A Rest Home

Registered Nurse, Mr B

Registered Nurse, Ms C

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC20395)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

A registered nurse was accused of slapping an elderly rest home resident in October 2007. This was claimed to have been witnessed by a caregiver, who reported the incident to her supervisors. Following an internal investigation, the registered nurse was dismissed and the Nursing Council of New Zealand was advised.

This report considers the available evidence to conclude whether the registered nurse slapped the rest home resident or, as he claimed, he just "flicked her hand away" while he was attempting to dress a wound.

The report also considers the actions of the registered nurse's employers when they became aware of the accusation.

Complaint and investigation

On 26 November 2007, the Health and Disability Commissioner (HDC) received a complaint from the Nursing Council of New Zealand (the Council) about the services provided by registered nurse Mr B to Mrs A. The complaint was forwarded after being sent to the Council by the Rest Home facility manager, Ms C. On 31 January 2008, I commenced an investigation into the following issues:

- *Did registered nurse Mr B provide appropriate care to Mrs A on 11 October 2007?*

- *Did the Rest Home provide appropriate care to Mrs A on 11 October 2007?*

On 27 March 2008, I extended my investigation to include the following issue:

- *Did the Rest Home and Manager Ms C respond appropriately to the allegation that Registered Nurse Mr B physically abused Mrs A on 11 October 2007?*

The parties involved in this investigation are:

Mrs A	Consumer
Mr B	Provider/Registered nurse
Ms C	Facility Manager
Ms D	Caregiver
Mr E	Human Resources Manager
Ms F	Quality Assurance Coordinator
Mr G	Regional Health Operations Manager
Ms H	Clinical Manager
Ms I	Registered Nurse
A Rest Home	Provider

Information has been provided by Mr B, Ms C, Ms D, Ms I, and the Rest Home owners.

Information gathered during investigation

Background

The Rest Home
The Rest Home has 69 beds: 10 in a Dementia Unit, 24 hospital level beds, and 35 rest home level beds. The Rest Home is owned by a company which purchased the facility in April 2007. References to the Rest Home in this report include the Rest Home Company.

In February 2007, Ms C became the Facility Manager; she is also a registered nurse (RN). The Clinical Manager in October 2007 was registered nurse Ms H.

Mr B
Mr B qualified as a nurse in the Philippines. From October 2001 until September 2005 he worked at a hospital in the Philippines. Mr B had no previous experience in elderly care before working at the Rest Home.

When Mr B decided to move to New Zealand, he provided his curriculum vitae to an employment agent. They arranged for a practising certificate and a visa to allow Mr B to work as a nurse in New Zealand.

The Nursing Council of New Zealand registered Mr B and issued him with an annual practising certificate in October 2006. Mr B provided a number of documents to support his application for registration, including a certificate of registration/good standing from the Philippines Board of Nursing, three written references, and a police check. He also successfully completed a competence assessment programme in September 2006.

Before Mr B left the Philippines, the employment agent found him a job as a registered nurse at the Rest Home. Having accepted the position, Mr B travelled to New Zealand. The then-owners of the Rest Home sponsored him to attend a course at an Institute of Technology to prepare him for working in New Zealand. As part of his course, he did a clinical placement on a surgical ward in a public hospital.[1]

Mr B's induction and training at the Rest Home
Mr B signed his job description on 11 August 2006 and, in late September 2006 he commenced work at the Rest Home. He lived on-site, initially working as a caregiver until his practising certificate was confirmed. He started work as a registered nurse on 17 October 2006.

[1] Mr B's accommodation, travel and training were paid for by the rest home company.

For his first two to three weeks of employment, Mr B worked with another registered nurse, Ms I. During this time, Ms I undertook a general staff orientation with Mr B. Mr B stated that from that point he worked mainly on nights, with occasional day shifts if the need arose.

The facility was purchased in April 2007. Between April and October 2007, Mr B attended in-service training sessions, and his competency was assessed in several areas relevant to elderly care. The new owners had a policy for assessing nurses' competencies, and listed those that should be checked at orientation;[2] within three months of employment;[3] and as and when required. However, none of Mr B's competencies were checked until after the company had owned the Rest Home for two months.

Of the competencies specifically named in the policy, there is no record that Mr B's competence was ever checked on the use of nebulisers, oxygen administration, or restraint. Ms C agreed that Mr B had not received training in these areas. Staff training on restraint had been offered on 16 and 26 June 2006, 11 August 2006, and 4 and 11 July 2007, but Mr B had not attended any of these sessions.

The Rest Home advised that Mr B "had irregular attendance to mandatory in-house training", and they have since undertaken to monitor more closely staff attendance at mandatory education sessions at all their aged-care facilities.

Although Mr B's job description stated that he was to have performance appraisals at three and six months after appointment, and then annually, Ms C confirmed that Mr B received no routine performance appraisals while he was employed by the Rest Home.[4] Ms C attempted to arrange appraisal meetings in July but was unsuccessful. Mr B's personnel file also records a draft letter on 17 September noting that a performance appraisal was due. However, this letter was not sent to Mr B. The Rest Home explained that this was due to management being busy with an upcoming certification audit.

Prior incidents

Mr B received training in completing incident forms during his induction on 26 October 2006. The records show that he was involved in two incidents prior to the purchase of the Rest Home, and three further incidents between July 2007 and the incident involving Mrs A.

On 6 March 2007, Mr B left a packet of medication in the staff toilet and, a few days later, he gave two residents each other's medication by mistake. Although the incident

[2] At orientation: restraint; drug administration; controlled drug administration; nebuliser; blood sugar levels and insulin administration; hoist use.
[3] Within three months of employment: oxygen administration; wound management; nursing assessment tools.
[4] Although the first six months of his employment were the responsibility of the previous company.

form for the latter event is undated, Ms C wrote to Mr B on 12 March 2007, and referred to "issue[s] raised on a few incident forms". In response to the March incidents, Mr B was asked to take more care. Ms C explained that she was concerned that the incidents may have occurred because Mr B was tired at the time. She later acknowledged that a more formal approach was required.

On 12 July 2007, Mr B administered an unprescribed Maxolon[5] injection to a resident, and was given a verbal warning. Ms C advised that Mr B gave unprescribed Maxolon on two occasions, although there is no documentation relating to the second incident.

On 19 September 2007, Mr B was reported to have locked a wandering resident in the nurses' station. A caregiver reported:

> "While doing afternoon tea, [a resident] was wandering and I overheard [Mr B] tell her to go into the office. When she was seated he came out and closed the door locking her in. Without saying anything to anyone then he went to [the] rest home."

This incident was never discussed with Mr B and no other action was taken.

Events of 11 October 2007

Mrs A, aged 95, was admitted to the Rest Home in September 2006. She was fully dependent on nursing staff for her cares, and suffered from dementia.

On the night of 10–11 October 2007, Mr B was working the second of three consecutive night shifts. He said he was called by a caregiver in the morning, towards the end of the shift, to inform him that Mrs A had some blood on her nightdress. On checking, he found that she had a small skin tear (three to five millimetres) on her left arm, and he decided to dress the wound.

Having collected the dressing materials, Mr B said that he knelt on the floor by Mrs A's bed to dress the wound (Mrs A was still in bed at this stage), with his back to the doorway.

However, because of her dementia, Mrs A became agitated when Mr B attempted to dress the wound. He stated that she tried to grab his arm and started to shout at him. Mr B said that he raised his voice to be heard. He called for assistance, but the caregiver on duty did not come. Mr B said that Mrs A resisted while he was attempting to dress her wound, and he "flicked" her hand away a few times to be able to site the dressing. At this point, caregiver Ms D walked into the room.[6] Mr B said that Mrs A lowered her voice when she saw Ms D, and he also lowered his voice.

[5] Maxolon is prescribed to treat nausea.

[6] Ms D's shift was due to start at 7am, but she stated that she was always early on duty. Consequently, at approximately 6.20am, she entered Mrs A's room because she (Ms D) had wanted to ask Mr B something.

Mr B did not document the dressing in the progress notes. He stated that he did not complete an incident form because he did not think the skin tear was serious enough to require an incident form to be completed. This was despite the policy (November 2005) on the use of accident/incident forms which specifically states that an incident form should be completed in "Any incident where a skin tear is sustained or found".

Ms D stated that she clearly saw Mr B slap Mrs A "hard" on her arms with both hands. She said she saw four slaps, and she saw the impact of the slaps on the upper part of Mrs A's right arm. Ms D said that Mr B appeared to have "lost the plot" and was shouting at Mrs A.

Ms D left the room and reported the incident to Ms I, who was the RN on duty that morning. Ms D also completed an incident form; she wrote:

> "Walked into resident's [bedroom]. RN was dressing a wound on her left arm. Resident start[ed] yelling 'Don't hurt me' and started hitting out at the RN. RN yelled at her to stop it and when she didn't he started slapping her arms and yelling at her to stop — at this stage RN realised I was watching and he stopped. Changed his tone and started talking to her quieter and carried on with the dressing. I walked out.
>
> On later inspection noticed fresh bruising on said arm."

In her interview with this Office, Ms D clarified her statement. She confirmed that she had seen and heard Mr B slap Mrs A four times. However, she stated that she went back to Mrs A soon after the incident and found that there were no marks on her right arm. On later inspection during the day, Ms D found that Mrs A's right arm was reddened where she had seen Mr B slap her. Ms D added that Mrs A was much more agitated than usual that day.

Ms I subsequently reported the incident to Ms H and Ms C. Later that day, Ms D spoke to Ms C and described the incident. Ms C's note states:

> "[Ms D] went to see if the nurses needed a hand getting someone up … This is when she saw [Mr B] doing [Mrs A's] dressing. As [Ms D] came to [Mrs A's] room she saw [Mr B] dressing a wound on her left arm. The resident was shouting 'Don't hurt me'. This is normal for her in the respect that she often shouts at the staff due to her having dementia … At the same time [Mrs A] was hitting [Mr B] also. [He] was shouting at her to stop, which she did not. Then [Mr B] slapped her 3–4 times on her arm. [Ms D] was very shocked at the sight of someone doing this to a resident. At this point [Mr B] then realised that [Ms D] was outside the room. He then lowered his tone of voice and started talking to [Mrs A] quietly. He carried on with the dressing and never said anything to [Ms D]."

The progress note written by Ms D later that day states:

> "RN redressed skin tear on [Mrs A's] left arm ... noticeable bruising above and below elbow."

Subsequent events
After speaking with Ms D, Ms C attended Mrs A. Ms C advised that she observed bruising and swelling on Mrs A's left arm. She did not document this finding.

Ms C then telephoned the Human Resources (HR) Manager, Mr E, for guidance. Ms C recalled that Mr E advised her to arrange a meeting as soon as possible with Mr B, and that he should not be suspended until after the meeting. Mr E referred Ms C to the Workplace Improvement Policy and Disciplinary Code,[7] which included a disciplinary process checklist.

Mr E does not recall discussing an incident involving Mr B on 11 October. He recalls speaking with Ms C about disciplinary procedures for another (unidentified) registered nurse and confirmed that he emailed her a copy of the Workplace Improvement Policy and Disciplinary Code.

Ms F, Quality Assurance Coordinator stated:

> "While we are unable to provide any documented notes regarding advice that was given to [Ms C] by the Human Resources department, we can confirm in the discussion that the HR Manager provided advice to [Ms C] in regard to ensuring that any actions and process she followed complied with the requirements of the Employment Relations Act.
>
> As such, the focus of the discussion was on ensuring that [Mr B] was given the opportunity to be supported during the investigation that was planned."

Ms C contacted Mr B the following morning, after he had completed his night shift of 11–12 October. She said that she did not take more urgent action because Mr E advised her that it would be acceptable to contact Mr B after he had completed the night shift.

At approximately 6.00am on 12 October, Ms C telephoned Mr B during his shift to arrange a meeting for 12.30pm that same day. (Mr B was due to work from 4pm to 11pm that day, having completed his night shift at 7am.)

Ms C wrote to Mr B to confirm the meeting. She left the letter for him, at the nurses' station.

[7] See Appendix A.

Ms C also contacted the Operations Manager, Mr G, to advise him of the incident. Mr G recalls this discussion:

> "... I was aware of the incident very soon after it occurred. I do recall the HR Manager becoming involved and providing advice to [Ms C] very early on post incident."

Mr B did not attend the meeting at 12.30pm. Ms C stated that he was late on duty that day and she stayed as late as she could (until 4.30pm) before she had to leave to attend to family duties. She left a further message inviting him to a meeting on 15 October at 3pm.

Mr B worked a further night shift on 14–15 October. He documented the care provided to Mrs A in the clinical record.

Mr B did not attend the meeting on 15 October, and a formal letter was drafted and delivered to his residence. The letter advised him of the seriousness of the situation and a further meeting was scheduled for 16 October at 3pm.

Mr B worked a 12-hour night shift (7pm to 7am) on 15–16 October. Again, he documented the care provided to Mrs A during that shift.

Ms C contacted Mr E on the morning of 16 October, requesting advice and support as Mr B had not attended the previous planned meetings. Ms C recalled that Mr E advised that, if Mr B did not attend the planned meeting that afternoon, she should write to him and advise that the investigation would proceed without his input.

In contrast, Mr E said that this was the first time he spoke with Ms C about Mr B, and (incorrectly) stated that this was after Mr B had been dismissed. Mr E recalled that he advised Ms C only about immigration and tenancy issues, as they related to Mr B.

On 16 October, Mr B attended the meeting with Ms C and Clinical Manager Ms H. Ms C stated that Mr B declined to have a support person present. The allegation that he slapped Mrs A was put to Mr B, and he was advised that an investigation was being carried out. Ms C said that Mr B did not respond to the allegation, and a meeting was arranged for the following morning. Ms C stated that she again reminded Mr B of his right to bring a support person to the meeting.

Mr B worked the night shift of 16–17 October. The caregiver noted the care provided to Mrs A.

Another meeting was held on the morning of 17 October, during which Mr B was supported by Ms I. Ms C recalled that, during this meeting, Mr B denied that he slapped Mrs A, although he admitted that he may have been forceful. Ms C also recalled that Mr B stated that he was aware of how to best manage challenging behaviour. Following a five-minute adjournment, Ms C told Mr B that, in her opinion, the allegation against him had been substantiated, and his employment would be

terminated. Ms C recalled that Mr B then stated that he "did accept responsibility for his own actions and that he had no one to blame but himself".

Although Mr B agreed that he made the above statement, he explained that he was "accepting that he could have documented more and could have tried harder to get a caregiver involved, [he was] not accepting that he hit [Mrs A]".

Ms C stated that she contacted Mr E after meeting Mr B. She said that she recommended that Mr B be dismissed, and she forwarded a draft dismissal letter to Mr E. Mr E made some alterations to the letter before it was finalised, and Mr B was dismissed later that day. Mr B was allowed to stay in his residence attached to the Rest Home for a further month.

Ms C told my Office:

> "Should a similar incident be reported again, my actions would be to immediately arrange contact with and suspension of the staff member until an investigation had been completed ..."

Further incidents

Mr B was reportedly involved in two further incidents in the period between 11 October, when the Rest Home became aware of the incident involving Mrs A, and 17 October when Mr B was dismissed.

On 12 October 2007, a caregiver found a packet of medication left in a resident's room by Mr B and reported this. Ms C did not complete the section of the incident form to indicate whether any action was taken against Mr B.

On 15 October 2007, another caregiver wrote an addendum to the incident form of 19 September: "This [locking a resident in the nurses' station] happened again 15/10/7." Ms C wrote on the form: "Staff member spoken to. No longer works for the Rest Home."

Mrs A's daughter was contacted by Ms C to discuss the allegation and the investigation outcome after Mr B had been dismissed. The daughter said she was reassured by the Rest Home's actions.

Response to Provisional Opinion

The majority of the parties' comments on my provisional opinion have been incorporated into the previous section. Remaining comments are outlined below:

The Rest Home
In response to the provisional finding of direct liability, the Rest Home accepted that it took too long to suspend Mr B following the reported incident, but did not believe that it could have prevented Mr B's actions.

In response to the incident, the Rest Home set out a number of changes and improvements that were either planned or had been actioned. These included:

- Recent appointment of a new General Manager for Human Resources;
- Plans to appoint a senior Human Resources professional specifically to support performance development and management;
- Plans to appoint a Learning and Development Manager to provide training and support to all Facility Managers, up-skilling the managers in leadership and management capability;
- Plans to develop a training programme on Customer Service Excellence in August 2008;
- Currently reviewing employment and disciplinary policies to reflect the overriding duty to minimise risk to residents;
- Senior management, who were relatively new in their positions at the time of the incident, being now more familiar with core processes.

In response to the finding of vicarious liability, the Rest Home noted that the management team underwent a full certification audit in March 2007, and was required to prepare for a DHB contract audit in August 2007 and another full certification audit in September 2007. The Rest Home stated:

> "The energy required from [the] management team to prepare and manage these as a matter of priority, coupled with monitoring and implementing various changes throughout the facility meant that understandably some areas were given less attention than may have been required."

Ms C advised that she was not the Facility Manager when Mr B was employed at the Rest Home so was not responsible for his three- and six-month appraisals. She began this role in February 2007 (before the company acquired the facility), but was not given any documentation or handover from the previous manager.

Following medication incidents that were alleged to have occurred in March 2007, Ms C said that additional support was offered but declined by Mr B. However, this was not documented in the incident forms or Mr B's personnel file. Ms C acknowledged that instead of simply asking Mr B to take more care, she should have dealt with these incidents in a more formal manner at the time.

The following specific changes and improvements have been made to incident reporting systems at the Rest Home:

- Incident and accident forms are all investigated and signed off by either the Facility or Clinical Manager.
- Additional training has been provided to staff on incident and accident reporting, within the past six months.
- A weekly Registered Nurses' forum is now held for the purposes of training, competency assessment, reflection and peer review, or to discuss more general topics.
- All staff are now up to date with planned performance appraisals.
- Documentation relating to disciplinary action has been improved.

Mr B

Mr B maintained that he did not slap Mrs A, and criticised the reliability of Ms D's account, noting:

- "[Ms D's] account suggests she was standing for some time observing what was going on."
- "[Ms D] ... clarified her statement ... [and] this of itself raises doubt regarding her evidence."
- "[Ms D] appears to have added more detail and gained in certainty ... [this] is not indicative of the usual pattern of detail and certainty of recall being lost over time."
- "There are references in some places to [Ms D] later seeing reddening and in other places to her seeing bruising. This area of her evidence seems very unclear."
- "There also appears to be contradictory evidence regarding where [Ms D] was. The notes from her discussion with [Ms C] on 11 October refer to [Ms D] being outside [Mrs A's] room, whereas her incident form refers to her walking inside [Mrs A's] room."
- "It is difficult or impossible to see how [Mr B] could have slapped the patient with both hands when he was in the middle of attempting to apply a dressing ..."

Mr B believed that the bruising on Mrs A's arm was attributable to the skin-tear itself, and noted that the presence of bruising was not necessarily indicative of excessive force being used, as Mrs A had a tendency to bruise easily. He stated:

> "It is quite possible that whatever [event caused the skin tear also] caused the bruising. ... It appears that [Mrs A] bruises easily. There is a reference, for example, in the clinical notes on 5 October 2007 to [Mrs A] hav[ing] a large number of bruises (apparently six), at that point."

Mr B denies that he avoided meeting with Ms C to discuss the incident on 11 October, and stated that there was a misunderstanding in one instance about when the meeting was to occur and, in another, he did not receive the letter about the proposed meeting times until after the specified time.

Mr B objected to the discussion of other allegations against him in the provisional opinion. He commented that those incidents had not been fully investigated by HDC or, in some cases, by the Rest Home management. In relation to the incident whereby Mr B gave two residents each other's medication by mistake, he clarified that the residents did not actually take the medication given to them, and in one of the incidents involving Maxolon, the drug was held in the medication room with the patient's name labelled on it.

Code of Health and Disability Services Consumers' Rights

The following Rights are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

…

(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

...

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

Opinion: Breach — Registered Nurse Mr B

The core issue in this case is whether Mr B slapped Mrs A on the morning of 11 October 2007. If he did, his action breached Right 4(2) of the Code in that he failed to provide services that complied with his legal, ethical and professional standards. As I stated in another case, "It is … plainly unprofessional to physically assault a patient. This is so fundamental that it requires little further comment."[8]

Mr B has stated that he "flicked" Mrs A's hands while he was doing his best to dress a skin tear and only raised his voice in order to be heard above Mrs A. He believed that the bruising on Mrs A's arm was attributable to the skin-tear itself, and noted that the presence of bruising was not necessarily indicative of excessive force being used, as Mrs A had a tendency to bruise easily.

While it is possible that the bruising and skin-tear were caused by the same incident, the bruising described by Ms D was extensive in comparison to the reportedly minor skin tear — so minor, in fact, that Mr B did not consider it required an incident report. In addition, there is no evidence that Mrs A bruises particularly easily, only that she had been involved in an incident resulting in a number of bruises.

The provisional finding that Mr B had slapped Mrs A was based in part on the fact that Ms D had witnessed the incident. In response to my provisional opinion, Mr B suggested that Ms D was not a credible witness. I do not accept this.

Ms D witnessed Mr B having "lost the plot". She stated that she clearly saw Mr B slap Mrs A "hard" on her arms, and he shouted at Mrs A. Ms D said that she saw and heard four slaps, and she saw the impact of slaps on the upper part of Mrs A's right arm.

Ms D also described Mrs A being more agitated later that day, and said that her arms were reddened where she had been slapped. Ms C also noted swelling and fresh bruising on Mrs A's arm later that day.

Mr B doubted Ms D's account as it suggested that she was standing there "for some time". However, there is no evidence to suggest that the incident reported by Ms D took more than a few moments to unfold, and I accept Ms D's recollection that the actual incident was brief.

Mr B was also concerned that Ms D later elaborated on her initial notes about the incident and noted that this appears to be contrary to the usual pattern where a witness's recall fades over time. I do not consider that Ms D should be discredited based on her process for note-taking. She has noted the incident in the succinct style customarily used for clinical notes. It is not necessarily a full record of her account. Ms D completed the incident form, and met with Ms C to discuss the incident within hours of the incident occurring. This would have significantly protected against erosion of her memory over time, and allowed her to provide an accurate and detailed

[8] 05HDC13588.

account to my Office. The information she provided through an interview as part of this investigation was consistent with her earlier accounts.

Mr B challenged Ms D's description of the bruising, noting that "there are references in some places to Ms D later seeing reddening and in other places to her seeing bruising". However, I consider that Ms D's description of initially seeing no marks, followed by reddening, then fresh bruising, is entirely consistent with the development of bruising.

Mr B was also concerned that there was "contradictory evidence regarding where [Ms D] was". The notes from her discussion with Ms C on 11 October refer to Ms D being outside Mrs A's room, whereas her incident form refers to her walking inside Mrs A's room. Although the two accounts are slightly inconsistent on this point, I note that in his interview with this Office, Mr B stated that "[Ms D] came half-way into the room". Considering that Ms D and Mr B's accounts are in agreement, this minor inconsistency does not affect the credibility of Ms D's evidence.

Finally, Mr B queried how he "could have slapped the patient with both hands when he was in the middle of attempting to apply a dressing..." However, it has never been suggested that he used both hands simultaneously, only that both of Mr B's hands were used to slap Mrs A.

In my view, Ms D's description of Mr B having "lost the plot", "yelling" and striking Mrs A is graphic and compelling. She immediately reported the incident, both verbally to Ms I and Ms C, and also completed an incident form. Her account of these events was corroborated by Ms C. There is no evidence to suggest that Ms D had any reason to be less than truthful about these events.

Ms C recalls that at the meeting of 17 October, Mr B denied slapping Mrs A but admitted that he may have been forceful. Mr B acknowledged at the time that "he did accept responsibility for his own actions and had no one to blame but himself", although he later explained that this was not an admission that he slapped Mrs A, and admitted only to having "flicked" her hands.

I acknowledge that working with an agitated and uncooperative resident at the end of a night shift can be challenging. However, Mr B's response to the situation was clearly inappropriate. Having carefully weighed all the information, I am satisfied that Mr B slapped Mrs A on the morning of 11 October 2007, which later caused her bruising, and he raised his voice at her.

To act in this way towards an elderly and vulnerable patient is a very serious departure from professional standards, and the Neglect and Abuse policy.[9] Slapping and yelling at a vulnerable elderly resident is completely unacceptable. Furthermore, Mr B also failed to follow correct procedure by failing to document either the skin-tear or Mrs

[9] See Appendix B.

A's subsequent agitation. Accordingly, he breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code).

Opinion: No breach — Ms C

As the Facility Manager, Ms C was obliged to respond appropriately to the allegation that Mr B had slapped Mrs A, and to ensure that residents were not at risk of further harm.

Response to incident report
The incident of 11 October 2006 was promptly reported to Ms C, and she acted quickly to obtain a detailed statement from the caregiver, Ms D, and ensure that Mrs A had not sustained any serious injury. She then contacted the Human Resources manager, Mr E, and the Operations Manager, Mr G.

Mr E advised Ms C that she could not suspend Mr B until meeting with him to discuss the allegation, and that the meeting could wait until the next day. Ms C then attempted to schedule a meeting with Mr B over the following days.

In response to my provisional opinion, Mr B denied that he avoided these meetings. He explained that there was a misunderstanding about one meeting time and that he did not receive the letter in time for the second meeting.

Ms C said that she did not accept that Mr B was confused about the meeting time on 12 October, because she spoke to him on the telephone and they both agreed on 12.30pm. Ms C recalled that she was working all day, so Mr B could have telephoned or called into her office if he wanted to clarify the meeting time. Ms C did not accept that Mr B failed to see the letter in the nurses' station that evening. She said that Mr B had not yet started his shift when she left the letter, so he would have seen it both when he started and finished his shift. Ms C said that she placed the letter next to the shift report, which Mr B, as the RN, needed to read before each shift and update and replace for the following shift. On balance, I am satisfied that Ms C did make attempts to meet with Mr B but that those attempts were resisted by Mr B.

Ms C was placed in a very awkward position when she wanted to deal with the incident promptly but was advised that she must follow certain processes or she would risk exposing the Rest Home to a potential employment dispute. Ms C has acknowledged that, if faced with the same situation again, she would "immediately arrange contact with and suspension of the staff member until an investigation had been completed".

As I have noted below, the overall response from the Rest Home to this incident was inadequate. However, that responsibility cannot be attributed solely to Ms C, who was acting on the basis of poor advice.

I am therefore satisfied that Ms C took reasonable actions in the circumstances and did not breach the Code.[10]

Opinion: Breach — The Rest Home

In accordance with Right 4(4), the Rest Home had a duty to provide Mrs A with services of an appropriate standard that minimised potential harm to her.

Direct liability
Although the Human Resources manager, Mr E, advised that he did not know of the incident involving RN Mr B until 16 October, both Ms C and Mr G recall that Mr E was made aware of the incident, and provided advice to Ms C, shortly after it occurred. I therefore accept Ms C's account of contacting Mr E on 11 October in relation to the allegation that RN Mr B slapped Mrs A, and that Mr E advised against suspending Mr B before interviewing him. According to Ms C, Mr E also advised that it would be acceptable to wait until the following morning to contact Mr B, despite Mr B being rostered to work a night shift that evening.

Ms F, Quality Assurance Coordinator, has confirmed that the focus of the advice to Ms C was complying with the Employment Relations Act and ensuring that Mr B was supported.

While I understand the requirements to be fair to staff, I do not accept that this was appropriate advice, given that Mr B had been accused of assaulting a resident — an action constituting serious misconduct under the Workplace Improvement Policy and Disciplinary Code. Furthermore, Ms C and the Rest Home had a duty to protect Mrs A and other residents from harm.

If Ms C had followed Mr E's advice, Mr B would have been presented with the allegations and suspended the next day. However, a further five days elapsed before Ms C met with Mr B. Ms C said that she was advised by Mr E that she could not suspend Mr B before meeting with him when, in fact, she was only obliged to provide him with an opportunity to respond to the proposed suspension.[11] To allow Mr B to work five further shifts as sole RN in charge was inappropriate, and placed the residents, including Mrs A, at further risk. In fact, Mr B was involved in two reported incidents during this period, one of which involved restraining a resident in an inappropriate manner.

[10] Clause 3 of the Code of Health and Disability Services Consumers' Rights.

[11] The Workplace Improvement Policy and Disciplinary Code states: "An employee should be suspended only when: ... The employee has been given the opportunity to make submissions on the issue of suspension."

I acknowledge that the Rest Home had a responsibility to follow fair employment law processes and that Mr B apparently tried to evade that process. However, it also had a duty to meet its obligations under the Code. As soon as it became aware of the allegation that Mr B had assaulted Mrs A, it had a responsibility to take immediate steps to address any ongoing risk to its residents. The disciplinary process should have been adapted to take those risks into account. Both Mr E and Ms C knew that they were dealing with a case of serious misconduct and it was inappropriate to delay their investigation of this matter. The incident on 11 October 2007 should have prompted an investigation that day, either through an urgent disciplinary meeting with Mr B when he reported for duty that evening, or, at the very least, notification of the allegations in writing and a request for his urgent response. Mr B could then have been either suspended or placed on other duties that did not involve direct contact with residents while the investigation was underway.

In a previous case, the Commissioner noted that providers have an overriding responsibility to provide for the safety of consumers:

> "The aim of any employing authority should be to recognise any potential risks to patient safety before they eventuate, and to respond in a decisive and timely manner. Patient safety should be the paramount consideration."[12]

In another HDC case,[13] a resident suffered a skin-tear and a fractured shoulder during a bed transfer. As there was no incident report and the staff member responsible did not come forward, the rest home immediately commenced a rigorous internal investigation, involving the Police and Age Concern. When the caregiver was identified through that process, the rest home immediately suspended the caregiver. In that case the caregiver was found to have breached Rights 4(1), 4(3) and 4(4) of the Code, but the rest home was found to have acted appropriately. The Commissioner noted:

> "Immediately on discovering Mrs A's injury, the rest home set in motion an investigation. In total, there were at least three staff meetings to try to encourage anyone who knew of Mrs A's injury to come forward. At least three sets of individual interviews were held with staff who were involved in Mrs A's care. I am satisfied that the management of the rest home approached the investigation in an open manner, with both Age Concern and the Police being involved in the investigation and interviews of staff. Staff were required to undergo extra training as a result of this incident. Ms J of Age Concern stated in her report that Mr D 'conducted this investigation in an honest and transparent manner'."

The Rest Home failed to act promptly and appropriately to investigate the truth of Ms D's allegation against Mr B, and ensure that residents were protected from potential harm. It is simply unacceptable that Mr B continued to care for Mrs A and other

[12] Opinion 04HDC07920. See http://www.hdc.org.nz/files/hdc/opinions/04hdc07920surgeon.pdf

[13] Opinion 05HDC16647.

residents for another five days following this incident, and the Rest Home must take responsibility for the further two incidents that occurred during that time.

In my view, the Rest Home did not provide Mrs A with services that minimised potential harm to her between 11 and 17 October 2007. Accordingly, it breached Right 4(4) of the Code.

Vicarious liability
Under section 72 of the Health and Disability Commissioner Act 1994 ("the Act") an employer is liable for acts or omissions by an employee unless they prove that they took such steps as were reasonably practicable to prevent the employee from breaching the Code. It is therefore necessary to also consider whether the Rest Home is vicariously liable for Mr B's breach of the Code.

In determining vicarious liability, I have taken into account the fact that the company did not take over ownership of the Rest Home until April 2007. However, the day-to-day management of the facility was the responsibility of Ms C, who had been employed as the Facility Manager since February 2007. The Rest Home therefore knew through its continued employment of Ms C that there had been concerns about certain aspects of Mr B's performance since March 2007. A number of issues also allegedly arose after April 2007. The issue then is whether the Rest Home took reasonable steps to address those concerns and monitor Mr B's performance in the months leading up to the incident on 11 October 2007.

Appraisals
Mr B was employed by the Rest Home in September 2006 and started working as a registered nurse in October, six months before the new company took ownership. He attended a course at an Institute of Technology before he commenced his employment and underwent a two-week induction with RN Ms I when he started.

Mr B's job description stated that he was to have performance appraisals at three and six months initially, and then annually. However, Mr B did not receive a routine performance appraisal at three and six months (under the previous company) or at 12 months (under the current company) while he was employed as a registered nurse at the Rest Home.

Ms C confirmed that Mr B did not receive routine performance appraisals while he was employed by the Rest Home. Ms C attempted to arrange appraisal meetings in July, but was unsuccessful. Mr B's personnel file also records a draft letter on 17 September noting that a performance appraisal was due. However, this letter was not sent to Mr B. The Rest Home explained that this was not followed up because management were busy preparing for a certification audit.

Regular appraisal meetings are a valuable tool for providing feedback to employees, and would have been particularly valuable for Mr B, having very recently emigrated to New Zealand, and without previous experience in aged care. Additionally, these

appraisals would have allowed his manager, Ms C, and his new employers to familiarise themselves with the performance of a nurse being trusted with residents' care.

Competency assessment
The Rest Home's competency assessment policy required certain competencies to be checked at induction and within three months of employment. However, Mr B did not have any of his competencies checked for two months after the company assumed responsibility for the facility. There was no evidence that Mr B's competence had been checked in relation to nebulisers, oxygen administration, or restraint, after he had been employed by the Rest Home for six months.

Although Mr B had previously worked in a Philippines hospital, and likely had an understanding of appropriate nebuliser use and oxygen administration, he had no experience in aged care, and there is no indication that he was competent in the use of restraint. The Rest Home acknowledged that Mr B's attendance at "mandatory" training sessions was "irregular".

During this investigation, I became aware of two other incidents in September and October 2007 where Mr B had reportedly used inappropriate restraint methods against a resident, namely locking the resident in the nurses' station.

Support and supervision of Mr B following incidents.
In her letter of 25 February 2008, the Quality Assurance Coordinator, Ms F, advised of medication incidents involving Mr B, which had occurred both before and after the company purchased the Rest Home. Ms F stated that he "was being actively monitored by the Facility Manager at this time". However, during her interview with my office, Ms C stated that she was unable to actively monitor Mr B as he mostly worked nights.

Following meetings with Mr B to discuss the incidents, he was reminded to be more careful, and was required to update his medication competency after administering an unprescribed medication to a resident. There is no evidence to support Ms C's claims that she offered Mr B extra support or supervision, and she has since acknowledged that a more formal approach was warranted.

In addition, Ms C failed to confront Mr B for three weeks after he was reported to have locked a resident in the nursing station on 19 September 2007. Although he was reported to have repeated the action on 15 October, Ms C did not discuss the incidents with Mr B before he was dismissed on 17 October.

Although I accept that the company did not own the Rest Home when the first two incidents were alleged to have occurred, they were aware of those incidents through the continuous employment of Ms C, and Mr B was allegedly involved in six further incidents before his employment was terminated. Accordingly, I do not think that the Rest Home responded appropriately to concerns about Mr B's performance. These

incidents were not adequately investigated, and Mr B was not adequately supervised, disciplined, or re-educated in response. In fact, the Rest Home did not respond at all to the allegation of inappropriate restraint on 19 September, which allegedly recurred on 15 October.

Despite concerns about his performance, Mr B continued to work night shifts as the sole RN without supervision. In this position, Mr B may have been a danger to residents, who relied upon him to accurately administer their medication and respond appropriately to their needs.

Summary
I acknowledge that the Rest Home management team was busy with auditing processes in the months immediately following the acquisition of the facility, and this may have delayed implementation of staff training, assessment and supervision policies. The Rest Home stated:

> "The energy required from [the Rest Home] management team to prepare and manage [the audits] as a matter of priority, coupled with monitoring and implementing various changes throughout the facility meant that understandably some areas were given less attention than may have been required."

However, the responsibility to ensure staff competence and residents' safety is a matter of primary importance and, in my view, there is no justification for such issues being given "less attention than may have been required". The company assumed responsibility for the facility in April 2007, and the next DHB audit was not until August 2007, some four months later. In my view, there was ample time for the Rest Home management to act on the emerging concerns about Mr B's competence and performance.

Mr B has objected to my discussion of the allegations that arose between February and September 2007 as he considers that they have not been fully investigated by either the Rest Home or HDC. I agree that these alleged incidents were not the main focus of my investigation and confirm that I have not made any factual findings in relation to them. The allegations are, however, relevant to the issue of whether the Rest Home management could reasonably have taken steps to address concerns about Mr B's competence or performance prior to the incident on 11 October 2007. The Rest Home management has acknowledged that there were concerns about Mr B from March 2007[14] onwards but that these concerns were not formally investigated, and nor did Mr B receive appropriate training and appraisals between April and October 2007. I therefore consider that the Rest Home did not take such steps as were reasonably

[14] Although the new owner did not assume responsibility for the facility until April 2007, it was aware of these previous concerns through the continuity of Ms C's employment as the Facility Manager from February 2007 onwards.

practicable to prevent Mr B from breaching the Code, and is vicariously liable for the breach that occurred on 11 October 2007.

Non-referral to Director of Proceedings for the Rest Home
This was a significant incident with potentially serious consequences, and the Rest Home did not respond appropriately. Of particular concern is that alleged previous incidents involving Mr B were not adequately documented, investigated or remedied, and residents were exposed to ongoing risk while disciplinary action was attempted against Mr B. For these reasons, a referral of the Rest Home to the Director of Proceedings for possible disciplinary proceedings was carefully considered. Mrs A's daughter indicated that she would support such a referral.

However, I have decided not to refer the Rest Home to the Director of Proceedings. In making this decision I have taken into account the Rest Home's sincere apology to Mrs A's family and its willingness to review relevant policies and procedures and ensure that staff in all facilities are adequately trained. The Rest Home has already initiated changes to its human resources, employment, and disciplinary processes to ensure risks to residents are minimised. It also admitted that it took too long to act on the concerns about Mr B. I have met with senior management of the Rest Home, and they are committed to improving the services offered in all their aged care facilities. This will be actively followed up by this Office.

In my view, the public interest in highlighting instances of deficient care and risk management will be sufficiently served by holding and the Rest Home and the owner accountable for breaching the Code of Rights; publishing an anonymised version of this report on the HDC website; and sending this report to the relevant agencies and rest home providers. Little more would be achieved by the additional step of disciplinary proceedings.

Other matters

Documentation of drug incidents
During his time at the Rest Home, Mr B was allegedly involved in five incidents relating to medication administration. However, only two were correctly documented.

The date was not recorded on an incident form reporting that Mr B had given two residents each other's pills, and Ms C did not complete the Facility Manager's section of an incident form dated 12 October 2007, where it was alleged that Mr B left a pack of medication in a resident's room. Ms C also advised my office that Mr B had administered unprescribed Maxolon to a resident, and this was not documented in an incident form.

Correct documentation of incidents is absolutely essential in a care setting, especially when incidents are serious and recurrent in nature, so that residents can receive prompt clinical attention and support. Faulty systems cannot be properly assessed, and staff members cannot be adequately identified, educated or disciplined unless incidents are clearly and accurately documented.

Recommendations

Since these events, Mrs A has passed away. However, I recommend that Mr B:

- apologise to Mrs A's family for his breach of the Code, with the letter to be sent to me for forwarding to the parties.

I recommend that Ms C:

- apologise to Mrs A's family, with the letter to be sent to me for forwarding to the parties.

I recommend that the Rest Home:

- review its employment/disciplinary policy and make appropriate changes to reflect its duty to minimise risk to residents and:
    - ensure that each Facility Manager has a copy of the Workplace Improvement Policy and Disciplinary Code; and
    - ensure that Facility Managers are aware of procedures for initiating disciplinary action, including who they are to discuss proposed action with; and
    - document all instances where disciplinary action is discussed or actioned, including the agreed facts and any advice given;
- review staff training, for all company facilities, on the importance of completing incident forms, to ensure that staff are aware of the type of incidents that require a form to be completed, and the action that needs to be taken;
- advise how incident forms for company facilities will be used to identify recurrent or similar incidents that may be attributed to identifiable staff members or systems.

The results of these reviews, the advice and the apology are to be sent to HDC by **27 October 2008.**

Follow-up actions

- Mr B 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.
- A copy of this report will be sent to the Nursing Council of New Zealand and Mr B's employment agent, HealthCert, and the district health board. The Nursing Council will be asked to consider an urgent review of Mr B's competence.

- A copy of this report, with details identifying the parties removed, will be sent to HealthCare Providers New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Addendum

The Director of Proceedings decided to lay a charge before the Health Practitioners Disciplinary Tribunal. In a decision dated 26 March 2009, the Tribunal found Mr B not guilty of the charge of slapping the woman on the arms. The Tribunal held that while evidence disclosed a disquieting situation, because of the way the charge was framed they needed to be sure that the nurse deliberately intended to slap the woman. By a narrow margin the evidence before it did not satisfy the Tribunal to the requisite standard that the charge had been proved. They declined to grant Mr B name suppression but granted permanent name suppression to the rest home, the staff involved and the consumer.

Appendix A

The policy *Workplace Improvement Policy and Disciplinary Code (August 2007)* states:

> 12. **Suspension**
>
> ...
>
> An employee should be suspended only when:
>
> - The matter being investigated is of a serious nature or constitutes serious misconduct and;
> - The employee has been given the opportunity to make submissions on the issue of suspension.
>
> ...
>
> 19. **Serious Misconduct**
>
> The following acts or omissions are likely to constitute serious misconduct:
>
> ...
>
> 19.6. Assaulting any person on [the] Premises
>
> ...
>
> 19.27. Fighting or assaulting another person during working hours.

Appendix B

The policy *Neglect and Abuse* (August 2005) defines abuse and neglect:

"…

Physical abuse — To cause physical pain or injury or to use force

Examples are:

…

- Slapping, pinching, hitting, kicking, pushing or burning a resident

…

Neglect — Conscious and intentional deprivation of necessities which result in physical or emotional distress

Examples are:

…

- Seclusion or isolation of a resident."

The policy *Workplace improvement Policy and Disciplinary Code (August 2007)* states:

"13. **Suspension**

...

An employee should be suspended only when:

- The matter being investigated is of a serious nature or constitutes serious misconduct; and
- The employee has been given the opportunity to make submissions on the issue of suspension."