cannot be established from review of hospital notes alone … Review of hospital notes and information noted from Armourdene Rest Home does not make it clear whether there was an existing pressure injury, or whether the pressure injury may have been as a result of the fall."

48. Following completion of the review, the DHB recommended a number of corrective actions[13] based on the available information, and closed its complaint investigation.

HealthCERT unannounced surveillance audit

49. In June 2019, HealthCERT undertook an unannounced surveillance audit, which resulted in 12 partially attained standards. The standards related to informed consent, communication, quality and risk management systems, adverse event reporting, human resource management, medicine management, nutrition, safe food and fluid management, planning (consumer service delivery plans), service delivery/interventions (consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes), evaluation (of consumers' service delivery plans), and facility specifications (consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose). All actions required by the audit were reported as having been completed by 18 September 2019.

Closure of Armourdene

50. On 27 May 2020, HealthCERT advised HDC that on 20 April 2020, the last resident was transferred out of Armourdene and the facility was closed.

HDC investigation

51. As outlined above, on 20 September 2018 Mrs B made a complaint to HDC. The complaint concerned the care provided to Mr A at Armourdene, including the circumstances surrounding his fall on Day 1, and about the facilities at Armourdene.

52. On 26 October 2018, HDC asked Armourdene to respond to the complaint and to provide HDC with a copy of Mr A's clinical records. Armourdene provided information about staffing and facilities at Armourdene, but did not provide Mr A's clinical records.

53. Clinical notes were also requested by HDC on the following occasions:

- Email dated 17 January 2019
- Two emails dated 18 January 2019
- Telephone conversation on 21 January 2019

[12] Indwelling urinary catheter.

[13] The corrective actions for Armourdene were that it (1) provide policies for UTIs, catheters, and pressure injuries, and training in penile and perianal hygiene, and (2) provide evidence of a process for checking emergency referral information.

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- Letter dated 29 March 2019 from Rose Wall, Deputy Health and Disability Commissioner
- Email dated 2 May 2019
- Email dated 14 June 2019
- Letter dated 8 July 2019 from Meenal Duggal, Deputy Health and Disability Commissioner
- Email dated 4 November 2019

54. On 13 November 2019, HDC again requested a copy of Mr A's clinical notes from Armourdene, including:

- interRAI assessments
- Short-term and long-term care plans
- Progress notes
- Monitoring charts
- Medication prescription and administration
- Falls risk assessments
- Wound assessment chart
- Wound care plan
- Family communication logs
- Pain scores
- Pain score assessment tool

55. Armourdene responded to HDC[14] but did not provide HDC with any of the requested clinical notes listed above.

56. In its response to HDC's request for clinical notes, Armourdene stated that it was concerned that the clinical notes could get lost in transit,[15] and that Armourdene had already submitted "volumes of information to the HDC in response to this particular case".[16]

57. On 14 November 2019, HDC asked Armourdene to provide its policies and procedures relating to falls, afterhours/weekend medical cover, transportation of residents, elimination, wound care, pain, and medication. Armourdene has not provided this information.

58. Armourdene was asked to provide statements from the staff members who were on duty when Mr A fell, and from Mr A's GP. Armourdene was also asked to provide information in relation to the family meeting with the family, and a copy of any incident report or internal investigation concerning the events. Armourdene has not provided this information.

59. In its response to HDC dated 18 November 2019, Armourdene stated that it had already provided "extensive and detailed factual evidence", that Mrs B's complaint was "fictitious,

[14] Armourdene responded to all HDC correspondence except the letter dated 8 July 2019.
[15] In an email dated 2 May 2019.
[16] In a letter dated 14 June 2019.

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false and essentially devoid of any factual documentation", and that "[Armourdene's] acceptance of an investigation by the HDC would provide a clear assumption [Armourdene] accept[s] [Mrs B's] complaint. This is not the case."

60. Armourdene requested that the complaint be "verified" by asking Mrs B to revise her statements about Armourdene and to provide evidence to support the statements, and by HDC addressing the "false, untrue and inaccurate statements".

61. Armourdene concluded:

> "It is with some regret that the directors of [Armourdene] are unable to accept the proposed HDC investigation in its current form."

Responses to provisional opinion

Mr C

62. Mr C was given an opportunity to comment on the "information gathered" section of the provisional opinion. Where relevant, his response has been incorporated into the "information gathered" section above.

63. In addition, Mr C stated:

> "[A]fter the fall our father was in severe pain due to the injury he sustained. It is very hard to understand how he could fall and fracture his hip and then be said to *'not appear to have any injuries'*. Once admitted to hospital he was on morphine until he died. If the accident occurred at 7am, why didn't [RN F] attend our father until 11.20am."

64. Mr C also expressed his concern that given Armourdene's contractual obligations to the DHB, the DHB could not compel Armourdene to provide the information it requested.

Armourdene

65. Armourdene was given an opportunity to comment on the provisional opinion. Armourdene submitted that it had provided information that showed that the allegations in the complaint were incorrect, and it re-presented the information. Armourdene also stated that there was evidence that Mr A was able to function independently because he participated in outings to a cultural club. Armourdene also submitted that if HDC had agreed to a revised investigative process then it would have participated in the investigation. Armourdene also provided the qualifications of the director of Armourdene and staff members, and an award and testimonial given to Armourdene, and photos of the room used by Mr A.

66. Armourdene also provided information that was outside the scope of this investigation and outside HDC's jurisdiction, including information relating to:

- Concerns about the DHB's internal investigation into this complaint
- The closure of Armourdene and another rest home
- Concerns about another consumer who was a resident at Armourdene

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- The DHB's response to those concerns

Opinion: Armourdene — breach

67. The role of HDC is to promote and protect the rights of consumers of health and disability services. The rights are set out in the Code of Health and Disability Services Consumers' Rights (the Code), together with the obligations for providers. Right 10(3) of the Code requires providers to facilitate the fair, simple, speedy, and efficient resolution of complaints.

68. In her complaint to HDC, Mrs B outlined her concerns about the care provided to Mr A at Armourdene, including her concerns about the adequacy of the facilities, the care provided to Mr A, and the circumstances of a fall on Day 1. Mrs B is a worthy advocate for her late brother-in-law.

69. HDC commenced an assessment of Mrs B's complaint and an investigation into the care provided to Mr A on the basis that the actions of Armourdene appeared to be in breach of the Code.[17] As part of any investigation of this nature, health providers are asked to produce the consumer's clinical records, all relevant company policies, and statements from staff members. The clinical records are crucial to an investigation; they are a record of the care provided to a consumer, and document the effectiveness of that care.

70. Armourdene was asked to provide Mr A's clinical records, relevant policies, and statements from staff members. This is a routine request, and one that other providers have no hesitation or difficulty in complying with. Providers are required to retain copies of their residents' clinical records for a period of 10 years. In its response, Amourdene challenged aspects of the complaint and provided information about the facility and its staff. However, Armourdene did not provide the clinical notes and other information that was requested. Armourdene stated:

> "It is with some regret that the directors of [Armourdene] are unable to accept the proposed HDC investigation in its current form."

71. Armourdene did not provide a reasonable explanation for failing to provide the clinical notes and other information. It stated only that it considered that sufficient information had already been provided and that the notes could get lost in transit. This is not a reasonable explanation, and could infer that Armourdene either no longer has possession of the notes, or the notes never existed and/or reflect poorly on the care that Armourdene provided. In any event, Armourdene's response is a deliberate decision not to co-operate with my investigation.

[17] Section 40(1) of the Health and Disability Commissioner Act 1994 provides: "The Commissioner may decide to investigate any action of a health care provider or a disability services provider if the action is, or appears to the Commissioner to be, in breach of the Code."

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72. This investigation is an impartial and fair process. It was an opportunity for Armourdene not only to clarify and resolve the issues raised by Mr A's family, but to provide information to support its assertion that the care provided to Mr A was appropriate. It was also an opportunity for Armourdene to reassure the general public that the rights of vulnerable consumers who resided at Armourdene were being protected. Armourdene did not take this opportunity, and I note that Armourdene's reluctance to provide information is not representative of the approach taken by the residential aged-care sector in general.

73. The concerns raised by Mr A's family are serious and appear to be in breach of the Code. Furthermore, the results from the regulator's independent audit undertaken in June 2019, some 12 months after Mr A was receiving care at the facility, were not reassuring, and highlighted significant shortcomings in the performance of the service in a number of key areas. This unannounced surveillance audit identified 12 Health and Disability Services Standards that had been complied with only partially. I note that all standards were complied with by 18 September 2019.

74. As a result of Armourdene's failure to co-operate with the assessment of Mrs B's complaint and HDC's investigation, it is not possible for me to substantiate these concerns or to determine whether Armourdene provided appropriate care. In addition, Mr A's family has been denied an opportunity to obtain a satisfactory resolution to their complaint.

75. Right 10(3) of the Code provides that every provider must facilitate the fair, simple, speedy, and efficient resolution of a complaint. In this case, Armourdene has not provided the information that was crucial to the investigation of the complaint and, as a result, has undermined and frustrated the investigation process. Armourdene has not facilitated the speedy and efficient resolution of the complaint and, accordingly, Armourdene has breached Right 10(3) of the Code.

Follow-up actions

76. Wilding International Limited (trading as Armourdene Rest Home) 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.

77. A copy of this report will be sent to the Office of the Coroner and the DHB.

78. A copy of this report with details identifying the parties removed, except Wilding International Limited (trading as Armourdene Rest Home), will be sent to the Ministry of Health (HealthCERT), the Health Quality & Safety Commission, and the New Zealand Aged Care Association, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Addendum

79. The Director of Proceedings decided to institute Human Rights Review Tribunal proceedings. Although initially filed on a defended basis, the defendant later agreed to the Tribunal issuing a declaration by consent. The Tribunal subsequently found the defendant in breach of Right 10(3) of the Code.

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