Registered Nurse, Mrs C

Clinical Co-ordinator, Ms D

Registered Nurse, Mr E

Registered Nurse, Ms F

Registered Nurse, Ms G

Oceania Care Company (No 1) Ltd

(Villa Gardens Home and Hospital)

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC15931)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

Mr A, aged 84 years, was admitted to Villa Gardens Home and Hospital (Villa Gardens) dementia unit in October 2004. Mrs A joined her husband three months later, and died at Villa Gardens in early 2007. Mr A's health declined and, on 7 April 2008, he was transferred to the hospital section of Villa Gardens. Mr A's daughter, Mrs B, alleges that during the time her father was in the hospital, he received inadequate nourishment, which resulted in rapid loss of weight (8kg in 10 days), he developed pressure sores on his buttocks and heels, and a chest infection that was not diagnosed by hospital staff. His hygiene and personal needs were not adequately managed, and he was neglected, left alone and unturned for long periods. She was also concerned that he was chemically restrained (sedated). Mr A died a few months after he was transferred to the hospital section. The post-mortem report noted that at the time of his death, Mr A had advanced pulmonary disease and was "markedly cachectic".[1]

Complaint

On 25 September 2008 the Health and Disability Commissioner (HDC) received a complaint from Mr and Mrs B about the services provided to Mrs B's father, Mr A, by Villa Gardens Home and Hospital. The following issues were identified for investigation:

Whether Villa Gardens Home & Hospital Facility Manager, registered nurse Mrs C, provided Mr A with reasonable treatment and care between April and August 2008.

Whether Mrs C adequately informed Mr A or his enduring power of attorney about his condition and treatment, and responded appropriately to complaints about his care.

Whether registered nurse Ms D provided Mr A with reasonable treatment and care between April and August 2008.

Whether registered nurse Mr E provided Mr A with reasonable treatment and care between April and August 2008.

Whether registered nurse Ms F provided Mr A with reasonable treatment and care between April and August 2008.

Whether registered nurse Ms G provided Mr A with reasonable treatment and care between April and August 2008.

[1] Abnormally low weight, weakness and general bodily decline associated with chronic disease such as cancer and pulmonary tuberculosis. (Mr A weighed 43kg and had a BMI (body mass index) of 15. A BMI of less than 18.5 is considered to be underweight.)

Whether Oceania Care Company (No 1) Ltd[2] [trading as] Villa Gardens Home & Hospital provided Mr A with reasonable treatment and care between April and August 2008.

An investigation was commenced on 16 October 2008.

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

The parties directly involved in the investigation were:

Mr A	Consumer (deceased)
Mrs B	Complainant/consumer's daughter
Mr B	Complainant/consumer's son-in-law
Mrs C	Provider/Villa Gardens Facility Manager
Ms D	Provider/Villa Gardens Clinical Co-ordinator
Mr E	Provider/registered nurse
Ms F	Provider/registered nurse
Ms G	Provider/registered nurse
Ms H	Oceania Care Company South Island Operations Manager

Information was reviewed from:

- Mrs B
- Mr B
- Mrs I, family friend
- Mrs C
- Ms D
- Mr E
- Ms F
- Ms G
- Ms H
- Ms J, Registered nurse
- Ms K, Oceania Care Company Quality & Risk Manager
- Ms L, DHB Funding & Planning Team Leader
- Sue Johnson, Coroner
- The DHB

Others mentioned in this report:

- Ms M, Eldercare Operations Manager
- Ms N, previous Care Manager

[2] During part of the period under investigation Villa Gardens was owned by Eldercare Green Valley Services Ltd. On 30 May 2008, Eldercare Green Valley Services Ltd changed its name to Oceania Care Company (No 1) Ltd.

- Mr O, registered nurse
- Dr P, medical practitioner
- Dr Q, medical practitioner
- Ms R, registered nurse
- Dr S, after-hours medical practitioner
- Ms T, Oceania Operations Manager
- Ms U, registered nurse
- Ms V, registered nurse
- Mr W, Oceania Chief Operating Manager

Independent expert advice was obtained from registered nurse Dr Stephen Neville and is attached as **Appendix A**.

Information gathered during investigation

Background

Villa Gardens Home and Hospital
Villa Gardens Home and Hospital (Villa Gardens) provides hospital, rest home and dementia care. It has 40 hospital level beds, 28 dementia care beds and 26 rest home beds. Eldercare Green Valley Services Ltd (Eldercare) purchased Villa Gardens on 9 September 2005. It subsequently merged with another company, and was rebranded as Oceania Care Company, on 30 May 2008.

Villa Gardens management
Mrs C, a registered nurse, was appointed by Eldercare as the Villa Gardens Facility Manager in June 2007. Mrs C previously worked in Auckland in aged care management positions. As Facility Manager at Villa Gardens, Mrs C was responsible for staff appointments, maintaining facility occupancy, and ensuring that the expenditure was within budget. She was also expected to comply with Eldercare (later Oceania) policies.[3]

From June 2007 until January 2008, Mrs C was supported in her role by Eldercare Operations Manager Ms M, who had oversight of business and quality. In January 2008 Ms H replaced Ms M.

[3] Although the Facility Manager position at that time did not have specific responsibility for ensuring the provision of appropriate standards of nursing assessment and care (the role of the Care Manager), the Facility Manager had overall responsibility for ensuring a quality service was provided. The Eldercare Quality Policy states, "The responsibilities of management and staff include commitment to ensure: … accurate assessment of resident dependency and needs to ensure appropriate care and support … the provision of appropriate staff numbers and skill mix."

On 28 April 2008, Eldercare appointed former agency registered nurse Ms D as the full-time Clinical Co-ordinator.[4]

Mr A

On 18 October 2004, Mr A was admitted to Villa Gardens Home and Hospital (Villa Gardens) dementia unit for long-term care. Mr A, who was 84 years old when admitted, suffered from chronic obstructive pulmonary disease (COPD) and dementia. Mr A's health declined and his Care Plan noted that there was a "general decline in overall functioning, becoming more dependent on care". Mrs B, Mr A's daughter, held enduring power of attorney (EPA) for Mr A. (Mrs B is a registered nurse.) Mr A's wife had also been a resident at Villa Gardens. She died in early 2007.

2008

On 13 January 2008 Mr A was weighed and found to be 60kg. On 25 January 2008, the then Care Manager, Ms N,[5] sent a referral to the District Health Board's Older Person's Health Specialist Service requesting that Mr A be assessed by a Speech Language Therapist because he was becoming increasingly difficult to feed. This assessment was undertaken on 28 January by the assessor, who noted that Mr A had a delayed swallow, and recommended that he be given thickened fluids. The assessor wrote out a feeding plan. She planned to review Mr A in two weeks' time and requested that she be advised if there were any changes in Mr A's swallow, such as an increase in coughing.

On 19 February 2008, registered nurse Mr O[6] revised Mr A's Lifestyle Plan (which was revised six monthly.) The plan provided guidance to caregiving staff on the management of Mr A's nutritional requirements, mobility, hygiene and independence. Mr O noted in the section headed "Nutrition" that Mr A required puréed food. The Care Plan noted that Mr A had to be fed his meals and was to be encouraged to eat slowly and to swallow before the next mouthful. There was no instruction in the plan to monitor Mr A's weight.

Mr O noted on the "Communication with families/friends/agents" form that Mr B[7] was advised that Mr A's lifestyle plan had been reviewed and changes made.

Registered nurse Mr E[8] stated that Mr A's general condition had steadily declined since 2006, and his ability to swallow had become compromised. This was initially

[4] Ms D worked at Villa Gardens as a part-time agency registered nurse one morning a week in 2007, and was asked to work full time in the Villa Gardens hospital from November 2007 until January 2008 to relieve the hospital's registered nurse, who was on leave.

[5] Ms N resigned in April 2008.

[6] Mr O was employed by the previous owners of Villa Gardens, to work 20 hours per week to write care plans for the dementia and rest home residents. The remaining 20 hours per week he was engaged in maintenance at the facility.

[7] Mrs B was away for three months from January 2008 and gave written instructions to Villa Gardens staff on 17 January 2008 that, in her absence, her husband, Mr B, "should be contacted in the first instance should advice be required".

[8] Mr E was employed in 2005 to work at Villa Gardens as a registered nurse in the dementia unit. From August 2007, because of significant staff shortages, his shifts progressively moved to the hospital wing and his position in the dementia unit was disestablished.

managed by providing soft food with a moist consistency to maximise his intake, but progressed to thickened fluids. Mr E stated that Mr A had to be positioned in an upright seated position when being fed to prevent choking. He was spoon fed.

Mr A's weight was recorded on 24 February as 52kg, an 8kg loss in just over a month. Although the updated Care Plan had identified a swallowing problem and instructed staff to take care when feeding Mr A, this apparent weight loss was not acknowledged.

In March 2008, the daily progress notes record that Mr A was becoming more frail. On 14 March a caregiver noted, "[Mr A] getting harder and harder to help with his cares." Mr A was not weighed in March. There was no instruction to staff to monitor his weight or his food and fluid intake.

Reassessment — March 2008
On 14 March 2008, medical practitioner Dr P sent a referral to the public hospital's Older Person's Health Specialist Service, requesting that Mr A, who was then 88 years old, be reassessed for hospital level care. Dr P noted that Mr A required two caregivers for standing, transferring, dressing and showering, that his feeding was "poor", and he required full assistance with his meals. He described Mr A as drowsy, and incontinent of urine and faeces.

That same day an entry in the "Communication with Families/Friends/Agents" form noted that Mrs B was advised of Dr P's review and the referral for a reassessment.

In the following days, Mr A was noted to be having difficulty breathing and managing his inhaler. Medical practitioner Dr Q was informed on 26 March, and advised staff to use a nebuliser four times daily.

Reassessment
On 31 March, the District Health Board Needs Assessor assessed Mr A. She noted, "It has become apparent that [Mr A's] physical health needs have deteriorated and now outweigh his mental health needs." She assessed Mr A as a Support Needs Level 5, requiring 24-hour care in a hospital environment with nursing and medical input. She noted that she discussed with Mr and Mrs B (who attended the assessment) the likelihood of Mr A requiring hospital level care. Mrs B told the Needs Assessor that she wanted her father to remain at Villa Gardens. The Needs Assessor recorded that psychiatric services would withdraw from Mr A's care but would be available to review him if required.

April–August 2008

Oral issues
The records show that Mr A was prescribed medication via nebulisers to control his breathing problems and congestion. On the afternoon of 3 April, staff reported that Mr A had "white blister like marks on his tongue". The team leader was informed and suggested that Mr A "may need to be seen by GP". There is no record that Mr A was seen by a doctor in relation to this.

On 6 April, the day before Mr A was to move to the hospital, the staff member performing his oral hygiene extracted a "large ball of phlegm" from his throat. She was concerned that he might choke and asked the hospital registered nurse to check him. The RN checked Mr A and advised that suction was not needed.

Hospital care
Mr A was moved to the hospital section of Villa Gardens on the afternoon of 7 April. That evening he was found trying to get out of bed over his cotsides. The records note that Mr A was able to walk with the assistance of two carers. He was referred for a mobility assessment.

On 9 April, Mr A had another choking episode. Dr Q was informed and advised that Mr A was to be given regular nebulisers.

Mrs B stated that her first visit to her father in the hospital was on 12 April at around 1.30pm. She found that he had been left unattended, and was slumped in his chair in a "very small and uninviting new room". The room was untidy and dirty, and her father's personal items were scattered around the room. The nebuliser was dirty and left running while the mask was on the floor. Mrs B recalls that it appeared that that her father had been left for some time with his arm hanging over the side of his chair. His arm was blue and Mrs B was concerned that he had a brachial block.[9] She recalls that her father's teeth were not clean and his tongue was coated. She was concerned that he had oral thrush and asked that the staff investigate this.

First complaint — April 2008
Mrs B stated that she requested a meeting with the nurse in charge of the hospital, Ms J. Ms J listened to Mrs B's concerns and together they spoke to the Facility Manager, Mrs C, about these issues. Mrs B recalls that Mrs C "acted dismissively and refused to come and see [Mr A] for herself". Mrs B recalls that when she asked Mrs C for, and was given, a complaint form, she was instructed to be "objective", which she found a "highly objectionable and thoroughly unprofessional statement".

Mrs B wrote a detailed complaint about her concerns on the form provided, noting that she had visited on 12 April. She noted that the charge nurse telephoned her the following day to advise that Mr A had been moved to a bigger room, and had invited Mrs B to visit. Mrs B told her that she would do so the next day. On the second page of the complaint form, Mrs B noted that she completed the document on 14 April. Mrs B was also concerned that her father's Care Plan had not been amended since his arrival in the hospital. In the section of the form headed "How would you like your comment to be used?", Mrs B noted, "In a teaching session to staff on positioning and the dangers of brachial damage in the elderly, in a teaching session to staff on ethics of care, in reviewing level of safe staffing on that particular shift Mon 12/4/08."

The nursing progress notes record that Mrs B visited on the afternoon of 14 April (not 12 April as Mrs B states) and complained to Mrs C about Mr A being neglected in his room. Ms J recorded:

[9] Impaired circulation to the arm caused by pressure to the armpit.

> "[Mr A] was resting in the lounge after lunch. As the carpet cleaner wanted to clean the carpet in the lounge, [Mr A] was brought back to his room just minutes before his daughter [Mrs B] came in. That was between 1415hrs and 1430hrs. [Mrs B] approached me and complained that she was not happy that [Mr A] was being neglected in his room. Brought her to [Mrs C], Manager, as she wanted to see her."

Ms J recalls that Mrs B came to the nurses' office around the time of changeover at 3pm to complain about how she had found Mr A, and the state of his room. Ms J stated that her recollection of events is not clear after 15 months, but she believes Mrs B's biggest concern was the small size of Mr A's new room. His room in the dementia unit had been much larger. Ms J recalls that she went straightaway to Mr A's room with Mrs B. Ms J told Mrs B that Mr A had just been moved back to his room from the lounge because the lounge needed to be cleaned, and that the afternoon staff would shortly put him back to bed.

Ms J recalls informing Mrs C immediately about Mrs B's concerns, because she thought that a bigger complaint would arise if the concerns were not immediately addressed.

Mrs C's recollection of this event differs from Mrs B's. Mrs C said that when she arrived at work that day, she found a complaint form on her desk, completed by Mrs B with an accompanying note from Ms J, who had been working the previous afternoon. Ms J advised Mrs C in her note that Mrs B had not listened to her explanation that Mr A had just been moved into his room when she arrived and found his arm hanging and his room untidy. Mrs C said she immediately telephoned Mrs B and apologised for the situation. She recalls that they had a "pleasant discussion" and Mrs B said she "did not like to complain". Mrs C told Mrs B that a larger room would be available for Mr A in two weeks' time but, in the meantime, they would attempt to clear some of the clutter from his room. Mrs C said she told Mrs B that she would ask Ms N to arrange some education for staff regarding patient positioning.

Mrs C said that Ms N subsequently organised this training for the staff around the beginning of May and that this should be documented in the "education calendar".[10]

Mrs C stated, "At no time did I refuse to go and see [Mr A], tell [Mrs B] to 'be objective' or be dismissive and unprofessional".

Mrs C said she followed up Mrs B's concerns a few days later with another telephone call. Mrs B appeared happy with the outcome. Mrs C said that Mrs B's complaint was discussed at the monthly staff meeting, which had a complaints section as part of the permanent agenda, and that this should be minuted.[11]

[10] The Education Log does not show any such training sessions during this period.
[11] The minutes note a discussion about a complaint from a "[…] family member" regarding the size of a room, and note the resident was shifted to a larger room.

Ms J does not recall leaving Mrs C a note. She stated that she is "pretty sure" that she took Mrs B to see Mrs C the afternoon the complaint was made, as she recorded in the notes. She said that she believes that Mrs C addressed Mrs B's issues promptly, because she recalls Mrs B being very happy with the action taken.

Referrals for medical care
On 16 April, the nursing notes record concern about Mr A having a "very sticky whitish discharge on his tongue" when his mouth cares were being done that morning. The following day there was a further record of a "sticky, whitish discharge" from Mr A's mouth.

The nursing notes record that Mr A was seen by Dr P on 18 April. Mrs B was present during Dr P's examination of Mr A (which she believes occurred on 16 April). Mrs B recalls that she questioned Dr P about the state of her father's mouth, suggesting that he might have oral thrush, and that Dr P agreed with her diagnosis. Dr P ordered Nilstatin to treat Mr A's thrush, and regular nebulisers to assist his breathing.

Mrs B told Dr P that she did not want her father transferred to a public hospital, should he develop any serious illness. She wanted him to remain at, and be managed by, Villa Gardens. However, she was concerned about her father's loss of weight, and was concerned that his oral thrush was not being treated.

The progress notes for that day, written by hospital registered nurse Ms R, record Mrs B's concerns and wishes, and state that Mr A was feeling better since having more regular nebulisers, and was tolerating the change to his diet. Ms R instructed staff to take particular care with Mr A's oral hygiene because "food stays in his mouth". He was weighed and noted to be 59kg. Ms R noted that Mr A's weight was "essentially in keeping with other occasions although last weight [on 24 February 2008] showed 52kg".

Registered nurse Mr E worked the morning duty the following day, 19 April. Mr E advised HDC that he has no recollection of a report that Mr A had an oral thrush infection or that Nilstat had been prescribed. Mr E's next duty was one week later on 26 April. He advised that if the Nilstat was not received from the pharmacy on 18 April (a Friday) it would not have been delivered until the Monday (21 April).

Mr A's weight chart shows that he was weighed twice in April. The second time was on 20 April when his weight was recorded as 49kg. There is nothing in the daily nursing notes about the 10kg disparity in the weights recorded at this time (two days apart). Mr A's care continued according to the Care Plan written by Mr O on 19 February.

On 25 April, Mrs C wrote to Mrs B to acknowledge her complaint. Mrs C stated that she understood that Mrs B had also discussed her concerns with RN Ms J, who had spoken with the caregivers responsible for Mr A's care about his care requirements. Mrs C noted that Mr A had been moved to a larger room, and that once the new Clinical Co-ordinator had been orientated (about mid-May) education sessions would be organised to cover the subjects Mrs B had recommended.

On 30 April, Dr Q reviewed Mr A and noted that he was managing well on twice-daily nebulisers.

May – June 2008
On 6 May, Mr A was noted to have blood in his urine. The new Clinical Co-ordinator, Ms D,[12] was advised and added Mr A to the list of patients to be seen by the doctor the next day.

Mrs B advised HDC that registered nurse Ms R told her that her father had blood in his urine and a possible urinary tract infection. Mrs B stated that as a consequence "a good plan and outcome was achieved, which I was happy with".

Dr Q saw Mr A on 7 May and started him on antibiotics for a bladder infection. The nursing notes for that day also indicate that Mr A's ability to swallow was declining and instructed staff to "take care with food and thickened fluids", and that he needed "lots of mouth cares". A message was left for Mrs B to contact Villa Gardens about this development. Later that day, one of the caregivers asked the duty registered nurse to review Mr A, because he appeared to have a temperature. Mr A's temperature was found to be elevated at 38°C and Dr Q was notified. Mr A was started on the antibiotic Noroxin, and staff were instructed to provide him with a nebuliser as required.

On 7 May an entry on the "Communication with Families/Friends/Agents" form indicates that Mrs B was informed about her father's condition.

Mr A's temperature was assessed regularly over the next 24 hours and had settled to 36.4°C by 10am on 8 May. On 9 May, Dr P was advised that the antibiotics were taking effect and Mr A's haematuria[13] was subsiding, and that his temperature had settled. There was further instruction to staff to encourage Mr A with food and fluids and to provide mouth cares.

The nursing notes indicate that Mr A was co-operative with cares and, although he walked daily (with assistance) to the lounge, he was more frail. On 13 May, Mr A's weight was recorded on the weight chart as 54kg.

Mrs B stated that she was concerned about the care her father received after Ms D was appointed to the position of Clinical Co-ordinator. Mrs B said that when her husband reported to Ms D that he believed Mr A was anxious and frightened, he was "dismissively treated and the obvious inference was that he clearly did not know much about the aging process and that they knew best". Mrs B stated that she suspected that her father was being chemically and physically restrained.[14] She said

[12] The Clinical Co-ordinator Job Description is attached as Appendix C.
[13] Blood in the urine.
[14] The medication administration records provided do not show Mr A receiving sedation in May and June 2008. There is no record in the nursing progress notes that Mr A was exhibiting any difficult behaviour at this time. It is noted that he occasionally refused a shower.

no attempt was made to contact or consult her about the management of any behavioural issues.

On 24 May, Mrs B advised Villa Gardens that she and her husband would be overseas from 25 May until 9 June. On 27 May 2008, a note was added to Mr A's file that in the event that Mr and Mrs B were unable to be contacted, a family friend, Mrs I, was to be notified of any change in his condition, and was available to settle him.

On 27 May, the "Communication with Families/Friends/Agents" form records that Mrs I visited and offered to come in at any time to help settle Mr A.

Ms D stated that staff usually communicated with either Mr B or the family's representative, Mrs I, who said she would pass on the concerns to Mrs B. Ms D accepted this situation because staff rarely saw Mrs B, who visited her father infrequently, never staying long. She said the Villa Gardens staff generally had only telephone contact with Mr B.

Mrs B stated that her visits were usually in the evening and frequently there were very few staff available at that time. When she was away she always ensured that there was a support person available to make decisions in her absence.

In June, Mr A's care continued as per the February 2008 Care Plan. Mr A was weighed again on 12 June and his weight was recorded as 55kg.

July 2008
Mr A's care continued unchanged until 30 July. The incidents of note during July were as follows:

- *Wound care*
  On 4 July he sustained a large skin tear to his left forearm, which registered nurse Ms F[15] cleaned, Steri-stripped and dressed. The skin tear and wound management was recorded on a Wound Care Plan and Management Sheet. The wound care plan, which also recorded a skin tear to the top of his right wrist, was updated on 8 July to indicate that the wounds were healing well.

- *Behaviour management*
  On 15 July, Mr A became very agitated, yelling and swearing and hitting at the registered nurse and caregivers. The progress notes record that he was given half a tablet of the sedative oxazepam (dose not noted) at 10.30am to control his agitation.

The doctor's record for 18 July, entered by after-hours medical practitioner Dr S, notes, "Has been violent with staff. Oxazepam hasn't helped. Staff are trying new management techniques (e.g flattery!) — better this morning. Try Haloperidol (low dose) instead of Oxazepam if necessary."

[15] Ms F trained as a nurse overseas and has a valid Nursing Council of New Zealand practising certificate. She commenced work at Villa Gardens in mid 2008.

Second complaint — July 2008

On 18 July, Mr B wrote to Mrs C stating that when he visited Mr A on 16 July and asked the duty registered nurse, Ms G, "how [Mr A] was managing", he was told that Mr A's aggressive behaviours were a concern. Mr B recalls that Ms D also spoke to him about the change in Mr A's condition and advised that aggressive behaviours were "common in older people and that it needed to be managed". Ms D told Mr B that Mr A was being given a sedative 20 minutes before cares. Mr B complained that at no time had the family been advised that Mr A was exhibiting aggressive behaviour, or that he was being given sedation as a restraint. Mr B reminded Mrs C of the Ministry of Health position on restraint. He stated:

> "I was astounded by this revelation and attempted to understand more but was dismissively treated. I contacted [Mrs B] (currently [working in another region]) who was equally surprised and alarmed. She is due back in [the city] 27 July and will contact you to discuss it further, namely the apparent lack of consultation and the use or not, of a sedative and other charted medication. Please be advised that this may well escalate to a complaint.
>
> She will also wish to discuss why she has not been formally told of [Mr A's] skin tears which remain taped. She originally learnt it through a family friend who visited.
>
> You will also recall that we lodged a complaint with you some months ago on a matter of apparent neglect that we took very seriously. You subsequently confirmed in writing that you had put procedures in place to ensure proper monitoring of [Mr A]. We can only assume that this has taken place."

Ms D recalls Mr B visiting this day. She was in the nurses' station doing paperwork when he arrived with Ms G. Mr B asked about the medications Mr A was prescribed. Ms D took the drug folder, looked up Mr A's drug sheets, and advised Mr B what he was prescribed and the actions of the drugs. When Mr B expressed concern that the drugs might be making Mr A anxious, she assured him that this was not the case. She went back to her work and left Ms G to talk further to Mr B. Ms D does not recall Mr B making a complaint about Mr A's care.

Mrs C recalls receiving a telephone call from Mr B in the late afternoon expressing concern that Mr A was being sedated.[16] Mrs C said that Mr B was very angry and wanted to know what medication his father-in-law was receiving. Mrs C told Mr B that she did not know, but would make enquiries and get back to him. She recalls that she had a family in her office when Mr B telephoned. Ms D had finished work earlier at 3pm, so Mrs C was unable to speak to her until the following morning. Ms D assured Mrs C that Mr A was not being sedated, and that she would talk to Mr B.

Mrs C said she subsequently asked Ms D for an update on the sedation matter, and whether she had been in contact with Mr B. Ms D told her that she had been unsuccessful in contacting Mr B.

[16] Mrs C thought the date of the call was 21 July, but accepts that it may have been 18 July.

Mrs C also recalls mentioning this complaint to Oceania's Operations Manager, Ms T, and that she was awaiting a written report back from Ms D. Ms T does not recall this.

On 22 July, Mr B again wrote to Mrs C. He referred to a letter of 15 July (a copy of this letter has not been provided), "in which you extol the merits of the [two companies'] merger. I do not share your enthusiasm". He stated his belief that there would be a "trade off" between commercial interests and residents' and staff well-being. He stated, "The glossy PR brochure does nothing to allay my fears or add anything new." Mrs C did not respond to this letter or his earlier letter of 18 July.

Medication recording
On 26 July the nursing notes state that Mr A was "very aggressive during morning cares. ½ Haloperidol [antipsychotic] given @ 10am with good effect." Again the dose was not specified. The progress records show that he was given paracetamol liquid, Paracare, occasionally for pain, but again the dose is not specified.

The medication documentation provided to HDC for Mr A consisted only of the three prescription sheets for August 2008 for morphine, clonazepam, oxygen and buscopan, and three routine daily administration sheets showing that he had been given the antidepressant citalopram 20mg and folic acid at breakfast from May to August 2008. There were also three non-routine/as required administration sheets showing that Mr A was given a nebuliser, Xalatan eye drops and Panadol in June 2008, and morphine and clonazepam on 4 and 5 August 2008. The medication information provided does not state when Mr A was first prescribed the citalopram, or provide any information about the oxazepam noted in the progress notes on 15 July and referred to by Dr S on 18 July, or the haloperidol referred to in the nursing notes on 26 July.

Mrs C's last duty
Mrs C stated that her last day at Villa Gardens was Monday 28 July 2008 when she went on leave. She had been on sick leave, but on 28 July returned at the request of Ms T, to assist with a DHB audit. Mrs C stated that "sometime" that morning she found Mr B's complaint letter. She was sure it had not been on her desk the previous week.

Mrs C stated that she left Villa Gardens at 11.30am to attend a counselling session. Before she left she gave Mr B's letter to Ms T and discussed the complaint with her, and the investigation she had expected Ms D to undertake (following the earlier phone call). They also discussed rostering issues. Mrs C went on sick leave from that date, and did not return to Villa Gardens.

Ms T confirmed that she became aware of the complaint at this time, but she cannot recall whether Mrs C gave her Mr B's letters or if she found them in the complaints folder.

Management changes
Oceania advised HDC that the DHB appointed RN Ms U as temporary manager at Villa Gardens on 23 July 2008. Ms T was seconded to the role of Acting Facility

Manager. Ms T was replaced by RN Ms V when Ms T stepped into the Clinical Co-ordinator role (acting) after Ms D resigned.[17]

Mrs B stated that her father's nutritional status was only appropriately managed when Ms U took over and confirmed her concerns about Mr A's "drastic weight loss".

At 10.10am on 28 July, Ms U recorded that she checked on Mr A and found that he had friction graze pressure areas on both heels, and that he had not been weighed since 12 June. (Mr A's progress notes also show that on 21 July it was noted that his wedding ring had become too loose to wear.) Ms U ordered the staff to weigh Mr A that day and report the outcome to her. She gave instructions to the duty registered nurse about the treatment required, and noted that she would contact Mr A's family to discuss his care needs.

Mr A was weighed on 30 July (in response to Ms U's directive of 28 July) and found to be 47kg. He had lost 8kg since he was last weighed, six weeks earlier. Staff were instructed to weigh Mr A weekly.

Pressure areas

Mrs B said that when she discovered that her father had pressure sores, she asked registered nurse Mr E to look at Mr A's sacral area, which was at risk of breaking down, and asked if he could arrange for a Dermoplast patch to be applied to prevent any further deterioration. Mrs B recalls that Mr E informed her that the Dermoplast was locked away and could only be used when the area had actually broken down. Mrs B stated that this is contrary to accepted practice.

Mr E stated that Mrs B's recollection of this conversation is incorrect. He recalls that he said, "Some nurses may not apply a hydrocolloid dressing to a pressure area at that stage (redness) and that they would only apply it to broken skin." He is aware of the prophylactic usefulness of this dressing. He was unable to find a Dermoplast dressing and asked the night nurse to locate one, which she did.

On 29 July, dressings (as ordered by the duty RN) were applied to Mr A's heels. The nursing note that afternoon records that a dressing was applied to Mr A's buttocks as a precaution as he had "small grazings". A Wound Care Plan and Management Sheet were completed to instruct staff on how to clean and redress Mr A's heels.

Care Plan

Ms D organised for the duty registered nurse to revise Mr A's lifestyle care plan on 30 July. The duty RN noted in the progress notes that a referral had been made to the dietitian, and directed staff to position Mr A in a chair in the lounge in sight of staff as he tended to slip down in his chair frequently. A falls risk assessment was done. Mr A was also commenced on the nutritional supplement Fortsip. The duty RN recorded that Mr A's heels were redressed and a pressure mattress ordered. He was reassessed as requiring full assistance with his mobility, and to be at high risk for falls and pressure sores. A food and fluid intake chart was started to monitor his intake.

[17] Ms D resigned on 4 July and left at the end of the month.

Ms D added a further instruction to the duty RN's Care Plan, instructing staff that Mr A "Can be aggressive during ADLs [daily living cares]", and, "As far is possible [Mr A] will remain calm with acceptable behaviour being displayed". Ms D used the Care Plan to remind caregiving staff that if Mr A was still aggressive when they followed her steps to calm him, such as leaving him alone for a few minutes, the registered nurse was to be advised, and they were to complete a behaviour chart and an "Unwanted Event" form. Ms D noted that Mr A had been prescribed PRN (as required) medication for his aggressive behaviour.

Mrs B said that this was the first care plan (written seven days before his death) to be written for her father since he was transferred to the hospital, and she was not consulted or asked to contribute to the plan. Mrs B stated that it was "sufficiently generic to have been applicable to any elder person". Mrs B was particularly concerned that the care plan noted, "Behaviour for [Mr A] to be appropriate." She asked, "Appropriate to who?"

Dietitian assessment
On 30 July, Ms D also recorded in the progress notes that a dietitian had visited to assess Mr A. The dietitian recorded her assessment in the doctors' notes. She found that Mr A had a BMI (body mass index) of 16.2,[18] which put him at high risk of malnutrition, and instructed the staff to continue to give Mr A "high protein milkshakes, icecream, bananas, Fortsip and Complan".

On 31 July, the dietitian wrote to the Villa Gardens management and confirmed her assessment of Mr A the previous day. She stated, "His weight loss has occurred primarily since April 08 … staff have been trialling [Mr A] on Fortsip supplements during the day and high protein milkshakes made especially for him which he is managing well. The dietitian faxed a "special authority" request to Pharmac for the nutritional supplement TwoCal HN (which provides calories in a concentrated volume), and instructed the Villa Gardens staff on an interim nutrition plan for Mr A until the TwoCal HN was approved and supplied. She asked that staff monitor his weight closely.

Lack of respect
Mrs B stated that meals were repeatedly delivered to her father's room and left on a bench by the door, "presumably for someone else to feed him". Mrs B stated that she twice asked registered nurses to tell the kitchen that her father did not need a meal. When she found a third time that a meal had been delivered, she spoke to registered nurse Ms G saying, "Please would you inform the kitchen that no meals are required for [Mr A]." Mrs B recalls that Ms G called back, "What has he been disposed of then?" Mrs B stated, "Language barriers aside, I took this to be thoroughly unprofessional and a shocking response showing little respect for my father or myself."

Ms G has not commented on this allegation.

[18] A body mass index of less than 18.5 is considered to be underweight.

RN Ms F
Mrs B recalls that when she visited her father on 1 August, she found that he had developed audible, moist breathing, and she was concerned that he had developed bronchopneumonia. She talked to the duty registered nurse, Ms F, about her concerns and asked if she would listen to his chest. Ms F put her ear to Mr A's chest and said, "He is breathing." Mrs B stated that she was very angry and gravely concerned about what she viewed as a lack of basic professional behaviour from Ms F. Mrs B stated that she approached Ms T (the acting Clinical Co-ordinator at Villa Gardens at the time) and asked for a stethoscope. Ms T provided a stethoscope, listened to Mr A's chest, and found limited air entry.

Mrs B said she did not expect that Ms F should be able to diagnose bronchopneumonia, but she had every expectation that she should have known the signs. Mrs B said that Ms F did not recognise the signs until they were brought to her attention, and did not initiate medical follow-up.

There is no record of this incident in the progress notes. The Villa Gardens staff roster for 1 August shows that Ms F was not on duty that day. Ms F worked the following two days, Saturday 2 August from 7am to 9pm, and Sunday 3 August from 7am to 7pm. A bureau nurse "special" was brought in by Villa Gardens on the afternoon of 1 August to provide one-on-one care to Mr A overnight.

Terminal cares
The clinical record for 1 August states that Dr S was called to see Mr A at 5.15pm. Dr S noted, "Asked to see patient as noted by staff to be chesty today and drinking less. No cough. No fever. No distress." Dr S ordered oxygen 2 litres per minute via nasal prongs, and the syrup form of the antibiotic Augmentin.

An entry in the "Communication with Families/Friends/Agents" form at 6.20pm on 1 August records that Mrs B had been telephoned to advise that her father had been seen by Dr S and started on Augmentin, and that a "special" nurse had been organised and an acute team would review him over the weekend. Mrs B advised that she would visit her father "in am".

The bureau nurse noted that Mr and Mrs B arrived to be with Mr A at 2.50am. Mr A's condition was deteriorating, and Ms T decided to request a further medical review. At 3.30am, an after-hours doctor visited and found that Mr A was semi-conscious. He noted, "Little value any active measures." The doctor recommended that Mr A be provided with comfort cares and a trial of morphine and clonazepam (sedation) drops.

Later that morning the doctor organised for Mr A to have a subcutaneous line introduced for the administration of morphine and clonazepam. At midday, community acute care registered nurse called at Villa Gardens and set up a system to administer subcutaneous fluids.

At 6.30pm, another doctor visited Mr A and talked to Mrs B about the possibility of moving her father to the public hospital for palliative care. It was decided that Mr A

would remain at Villa Gardens. Mr and Mrs B attended Mr A almost constantly over the next few days.

Mr A was provided with comfort care until his death. At 4.45pm Ms V telephoned Mr B and advised him that Mr A had passed away. Mr B stated that he would advise his wife and reiterated that they wanted the Coroner to be notified. Ms V telephoned the Police at 5.15pm to request their attendance at Villa Gardens for a Coroner's case. At 5.30pm, Dr Q called at Villa Gardens to record Mr A's death. He noted Mrs B's wish that her father's death be referred to the Coroner, "due to concerns with [Mr A's] care".

Post-mortem report

A post mortem was conducted on Mr A the following day, by a pathologist. The post-mortem report described Mr A as "markedly cachectic", he weighed 43kg, and his BMI was 15. He had a 15mm diameter pressure sore on the back of his right heel. His skin was extremely fragile and he had healed skin lacerations on his left forearm and the back of his right wrist. He was well hydrated and showed no new injuries.

The pathologist found the cause of Mr A's death to be "bilateral bronchopneumonia, advanced pulmonary emphysema and Alzheimer's type dementia", and the manner of his death to be "natural causes".

Additional information

Mrs B
Mrs B was concerned about the level of care being provided to her father after his transfer to the hospital section of Villa Gardens. She said:

> "[Mr A] was transferred to the hospital wing because of the increased level of care he required. I endorsed a [public] Hospital assessment suggesting that he be moved because of the greater capacity of the hospital wing to manage his care, especially nutritional needs supervision and to minimise any likelihood of falling.
>
> I had an expectation that hospital level care would cater for his increased needs and that the wing was suitably staffed, resourced and led. The reverse turns out to be the case. The hospital inflicted harm on him and was toxic to his wellbeing. It shortened his life and caused him pain, distress and anguish. For me, the sorrow, the distress and guilt I now feel weighs heavily on me.
>
> As a Registered Nurse (RN) of some considerable standing, for me to learn that the RN guided and led care at Villa Gardens fell short of the required professional standards leaves me stressed and gravely concerned.
>
> Nurses are personally accountable for their actions. This to me means that they are answerable for actions and or omissions regardless of advice or directions from other professionals. My father was denied safe, effective and competent hospital level care while at Villa Gardens."

In response to the provisional opinion, Mrs B commented that the statements from Villa Gardens senior management that they have learnt from these events and "will do better from here on" were not good enough. She said that the standard of care might be better now, but that is not the "centre piece of this enquiry". She said that her father had no alternative, or choice about the care or lack of it, he received.

Mrs B stated:

> "I have no justifiable cause to alter my view that my father's care and ultimate death was not just about a few nurses not performing as well as could be expected. Neither is it adequate to say that it is a systems and processes failure. … The repeated concerns regarding my father's nutritional status was a classic case of where important clinical indicators were missed or rather 'fell through the holes'. The fact that my father became a casualty of 'multiple holes in the system' requires me to continue to pursue accountability of individual health practitioners at both clinical and managerial level. I remain convinced that a significant number of key practitioners and management knowingly and errantly deviated from acceptable and reasonable standards of care. … I feel an overwhelming concern that little compassion either collectively or individually was shown to my father."

Mrs I

Mrs I advised the Coroner that she, her husband and daughter visited Mr and Mrs A at Villa Gardens frequently. Mrs I said that when Mr A moved to the hospital section, she visited him at least once a day, usually later in the day, after school or around dinner time. She noticed a "massive change" in him after he went into the hospital. Mrs I said:

> "He often seemed to spend most of his day in his room slumped in his chair with the curtain partially closed without view or stimulation. … He just seemed to lose the joy in life and would rarely smile which was so different from his normal nature. Most staff tried to do their best but the hospital seemed to be understaffed and the staff overworked and under stress. There just didn't seem to be anyone around to tend to his needs and his hygiene was being neglected."

Mrs I said that she noticed that he was losing weight and becoming "very gaunt" in the face, and she was "shocked" at how much weight he had lost. She found it difficult to find caregiving staff when she wanted to raise an issue about Mr A's care, such as when he appeared to be in pain. On occasions she found caregiving staff doing dishes in the evening.

Mrs I said that on two occasions she saw Mr A swing his arm out at a staff member. She was told by staff that his aggression made it difficult to care for him. She found this surprising, as this was not Mr A's nature. She told the staff that if sedatives were required, the staff should contact Mrs B (who at that time was working in another city) to discuss the situation. Mrs I said she telephoned Mrs B "from time to time to let her know how [Mr A] was getting on". She said that Mrs B came back in mid-July and looked after her father's interests from that time. Mrs I stated:

> "I do not believe that [Mr A] received the care he should have received in a hospital and that the time leading to his death was an unnecessarily miserable and painful time for him."

Ms D

Ms D stated that she was not adequately orientated into the position of Clinical Co-ordinator. The letter confirming her appointment to the position stated that she would be given three days' induction with a senior staff member and the facility manager. Instead, she had two half-hour meetings with the South Island Operations Manager, Ms H. Ms D said that she was told by Mrs C:

> "The RNs in the hospital, [Ms R], [Mr E], [Ms J] and [another nurse] (who worked over 3 shifts) were competent and could manage the hospital. I was to concentrate on getting the Audits and the paperwork up to date, as the previous Clinical Co-ordinator had not completed Audits and other paperwork for the previous 13 months or so. I was also to be the RN for the Dementia Unit and Rest-Home. Approximately 50 patients and residents. …
>
> [Mrs B] stated that there was not a careplan for [Mr A]; there was. It may not have been up to date. When I took up the position as Clinical Co-ordinator I discovered that very few careplans were up to date. The careplans were divided between the RNs and 2 nurse assistants (ENs). I had 48 to do; the dementia Unit and Rest-Home. I frequently worked overtime (without pay) to endeavour to get these careplans up to date. I didn't quite achieve this due to a huge overall workload."

Ms D noted that Mrs B quoted sections from the Clinical Co-ordinator Job Description, and alleges that under her oversight as Clinical Co-ordinator, Mr A's health declined dramatically. Ms D stated, "Unfortunately the job description is meaningless, considering what I was actually allowed to do and meaningless considering what I was told to do."

Ms D said that when she had been in the role a few weeks, she spoke to Ms H and told her that she was not allowed to do her job, and that Mrs C would not listen to her concerns about staffing. Ms D felt that her concerns were being "dismissed or ignored". Ms H spoke to Ms D and Mrs C together, but this did not result in any changes. Ms D said she also brought her concerns to Ms T, "to no avail". Ms D stated that, although she had "lost faith" in the facility, she "kept plugging away" hoping that she could make changes, but when she realised that the underlying issues were not being addressed, she resigned on 4 July 2008.

Ms G

Ms G stated that during the time she was employed at Villa Gardens (from 1 July to 4 September 2008) she implemented some changes. She stated that the staffing levels were insufficient, and that she and Ms D were "trying very hard to rise the level of care in the establishment, without any support from management".

Ms G said that Mr A spent most of his time in bed. She could see no valid reason for this, and asked staff to get him up every day in his armchair and reposition him every

two hours. She stated that part of severe dementia is weight loss and loss of appetite. Ms G said that before she started at Villa Gardens, Ms D had organised a supply of Fortsip for Mr A, which was offered to him without success. Mr A was given a shake instead, which consisted of a banana, Fortsip, milk, cream, polycose and some flavouring. He would drink some of this.

Ms G stated that when she first started to care for Mr A he did not have any pressure areas, but his skin was fragile, and an air mattress and bootees were organised to protect his pressure areas. She said, "Not once during the short time I was caring for [Mr A], did I [think] he needed some pain control medication."

Ms G stated:

> "I myself, never met [Mrs B] or her husband until [Mr A's] death was imminent and it did appear to me that they had not been kept informed. So [now] if a patient's family does not approach me, I will do everything possible to get in touch and request a meeting to give them a thorough report on the patient's health."

Mr E

Mr E stated that he found the change to working in the hospital challenging, especially because of the demands of the role, which included replacing absent or sick staff, co-ordinating and overseeing bureau staff on a regular basis, staff supervision, dispensing medicines, maintaining routines, and responding to illness, accidents and family enquiries. As well as responding to any issues raised by caregivers and enrolled nurses throughout the facility, there was an expectation that all documentation was to be completed fully and in a timely manner. He said that he met with management to raise his concern about the impact of the staffing levels on the provision of care. He said, "Unfortunately my constant voicing of concerns did not do much to change things."

On 31 March, Mr E completed an "Unwanted Event Reporting Form", reporting that he was the sole RN with no EN support. He had to attend an incident in the dementia unit with the result that the nutritional supplements and eye drops were not being given at midday. On 12 May 2008, Mr E recorded on the "Managers Daily Report Hospital" that "Should there have been any acute unwellness/injury-falls tonight as sole nurse in hospital wing I feel my ability to respond would have been compromised due to lack of nursing support."

Mr E stated that there was "considerable change and staff shortages" at Villa Gardens during the time Mr A was a resident, and "absences were frequent". There was a period when there was no enrolled nurse to work with him[19]. He said that there were insufficient rostered caregivers, and insufficient time to update and document care plans. He met with Mrs C on a number of occasions to discuss the difficulties he was

[19] In his statement to HDC, Mr E said that as a result of his reported concerns about staffing levels, an Enrolled Nurse was rostered onto the afternoon shifts. Mr E did not provide a date for when this increase in staffing occurred, and Oceania has not provided this information.

having coping with the work load, in particular the time spent administering routine medications. He recalls that Mrs C told him he was "too conscientious".

Mr E stated that prescribed nutritional supplement drinks were administered routinely to residents and patients two, three and four times a day, by either nurses or caregivers. When registered nurses and enrolled nurses gave the supplements they would sign them off. At the time of this complaint the boxes of supplements were stored in the resident's wardrobe, but the supplements are now stored in the hospital dining room cupboard.

In response to the provisional opinion, Mr E stated that it was generally the responsibility of the morning shift registered nurses and/or charge nurse to implement food and fluid recording, and weight charts.

Mr E recalls that as Mr A became more frail he had his meals in a Lazy-boy chair and spent increasing time in bed. Mr E suggested to the caregivers that a regular positioning recording form be started for Mr A. He said, "I received a clear negative response to this and was confidently informed that [Mr A] continued to be able to reposition himself."

Mr E said that he worked as part of a team of registered nurses. He stated that he worked professionally and competently to provide Mr A and other residents with good care, but his direct contact with Mr A was limited.

Ms F

Ms F advised that she was new to Villa Gardens at the time of these events, and she has little memory of the individuals she cared for. Her usual way of informing herself about the care of residents is to follow their Care Plan. In relation to Mr A, she followed the Care Plan of 19 February 2008 and then the revised Care Plan of 30 July 2008.

Ms F stated that since orientation and induction to Villa Gardens she has continued to develop her practice in line with the organisation's policies and procedures. She was required by the Nursing Council to undertake a Competency Assessment, which she did from 15 September to 10 October 2008. There are currently no restrictions on her practice.

Ms F stated:

> "I would like to apologise if at any time I cause offence to [Mr A] or his family. As a newly practicing registered nurse, I, at all times was trying to give excellent care to the residents at Villa Gardens. I do not believe I failed to do this but language accents may have made me difficult to understand."

Mrs C

Mrs C has been a registered nurse for 41 years, the last 14 of these in management roles. She advised that during the time she was managing a facility in Auckland she successfully ran both the clinical and business side of the facility for two years before

a clinical manager was appointed. Mrs C stated that the position at Villa Gardens was offered to her by the then General Manager of Eldercare, who had been offering her positions in the company for some time.

When Mrs C took up her position at Villa Gardens in June 2007, she became aware that there was resistance against adopting the Eldercare policies and procedures. Mrs C found the clinical care at Villa Gardens was "old fashioned" and the care plans and clinical documentation not up to standard. From the time of her appointment, she encountered problems in establishing a harmonious team. Mrs C discussed the staffing, documentation and care issues, initially with Operations Manager Ms M and, from January 2008, with Ms H, at weekly meetings. The weekly meetings were documented and management plans were put in place.

Mrs C stated that she had to do a lot of reporting, and told Ms H that she could not be "on the floor" and do everything else, such as keep the beds full, "hire and fire" in the kitchen, laundry and the cleaning areas where there were problems. Mrs C stated that Ms H "micromanaged". Mrs C felt she "did not always have a lot of say in how things were going to be done".

Mrs C advised HDC that Ms H repeatedly told her that she should be spending time away from Villa Gardens, networking and spending time at the other facilities owned by Oceania. She said this would be reflected in her performance review of June 2008. The review document shows that "networking" was identified as an area for improvement.

Mrs C said that in 2008, the manager at another of Oceania's aged care facilities, resigned and Ms H asked Mrs C to provide support there. Mrs C stated that she felt she needed to concentrate on Villa Gardens, but agreed to be "on call" for the other facility on alternate weekends. She continued to provide this cover until she went on leave in July 2008.

Mrs C stated that Ms D was an excellent nurse, and the families and staff thought she was wonderful and things "ran like clockwork". When Ms D was appointed to the position of Clinical Co-ordinator, Mrs C had intended her to start work at 7.30am, work on the floor until 1pm, and then spend one or two hours in the afternoon going through the policies and procedures. Mrs C stated that Ms H wanted Ms D to familiarise herself with these documents, as she would be training the other nurses. She said that Ms D had two full weeks of orientation with Ms N before taking up the position of Clinical Co-ordinator when Ms N resigned. Mrs C maintained that Ms D was very familiar with the facility, staff, staffing issues, residents and their families, having previously worked there as a registered nurse.

Mrs C said that Ms D had indicated in her job interview that the IT part of the job would not be a problem. However, Ms D struggled with the IT component. She was in the position for only about three months when "things fell over" and Ms D told Ms H and Mrs C that she did not think she could do the job. Mrs C told Ms D and Ms H that after "things settled we could do some management stuff or do some mentoring … but [Ms H] was insistent that went the other way". Ms H said she wanted Ms D to "pull

away from the floor and just concentrate on learning policies and procedures and how things run". Mrs C stated:

> "That made me a little bit uneasy because I felt that she needed to be there, because when the charge nurse left [in June 2007] [Ms M] decided that we wouldn't have a charge nurse, just have the clinical person. I went along with it and things improved a bit."

Mrs C advised HDC that Villa Gardens was a difficult site with "deep rooted issues". She stated, "I probably should have put my hand up and said, 'Look, the staffing issues here are huge. I need someone to come in you know. I can't just walk in and clean it all up', which seemed to be the expectation."

Mrs C advised Ms M and, after January 2008, Ms H, about the problems she was having employing registered nurses. The minutes for their meeting on 29 January 2008 noted, "RN shortage. No response from advertising. 1 booked with Medcall. [Mrs C] to book another." There were further references about the need to hire more registered nurses in February and March 2008 meetings.

In response to the provisional opinion, Mrs C stated that she "deeply regrets" any distress she may have caused to the residents and families in her care. She said that her apologies to Mr A's family in previous correspondence have been "sincere and with great faith".

Ms H

Ms H advised HDC that she visited Villa Gardens every seven to ten days, to discuss the business and management of Villa Gardens. The meetings would usually involve discussion about outstanding issues from the previous meeting and any new issues, such as complaints, and a walk through the facility. Ms H stated that she advised Mrs C to spend more time in the facility, and said that she needed to spend more time building relationships with the families, but Mrs C did not follow through on this advice.

Ms H advised that Mrs C inherited significant staff/human resources difficulties, which had been exacerbated by Villa Gardens' transition to being part of the Eldercare organisation. She was aware of a "very dysfunctional relationship" between Mrs C and Ms N (the previous Care Manager), and discussed this with Mrs C frequently. Ms H said that some of the Villa Gardens staff were resistant to the corporate model and the new policies and procedures. Mrs C was the representation of this. Ms H stated, "There was not enough work from Eldercare in relation to this transition."

Ms H stated that she had advised Mrs C to "go slower" in relation to handing responsibility to Ms D. Ms D had discussed her concerns with Ms H but was reluctant to talk directly to Mrs C. Ms H accepts "with hindsight" that Ms D was overloaded.

Ms H stated that there was an expectation when a complaint was received that the Facility Manager would, in keeping with the Eldercare policy,[20] acknowledge receipt of the complaint within five days, and notify the Operations Manager. She said she was responsible for checking through the clinical records for information relating to complaints and sending this information to the Eldercare Director of Nursing. The responses to complaints were not sent until they had been reviewed.

Ms H recalls first being aware of Mr A's family's concerns when she saw Mr B's letter on Mrs C's desk around 25 July. Ms H said she then realised that Mrs C had not "shared" any of the complaints from Mr and Mrs B.

Oceania Care Company (No1) Ltd
On 27 November 2008 Oceania Chief Operating Manager Mr W advised HDC:

> "We wish to make it plain from the outset that we consider [Mrs B's] complaint to be well-founded in some respects. We agree and acknowledge that [Mr A] did not receive the standard of care that we would expect our residents to receive in our facilities. As you may be aware, Villa Gardens has been under a lot of scrutiny in the last year because of perceptions — both justified and unjustified — that the facility is underperforming.[21] We think that [Mr A's] experience is part of that larger picture. …
>
> It is suggested in the complaint that carers were required to look after up to 13 residents at a time. This is not right: the ratio in Villa Gardens averaged (in July 2008) one to 5.3 in the morning, and one to 7.1 in the afternoon. Another criticism which we think is unjustified is a complaint that a nurse did not know how to diagnose broncho-pneumonia. We would not expect a nurse to be able to make such a diagnosis, and the person whose conduct is complained of quite rightly said to [Mrs B] that a doctor would need to make the diagnosis. The doctor was called, and did make the diagnosis promptly. …
>
> There is a more serious allegation relating to weight loss. We think that this issue can be answered by advising that the scales which the facility was using were not being operated by staff correctly and our internal policy was not being observed. In addition, we now know that the scales were not correctly calibrated. We also believe that residents shifting and moving whilst being weighed, for example in their wheelchairs, may have resulted in inaccuracy in weight measurements from time to time. In short, operator error, together with a fault in the calibration of the scales threw up questionable data and inaccurate readings. This problem affected all residents. It seems that staff were also applying their own judgement to how residents 'looked', and it was not until August 2008 that the [DHB] temporary manager and our temporary manager, [Ms V], recognised that the scales needed to be replaced and staff were appropriately trained in the use of the new scales. …

[20] A copy of the Eldercare complaints policy is attached as Appendix D.
[21] Mr W was apparently referring to media coverage about Villa Gardens.

> Particular attention has been given to senior management and also to our staffing policies. A number of problems that arose were due to the need to rely on bureau nurses, rather than permanent employees. We were trying to rectify this, although there is a severe shortage of registered nurses in the region. Nevertheless we consider that we have made good progress in improving the overall quality of our nursing staff. There were clearly some serious problems with our complement of registered nurses and caregivers, throughout the period that [Mr A] was with us."

Follow-up actions

DHB audit

The DHB commissioned an issues-based contractual audit of Villa Gardens after receiving a number of complaints following the publication of articles in *The Press* identifying issues with care at Villa Gardens. The audit took place on 28 and 29 July 2008. The audit found a number of service areas where high priority action was required, which included providing adequate staffing, in particular minimum staffing levels for the hospital, and risk management. Moderate priority actions were required to be taken in areas of care planning, strategies for managing behaviours, and resident assessments. Of note was care plan documentation. The auditors recorded, "The reviews were not up to date for the most part; for example one resident who had been reviewed as hospital level had not had a full review of his Care Plan."

On 22 August 2008, the DHB Chair wrote to Mrs B to offer "sincere condolences" and to outline the action being taken by the Board to identify and address the issues at Villa Gardens.

The DHB Team Leader, Planning and Funding, Ms L, advised HDC that the DHB subsequently required a series of unannounced audits at Villa Gardens in the 12 months from 3 November 2008 to October 2009. There was no monthly audit requirement. By January 2009 the high risk clinical and care issues at Villa Gardens had been addressed. In January the focus moved to the infrastructure development such as policy and procedure development and implementation.

Oceania's response to complaints

Ms V and Ms T investigated the situation at Villa Gardens. Their report of July/August 2008 identified multiple issues to be addressed by the Oceania team to remedy inferior systems and processes. The issues included: complaints, management of challenging behaviour, use of bureau staff, care plans, medication management, personal grooming/hygiene, and restraint.

Ms V and Ms T's report summary stated:

> "Our initial impressions are that insufficient vigour in monitoring this facility's care delivery has significantly contributed to deficiencies at Villa Gardens. This was compounded by the Manager (RN) and the Clinical Manager's failure to manage inputs into quality clinical outcomes and the failure of Regional Managers to review adequately and pick up early on issues."

On 9 September 2008, Mr W wrote to Mrs B in response to her complaint letters of 14 April, 18 and 22 July 2008 and email of 29 August 2008. Mr W expressed his "heartfelt apologies for the delay in responding to the above communications". He noted that Mrs C had responded to the April letter, had apologised to Mrs B for the distress caused regarding the care of Mr A, and had outlined her plans to arrange education sessions for staff in relation to patient positioning and ethics of care for the aged, as Mrs B had recommended in her complaint. Mrs C had advised that these sessions would likely occur in May 2008 after the Clinical Co-ordinator's orientation programme was completed.

Mr W addressed the specific issues Mrs B raised in her husband's two letters regarding the restraint of Mr A via sedation, and Oceania's brochure relating to the merger with Eldercare and the second company. He stated that the delay in responding to these issues was "largely due to the ongoing investigation and audit of issues occurring at Villa Gardens". He noted that a number of Mrs B's concerns had been discussed when he had met with her on 21 August 2008. Mr W advised that the training that Mrs C had referred to had not taken place, but would be undertaken in October 2008. He said that Mrs B would be advised when this training programme was completed. He stated that Oceania intended, by the changes being made, "to restore not only the perception of quality care delivery but the reality of this as well".

Mr W concluded:

> "[Mrs B], I am truly sorry that there has been such a hiatus in our communication particularly in relation to the direct responses you have requested. I am also sorry that this has obviously increased the grief and sadness you are experiencing with regard to your father's recent passing. Words simply will not fill that void and I do appreciate that."

Ongoing monitoring
Since these events, Oceania Care Company Group Quality and Risk Manager, Ms K, has commissioned additional unannounced audits.

The January 2009 unannounced audit of Villa Gardens, conducted by Ms U, found that there had been a number of improvements in the areas of clinical recording, eating and hydration needs, weight monitoring and maintenance, and that staffing and management had been stabilised. There was still work to be done on reviewing and updating policies and procedures.

On 27 January 2009, Ms L advised that the DHB was satisfied with the progress being made by Villa Gardens, but continues to keep a close watch on progress. Policy and procedure development is now the focus. Ms L stated that the present leadership at Oceania Care Company is "turning things around" at Villa Gardens.

Also in January 2009, Ms K stated that while the situation at Villa Gardens has been difficult for residents, their families, staff and the business, Oceania has taken this opportunity to review all systems and establish the factors contributing to the situation. She stated, "We envisage continuing to work in partnership with [the] DHB

to ensure that the quality of care and safety of residents at Villa Gardens reflects quality and satisfaction for all parties."

The Oceania Group Chief Executive Officer advised HDC that since Oceania took over ownership of Villa Gardens, significant effort has been made to address the issues of concern through review of clinical systems at both a local and national level, recruitment of staff and sound clinical guidance, mentorship and monitoring. He said that Villa Gardens is now robustly managed by an experienced and dedicated team and is a "very different place now to what it was during the time that [Mr A] was a resident".

Opinion

Breach — Oceania Care Company (No 1) Ltd (trading as Villa Gardens)

Villa Gardens and its staff had a duty of care to Mr A. He was admitted to Villa Gardens' dementia unit from the rest home section of the facility in October 2004 for long-term care. Over the next three years his condition deteriorated and, in March 2008, it became apparent that his physical needs outweighed his mental health needs.

On 7 April 2008, Mr A was moved to the hospital wing and, from that time, his daughter, Mrs B, became increasingly concerned about the standard of care that was being provided to her father. As a registered nurse herself, she has complained that her father did not receive adequate nutrition, developed pressure sores on his buttocks and heels, and was left unattended and generally neglected. In her view, poor care contributed to her father's death.

Mr A's condition deteriorated dramatically after he was moved to the hospital. It is unclear whether his decline was the result of his medical conditions of emphysema and Alzheimer's-type dementia, or lack of care as Mrs B alleges. However, it is clear that there were failings in his care.

Oceania's Chief Operating Officer, Mr W, has acknowledged this. In his letter to HDC in November 2008, he agreed that "[Mr A] did not receive the standard of care that we would expect our residents to receive in our facilities". Mr W explained that Mr A's experience was part of a "wider picture", including nursing shortages and problems with the quality of nursing and caregiving staff. He accepted that Mrs B's complaint was "well founded in some respects".

I agree. In my view, Mr A's care between April and August 2008 was compromised by the staffing and organisational difficulties that existed at Villa Gardens at this time and in the previous months. Although the difficulties were known, they were not effectively addressed until after the district health board stepped in.

Support for Facility Manager and Clinical Co-ordinator

As my nursing expert, Dr Neville, noted, the staffing and organisational issues undoubtedly placed stress on the Facility Manager, Mrs C, and (from late April) the Clinical Co-ordinator, Ms D, and the registered nurses. He advised that there were clinical governance and quality structures in place at Villa Gardens, but they were not operating effectively.

Mrs C and Ms D have both reported that they felt unsupported and overloaded during this period.

Mrs C discussed staffing, documentation and care issues at weekly meetings with her regional managers (both Ms H and her predecessor). These meetings were documented and record continuing, unresolved staffing and recruitment difficulties.

Even after Ms D was appointed, Mrs C has indicated that she continued to feel she was being asked to carry out too many duties and was insufficiently supported in her role.

When Ms D became Clinical Co-ordinator on 28 April 2008, she did not receive the orientation that had been specified in her letter of appointment. She found that her job bore no resemblance to the job description. Although she was responsible for clinical leadership, she was instructed to concentrate on preparing the facility for audits by reviewing and updating residents' paperwork, which had not been attended to for 13 months, as well as being the registered nurse for the dementia unit and rest home. She was told by Mrs C to leave the care of hospital patients to the nurses who worked there.

After a few weeks in the job, Ms D told Ms H that she was unable to fulfil her role, because of inadequate staffing and the restrictions placed upon her by Mrs C. She attended a discussion between Mrs C and Ms H about the concerns she had raised, but her situation did not change.

Mrs C and Ms H had quite different views on how to respond to Ms D's concerns. Mrs C said she wanted Ms D to be able to concentrate on the role of Clinical Co-ordinator (which in her view was to co-ordinate what staff needed). She thought Ms D could carry out clinical duties in the morning, and do paperwork in the afternoon. However, Ms H wanted to take Ms D "off the floor" so she could concentrate on learning policies, procedures, and how things ran.

Mrs C felt "micromanaged" and that she did not have a "lot of say" about this. She stated, "I probably should have put my hand up and said, 'Look staffing issues here are huge. I need someone to come in you know. I can't just walk in and clean it all up', which seemed to be the expectation."

Ms D also raised her concerns with Ms T, but again nothing changed. She stated that she lost faith in the organisation. When she realised that the underlying issues that

were affecting the delivery of care were not being addressed she resigned and left after just over three months in the job.

Ms H confirmed that Ms D had talked to her about her concerns about her role and feeling that Mrs C did not listen to her. Ms H knew Ms D was not comfortable talking to Mrs C. She said that she advised Mrs C to "go slower" in relation to handing responsibility to Ms D. Ms H accepted "with hindsight" that Ms D was overloaded.

Ms H also advised that Mrs C had inherited significant staffing difficulties, which had been exacerbated by Villa Gardens' transition to being part of the Eldercare organisation. She acknowledged that some staff were resistant to the corporate model and the new policies and procedures. Ms H stated, "There was not enough work from Eldercare in relation to this transition."

Dr Neville was of the view that Villa Gardens did not adequately support Ms D in her role and could have done more. Mrs C has contested this (saying Ms D was orientated by the former clinical co-ordinator and also knew the facility well), but Oceania has not. While acknowledging that Ms D should have been more proactive about her orientation, Dr Neville said that a comprehensive orientation programme for all staff should have been made available and mandatory. Considering the importance of the clinical co-ordinator in ensuring that quality care is provided, he ranked Villa Gardens' action in relation to this issue as a "moderate" departure from the expected standards.

Dr Neville advised that the staffing and organisational issues put "undue stress" on the registered nurse workforce. Given that the challenges in recruiting and retaining suitably qualified staff in residential aged care are not new, Dr Neville stated that there should have been contingency plans in place to address this.

Care provided to Mr A

Dr Neville has advised that most of Mr A's care appears reasonable in the circumstances. However, he has criticised some aspects of the individual nursing care provided to Mr A, and it appears that these were common failings. In my view, this suggests wider systemic and management issues rather than matters of individual competence. Guided by Dr Neville's advice, I consider that the following aspects of Mr A's care were deficient.

Weight loss

Mr A's nutritional difficulties were well known to nursing staff before he was transferred to the Villa Gardens' hospital. In January 2008, after concern about his ability to swallow without choking, and whether his nutritional requirements were being met, it was recommended that he start on thickened fluids. On 19 February his care plan was updated and it was directed that he should be given puréed food softened with liquids. Staff were instructed to encourage him to eat slowly and swallow before taking the next mouthful.

On 13 January 2008 Mr A was recorded as weighing 60kg. On 24 February his weight was 52kg — an 8kg loss — but this was not acknowledged or acted on.

The progress notes also reminded staff to encourage Mr A with food and fluids, and to pay particular attention to his oral hygiene, but no food and fluid chart was started to monitor his intake. From February to July, staff continued to report Mr A's food and fluid intake in a general way in the progress notes. There is also evidence that nutritional supplements such as high-protein milkshakes, icecream and Fortisip were trialled from April 2008.

When Mr A was weighed again on 18 April he was found to be 59kg. It was noted that his weight had increased by 7kg since his previously recorded weight in February. However, two days later, on 20 April, his weight was recorded as 49kg. The 18 April weight was noted in the nursing progress notes, and it was recorded that Mrs B had visited that day and expressed concern about her father's weight loss, but there is no mention of the disparity in the weight taken two days later. A family friend who was visiting, Mrs I, had also observed that Mr A was losing weight. She described him as "very gaunt".

On 13 May, Mr A was weighed again. He was 54kg. On 12 June his weight was recorded at 55kg.

On 21 July it was recorded that Mrs B needed to be contacted and asked to collect her father's ring as it was "literally falling off his finger".

When Mr A was next weighed on 30 July, on the instruction of the interim manager, he was found to weigh 47kg — an apparent 8kg weight loss in the six weeks since mid-June. At this stage, Ms D ensured that an urgent referral was made to the dietician, and arranged for the hospital registered nurse to revise Mr A's Care Plan to reflect his changed status, and start a food and fluid intake chart for him.

Dr Neville noted that Mr A's Care Plan outlined his nutritional needs, including the type of assistance required in order to meet those needs. However, he advised that any older person whose nutritional status is compromised should be placed on a food and fluid chart as well as a 24-hour fluid balance chart. This was not done until 30 July. He said that this omission would be viewed as a mild departure from the standard. He noted that each of the nurses under investigation failed to do this.

Mr W is of the view that staff were not using the scales correctly and they were incorrectly calibrated. He has advised that operator error together with a fault in the calibration "threw up questionable data and inaccurate readings" affecting all residents. Additionally, staff were "applying their own judgement to how residents looked".

This explains the problem, but it does not excuse it. The fact remains that Mr A was known to have particular needs in relation to nutrition, his weight was apparently fluctuating, his daughter and others had raised concerns, yet no one started a nutrition

and fluid chart, and even a 10kg discrepancy in his recorded weight in April went unnoticed and unquestioned by any of the managers or staff.

Care planning and needs assessment
Mrs B was concerned that her father's Care Plan was not amended when he was assessed as requiring hospital level care and moved from the dementia unit to the hospital wing. She stated that when his Care Plan was finally revised on 30 July 2008, it was "sufficiently generic to be applicable to any elder person".

Villa Gardens employed a part-time registered nurse, Mr O, to write resident Care Plans. Mr A had a Care Plan that was reviewed six-monthly, and it was reviewed in February 2008 following concern that there was a "general decline" in his condition and he was "becoming more dependent on care". On 19 February, Mr O amended Mr A's Care Plan to provide guidance to caregiving staff on the management of his nutrition, mobility, hygiene and independence needs.

Mrs B is correct that Mr A's Care Plan was not further reviewed or amended after he was reassessed in March and transferred to the hospital in April. His Care Plan did not change until 30 July 2008, when Ms D amended it to instruct staff on the management of Mr A.

There is evidence that by this time Mr A's behaviour had changed and he had started to become aggressive and resistant to care. The progress notes show that Mr A was given oxazepam[22] to control his agitation. Ms D gave direction for staff to try diversion, and to record unresolved issues in a behaviour chart, and noted that he had been prescribed PRN (as required) medication for his aggression.

Dr Neville advised that Mr A's Care Plan adequately reflected his needs and was largely kept up to date. When concern about Mr A's weight was brought to Ms D's attention on 30 July, she directed that the plan be updated and reviewed, and amended the plan.

I acknowledge Dr Neville's advice. However, I am concerned that the Care Plan was not at least reviewed on Mr A's transfer to the hospital, given that it had been decided that his physical needs necessitated a higher level of care.

I also note that the audit by the DHB in July 2008 looked at a sample of unnamed Villa Gardens residents' care plans and found many were long overdue for updating. Additionally, in the sample reviewed by the audit team, one Care Plan recorded that all of an unnamed resident's care goals had been met when, in fact, that resident had declined so significantly he was reassessed as needing hospital level care. The audit findings cast considerable doubt about the reliability of all residents' care plans at this time, including Mr A's.

[22] The medication administration record for this medication was not provided, so the number of times this drug was administered was unable to be established.

Informing the family
Mrs B complained that she was not advised about the introduction of sedation to control Mr A's aggression. The progress notes show that this behaviour was becoming an issue early in July 2008.

There are a number of examples where the Villa Gardens staff failed to communicate adequately with Mr A's family. While Mrs C responded within two weeks to the written complaint submitted by Mrs B on 14 April 2008, and discussed it at a subsequent staff meeting, the actions she outlined to remedy Mrs B's concerns, such as education sessions for staff, did not eventuate and there was no follow-up communication with the family. While Mrs C has stated that she responded to a telephone complaint from Mr B, she relied on Ms D to contact him and she was unable to do so. The complaints sent to Villa Gardens in July were not acknowledged until after Mrs C's departure (discussed further later).

There were records kept about the regular interactions with the family which provided opportunity for discussion about management issues. While I acknowledge that it was not always easy for staff to contact Mrs B (who was frequently away) it appears there were lines of communication available through Mrs I (a regular visitor) and Mr B. Mrs B had indicated that they could be spoken to in her stead, and this happened on occasion. Nonetheless, it appears that Mrs B was not consulted about the use of sedation from July 2008, so that staff could care for her father when other planned strategies were ineffective in managing his aggression. I do not consider that Mrs C had the sole responsibility for advising the family of this matter, as she had very little direct contact with Mrs B and her husband. Other nursing staff had more contact with the family and the opportunity to discuss the management problems, as did Ms D. It appears that when Mr B asked two nurses on 16 July about Mr A's condition, he learnt for the first time about his father-in-law's aggression and sedation. When he raised concern, it was not adequately addressed.

It is unfortunate that Villa Gardens staff did not take steps to consult Mrs B, as EPA, or her husband before any major decisions were made to change the treatment plan, such as the introduction of sedation. Although sedation may have been viewed as standard medical treatment intended to prevent serious damage to Mr A's health, Mrs C, Ms D and the hospital registered nurses did not canvas Mrs B's view on the management of her father, and missed this opportunity to benefit from her experience and knowledge of her father. They should have done so. It is evident that the staff were stretched and operating in a reactive rather than proactive environment.

Summary

As Dr Neville noted, and Oceania has confirmed, at the time of the events complained about, there were workforce difficulties and a lack of organisational leadership at Villa Gardens. There were clinical governance and quality structures in place but operationally they were lacking and inadequate.

Furthermore, Dr Neville has advised that although the individual nursing care provided to Mr A was largely reasonable, there were common omissions, particularly

in relation to documentation. He particularly noted the failure of nursing staff to appropriately monitor and document Mr A's nutrition and fluids.

In my view there were also omissions in communicating with Mrs B as EPA for her father, and in the care planning. Oceania has acknowledged that there were failings and has largely attributed the problems to staff shortages and difficulties with the quality of some of its former staff. However, as I noted in a recent opinion that involved another rest home,[23] "The inaction and failure to follow policies … demonstrates a culture of non-compliance, systemic failings, and an environment that did not sufficiently support and assist staff to do what was required of them. The Home must take responsibility for this." That is also the case here. Staff were working in an environment that did not adequately support them.

I note, too, that these events also occurred during a continuing time of transition. In 2005 Villa Gardens was bought by Eldercare. Even by mid-2007, when Mrs C started, it is clear there were ongoing difficulties changing to the new Eldercare policies and procedures, and some ongoing staff resistance to the changes. In May 2008 there was further change when Eldercare became Oceania.

In another recent opinion relating to a residential care facility,[24] I acknowledged that there can be difficulties when an organisation takes over and introduces its own policies and procedures. However, that does not excuse the organisation of its duty, during any time of transition, "to ensure first and foremost that residents continue to be well cared for whilst changes are being implemented and to support staff in key management positions during the transition period".

Again, this is the case here. While it is clear that Mrs C and Ms D both had raised staffing difficulties and other issues with senior managers, no evidence has been presented of effective action being taken to address what were clearly ongoing problems. I agree with Dr Neville that there was inadequate support for Ms D and, while I have some concerns about Mrs C's actions (discussed below), I also accept that Mrs C was insufficiently supported. Furthermore, there is consistent evidence from some nursing staff that the ongoing staffing and organisational issues undermined their ability to provide good care.

Accordingly, Villa Gardens Home and Hospital (and its owners, Eldercare, now Oceania Care Company (No 1) Ltd) failed to provide Mr A with reasonable care and services that met his needs and optimised his quality of life and, therefore, breached Rights 4(1), 4(3) and 4(4) of the Code of Health and Disability Services Consumers' Rights (the Code).

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[23] Opinion 07HDC16959, page 18.
[24] Opinion 08HDC04291, page 22.

Opinion: Breach — Mrs C

Mrs C had been the Facility Manager for several months by the time Mr A was moved to the Villa Gardens hospital in April 2008. As previously noted, her responsibilities were business focussed but she had the overall responsibility to ensure that quality services were provided. She held the role until 23 July 2008 when the DHB appointed an Acting Manager. Her last day at Villa Gardens was 28 July 2008.

Care issues
Dr Neville noted that Mrs C's key responsibility as Facility Manager was to concentrate on running the business. Her appointment of a Clinical Co-ordinator to take responsibility for all clinical matters, such as ensuring the provision of appropriate standards of nursing assessment and care, meant that she took appropriate steps to ensure a suitable level of care was provided.

I respect Dr Neville's view that Mrs C should have been able to rely on her Clinical Co-ordinator and senior registered nurses to provide the expected levels of care, while she attended to her key tasks, the business of the facility. I also acknowledge that Mrs C needed good support from above — her own manager and the Eldercare (then Oceania) management team — and, as discussed earlier, this was inadequate.

However, although the responsibility for implementing and monitoring care standards at Villa Gardens primarily lay first with Ms N, and then with Ms D, Mrs C had overall responsibility for the quality of the services provided to Mr A and other residents. Given that there was a change of clinical co-ordinator in April, it was particularly important for her to ensure that a quality service was consistently provided while Ms D was new to the role. As Ms D found her feet, she needed, and should have been able to expect, good support from Mrs C. It does not appear that this was the case.

Ms D was given an unenviable task. As well as being asked to review and update outdated residents' care plans and other paperwork, she was the registered nurse for the rest home and dementia unit. Her orientation involved two short sessions with the South Island Operations Manager. Although Mrs C states that Ms D also received two weeks' orientation from her predecessor, Ms N, the sessions with Mrs C (as outlined in Ms D's letter of appointment) were not provided. Ms D said she was told by Mrs C that the four hospital nurses were competent and could manage the hospital.

Mrs C has indicated that she wanted to free up Ms D so she could concentrate on her clinical co-ordinator duties but felt she did not have a lot of say on this. Ms H has confirmed that she advised Mrs C to go slower in handing responsibility to Ms D. Ms H advised that Ms D discussed concerns with her and was reluctant to talk about them with Mrs C. Ms H now accepts that Ms D was overloaded.

Summary

I accept that Mrs C was not directly responsible for clinical care and was not sufficiently supported by her line manager in addressing the workload issues, particularly in relation to Ms D. I also note that she was very stretched, including being on call for another facility on weekends. However, it is clear that Mrs C was the most experienced senior nurse and was responsible for the overall service provided at Villa Gardens. She had been in the role for almost a year at the time of these events, and she was well aware of the staffing issues. Concerns about the impact it was having on care had been raised with her by both Ms D and nurses such as Mr E. Mrs C has herself acknowledged that she could have done more.

The problems were confirmed when the DHB commissioned an issues-based audit of Villa Gardens in July 2008. The auditors found a number of service areas where high priority action was required, in particular the need for increased staffing levels in the hospital, care planning and assessments, and in the area of managing behaviours. Mrs C, as Facility Manager, has to take some responsibility for this. When she found that she was not receiving the support she needed from her immediate manager, she should have escalated her concerns to the national management. I do not accept that she sufficiently fulfilled her responsibilities and took appropriate steps to ensure that Mr A was provided with reasonable care between April and August 2008. In my opinion, Mrs C breached Right 4(1) of the Code.

Adverse comment — Mrs C

Mr A's family complained on three occasions in writing (14 April,[25] 18 July and 22 July 2008), and at least once verbally (on 18 April).

On 14 April, Mrs B spoke to registered nurse Ms J about her concerns about her father's care. Mrs B had found him unattended and slumped in his chair. His nebuliser was dirty and left running with the face mask on the floor, personal items were scattered around his room, and his teeth had not been cleaned. Mrs B was also concerned about the small size of her father's room.

There is discrepancy in the information provided to HDC about this incident. Mrs B stated that Ms J suggested she discuss her concerns with Mrs C and accompanied her to Mrs C's office. Mrs B asked Mrs C to accompany her to Mr A's room to witness her concerns, but Mrs C "acted dismissively", and refused to go to see Mr A. Mrs B recalls that Mrs C asked her to complete a Complaint Form, instructing her to be objective when she filled out the form. Mrs B found this comment a "highly objectionable and thoroughly unprofessional statement".

[25] Mrs B believes that she made her first complaint on 12 April. However, as Ms J has recorded the event in the progress notes, which are chronological, I consider that the correct date is 14 April.

Mrs C recalls that she arrived at work to find a complaint form on her desk, completed by Mrs B, with an attached note from Ms J explaining that she had attempted to placate Mrs B by telling her that Mr A had been in the lounge for the greater part of the day, and had only just been moved back to his room because the lounge needed to be cleaned. Mrs C stated that she immediately contacted Mrs B and apologised. She said that at no time did she refuse to go to see Mr A, be dismissive of Mrs B, or act unprofessionally.

Ms J said she has no clear recall of the incident after 15 months, but she is "pretty sure" she took Mrs B immediately to see Mrs C on 14 April. She recalls informing Mrs C immediately about Mrs B's concerns, because she thought that a bigger complaint would arise if her concerns were not immediately addressed.

Mrs B was present, four days later, when Dr P, accompanied by Ms J, reviewed Mr A. Mrs B told Dr P that she suspected that her father had oral thrush. She told the doctor and the RN that she was concerned about her father's weight loss. These issues were recorded in the progress notes, but there is no evidence that Mrs C was notified about this conversation.

On 25 April, Mrs C wrote to Mrs B to acknowledge her complaint of 14 April. Mrs C stated that she understood that Mrs B had also discussed her concerns with RN Ms J, who had spoken with the caregivers responsible for Mr A about his care requirements. Mrs C noted that Mr A had been moved to a larger room. Mrs C advised Mrs B that once the new Clinical Co-ordinator had been orientated (about mid-May), education sessions, which included personal well-being, positioning and care ethics, would be organised to cover the subjects Mrs B had recommended. On 29 April, Mr A's move to a larger room, and the complaint that prompted it, was discussed at a staff meeting.

I am unable to be sure whether Mrs C refused to go with Mrs B to Mr A's room to check out her concerns on 14 April, although I note the records and Ms J appear to support Mrs B's recall. What is clear is that although Mrs C followed up the incident with Mrs B, and with staff, and moved Mr A to another room, she could have been more proactive regarding the undertakings she gave in response to the complaint.

As Dr Neville commented, there is no evidence that Mrs C followed up her letter to Mrs B to find out if the issues she raised had been adequately addressed. He stated that Mrs C should have taken all steps in the quality assurance process and clearly documented that process — "Doing so would have been an important quality assurance task". When the promised education sessions did not happen after Ms D's appointment, again there is no evidence of follow-up with Mrs B.

On 18 July, Mr B wrote to Mrs C on behalf of his wife. He expressed concern about Mr A being sedated without the family's knowledge. He stated that when he visited on 16 July, the hospital duty RN had informed him that Mr A was being given sedation 20 minutes before cares, to manage his aggression. Ms D had confirmed this. Mr B complained that the family had not been advised of the change in Mr A's behaviour, and the need for this form of restraint had not been discussed with them. Mr B stated that he had advised Mrs B, who was working outside the area until 27

July, and who would want to discuss this issue, and the management of Mr A's skin tears, with Mrs C on her return.

Mrs C recalls that Mr B telephoned her and she discussed his complaint with Ms D, who told her that Mr A was not being sedated,[26] and undertook to contact Mr B. Ms D later told her that she had tried to contact Mr B on several occasions without success.

A few days later, Mr B again wrote to Mrs C acknowledging her letter of 15 July, which appears to have advised the families of Villa Gardens' residents and patients about Eldercare's merger, and provided a brochure explaining the merger. He expressed concern about the effect of "commercial merits" on the well-being of residents and staff.

There is no record of Mrs C responding to these letters before she left Villa Gardens in late July. However, Mrs C advised HDC that she had been on sick leave during the week of 21 July 2008. She said she found Mr B's letters on her desk on 28 July when she returned to Villa Gardens for just one day, to assist with the DHB audit. She does not recall seeing the letters previously.

Mrs C said she gave the complaint to the regional Operations Manager, Ms T, and discussed it with her. Mrs C recalls telling Ms T that she was awaiting a report from Ms D in response to Mr B's concerns about Mr A's medication. Ms T has confirmed that she became aware of the complaint that day but she does not recall the details. Ms H has also said that she was not aware of Mr and Mrs B's concerns until the last week in July. Mrs B did not get a comprehensive and appropriate response until the Oceania Chief Operating Manager, Mr W, wrote to her on 9 September 2008.

As Mr W acknowledged at the time, the delay in responding to Mr and Mrs B's complaints was unsatisfactory. However, it must be acknowledged that the July complaints arrived around the time Mrs C was away on leave, and at a time when there were various management changes, and shortly before her departure. All of this undoubtedly complicated matters.

In my view, while Mrs C could have done more to follow up the April complaint, it is reasonable under the circumstances to conclude that she was not responsible for the inadequate response in July, and no further action is warranted.

Opinion: No breach — Ms D

Ms D became the new Clinical Co-ordinator in the same month that Mr A transferred to the Villa Gardens hospital. As such, she was responsible for managing the clinical aspects of the facility, monitoring the clinical care provided to the residents and patients, and ensuring that clinical and care staff complied with Eldercare's systems,

[26] The progress notes indicate that oxazepam and haloperidol were being given to assist with behaviour management.

structures, processes, and policies and procedures. Nursing and care staff reported to her and she was expected to be a role model for "compliant practice" at all times.

It is clear that there were aspects of the nursing care provided to Mr A that did not comply with professional standards. However, as discussed earlier, I accept that Ms D was inadequately supported in her role. I also accept that her job description does not reflect the actual duties she was asked to carry out. Furthermore, it appears that she appropriately tried to do something about the difficulties she faced. She raised concerns about staffing and her workload and duties with her manager, Mrs C, Mrs C's manager, Ms H, and Ms T at Oceania. Nothing changed.

It is telling that Ms D resigned just three months after taking on the Clinical Co-ordinator's role, and Ms H has acknowledged that she was overloaded.

Summary

In my opinion, while Ms D bore a significant responsibility to ensure that a reasonable standard of care was provided to Villa Gardens residents and patients, she was left with little time and encouragement to adequately fulfil her responsibilities as Clinical Co-ordinator, and to acquaint herself with the details of the care being provided to the hospital patients. During her three months in the role, she was not adequately supported, and felt frustrated by her lack of control over the staffing situation.

It was unwise and unrealistic to expect her to function adequately in this role under these circumstances. In my opinion, overall responsibility for the lapses in the care provided to Mr A lies with Villa Gardens and, to a lesser extent, Mrs C, and it would be unreasonable to hold Ms D responsible for the omissions in Mr A's care.

Opinion: No Breach — Mr E

Mrs B was concerned about RN Mr E's management of two aspects of her father's care. She stated that the treatment for Mr A's oral thrush, for which Dr P had prescribed Nilstat on 18 April, was not given. Mrs B also complained about the response she received from Mr E when she suggested using a Dermoplast dressing on her father's pressure sores.

Oral thrush care

Mr E stated that, because of considerable staff shortages at this time, and the resulting pressures, his direct contact with Mr A was limited. Although the clinical records show that Dr P prescribed Nilstat for Mr A, Mr E does not recall this. Dr Neville noted that the clinical records of 18 April confirm that Mr A was prescribed Nilstat, but there is no record of Mr E actioning this recommendation.

Dr Neville advised that as the registered nurse, Mr E had overall responsibility for all the patients in his care, and he had the discretion to delegate tasks to other care

workers if he was too busy. His failure to do this would be viewed as a mild departure from the standards.

Mr E subsequently advised that he was not working on 18 April as he only did three shifts a week. He worked the morning shift on Saturday 19 April, but has no recollection of Mr A having been diagnosed with oral thrush, or his prescription. He stated that if the Nilstat was not delivered on Friday 18 April it would not have arrived until Monday 21 April when again he was not on duty. He did not work again until 26 April. Mr E also submitted that a number of other nurses were involved in Mr A's care at this time, and were more directly involved than him.

Pressure areas
Mrs B recalls her concern on about 28 July 2008, when she asked Mr E if he could arrange for a Dermoplast patch to prevent any further deterioration of her father's pressure areas, and he told her that this dressing was only to be used on areas that had actually broken down. In contrast, Mr E advised that he was aware of the prophylactic usefulness of Dermoplast patches. The progress notes indicate that he asked the night nurse to apply the dressing, and that this was done.

Fluid and food recording
Prior to the period under investigation, on two occasions (31 March and 12 May 2008), Mr E had notified Mrs C in writing that staffing levels were unsafe, and he felt that if there was any acute illness, injury or falls, his ability to respond appropriately would be compromised. Mr E was concerned that because there was no Enrolled Nurse support, he was not fulfilling his role, and tasks such as eye drops and nutritional supplements were not being given as directed. He stated that he had no time to update and document care plans.

Dr Neville commented that Mr E and other nurses should have documented Mr A's food and fluid intake on a fluid balance chart when it was evident that Mr A's nutritional status was compromised. Dr Neville said that Mr E had the discretion to delegate tasks to other caregivers if he was too busy to do this himself. He viewed this as a mild departure from the expected standard of care. Mr E responded that implementing such charts would generally be the responsibility of the morning shift staff. He worked only three of the possible 21 shifts, so he ought not be personally held responsible for the lack of a food or fluid chart.

Summary

In the circumstances, I do not consider that Mr E's two minor departures from the standards (in relation to the Nilstat and the food and fluid monitoring) justify a finding of a breach of the Code. In my opinion, Mr E endeavoured to provide a reasonable level of care to his patients, including Mr A, under very difficult conditions. He appropriately reported his concerns to Mrs C and, apparently in response, an Enrolled Nurse was rostered to provide backup on the afternoon shift (although there is no evidence of when or for what period this extra staff member was provided). It appears that Mr E continued to be anxious about the risk the "considerable changes and staff shortages" posed to patients.

I also accept that Mr E was a part-time member of a team of registered nurses, and his direct contact with Mr A during the period under investigation was limited. While he has to share some responsibility for lapses in the care, I accept that it would be unfair to single him out when there were wider systemic issues that he, at least partly, tried to do something about, and his involvement was limited. Mr E said that he has reflected on his practice in light of these events.

Adverse comment — Ms G

Respect issues
Mrs B expressed her concern about registered nurse Ms G's unprofessional and disrespectful attitude when she was asked to inform the kitchen to stop meals for Mr A. Mrs B stated that a lack of understanding of the English language would not account for Ms G's "shocking response" to this request — "What has he been disposed of then?" Mrs B stated that this was disrespectful to Mr A and her.

Mrs B also complained that Ms G was dismissive when Mr B visited on 16 July and asked about Mr A's condition.

Ms G did not comment on Mrs B's complaint that she was unprofessional, dismissive and disrespectful when talking to her and her husband. I have no reason to disbelieve Mrs B's account of these interactions, and consider that Ms G's comments were ill-judged. The comment in relation to the meal delivery was not made to Mr A directly, but Mrs B certainly took the remark to be disrespectful.

Ms G advised that, together with Ms D, she tried to raise the standard of care at Villa Gardens, but staffing levels were insufficient and they had no support from management. She does not recall meeting Mr and Mrs B until Mr A's death was imminent. Ms G stated that she realised when speaking with them that they had not been adequately informed about Mr A's condition. This has been a learning experience for her, and she now ensures that families she is involved with have a thorough report on the patient's health.

Ms G may not have intended for her comments to be disrespectful, but this is how they were interpreted at the time. Ms G would do well to reflect on her communication with families in these types of situations.

Opinion: No further action — Ms F

Registered nurse Ms F was a newly registered nurse at the time of these events. She started work at Villa Gardens on 19 June 2008.

Mrs B complained that when visiting her father in 1 August 2008 she found that his breathing was moist and audible, indicating to her that he might have developed pneumonia. She asked Ms F to examine Mr A to confirm her suspicion, and was "very angry and gravely concerned" when Ms F put her ear to Mr A's chest and confirmed that he was breathing.

There is no record of this incident in the progress notes, and the staff roster shows that Ms F did not work that day.[27] On the afternoon of 1 August, Villa Gardens engaged an agency nurse to provided one-on-one care to Mr A overnight. The notes record that staff were concerned that afternoon that Mr A was "chesty" and, at 5.15pm, called in the after-hours doctor, Dr S, who found Mr A had "No cough. No fever. No distress."

Summary

Although the information gathered does not support Mrs B's recollection of the timing of the event, Ms F provided an apology to Mr A and his family for any offence she might have caused. Dr Neville's only comment about the standard of care Ms F provided to Mr A was about her lack of documentation regarding his food and fluid intake. In September 2008, Ms F commenced a Nursing Council performance assessment, which she successfully completed on 10 October 2008. She has also undertaken ongoing in-house training with Oceania Care Company, and continues to develop her practice in line with these policies and procedures. Accordingly, I do not propose to take any further action in relation to this aspect of Mrs B's complaint.

Naming

I have discretion to name group providers in any breach reports that are published on the HDC website and sent to relevant agencies. However, each case is considered on it own merits. In this case, Oceania Care Company (No 1) Ltd submitted that it would be inappropriate to publish its name in my report because it was not in existence for some of the time when the breaches occurred. I have carefully considered this issue and decided that, on balance, the public interest favours publication. Accordingly, Oceania Care Company (No 1) Ltd will be named along with Eldercare, and Villa Gardens, in the report published on the HDC website and sent to relevant agencies.

[27] The staff roster shows that Ms F was not working on 1 August. She worked from 7am to 9pm on 2 August and 7am to 7pm on 3 August.

Recommendations

Mrs C
I recommend that Mrs C:

- provide a written apology by **30 September 2009** to Mr A's family for her breaches of the Code. The apology is to be sent to HDC for forwarding to the family.

Oceania Care Company(No 1) Ltd (trading as Villa Gardens)
Oceania Care Company has already provided a written apology to Mr A's family for its breaches of the Code. The apology has been sent to Mrs B.

I recommend that Oceania Care Company:

- review this report, and advise me by **30 September 2009** of any additional changes implemented at Villa Gardens since the June 2009 report for the DHB. Particular attention should be given to the policies and procedures for documenting and managing nutrition and fluids, and the support systems in place for the Facility Manager and Clinical Co-ordinator.

Follow-up actions

- A copy of this report will be sent to the Nursing Council of New Zealand, the Ministry of Health (HealthCERT), and the District Health Board.

- A copy of this report, with details identifying the parties removed except the names of Villa Gardens Home and Hospital, Eldercare, and Oceania Care Company (No 1) Ltd, and the expert who advised on this case, will be sent to HealthCare Providers New Zealand and the Association of Residential Care Homes, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A — Expert advice from registered nurse Dr Stephen Neville

"Thank you for giving me the opportunity to review and give advice on the above case. The aim of the contents of this report to the Health and Disability Commissioner is to provide advice, as to whether in my professional opinion:

Oceania Care Company (No 1) Ltd t/a Villa Gardens Home and Hospital, Facility Manager registered nurse [Mrs C], Clinical Co-ordinator registered nurse [Ms D], and registered nurses [Mr E], [Ms G] and [Ms F], provided an appropriate standard of care to [Mr A].

Complaint

- *Whether Villa Gardens Home & Hospital Facility Manager, registered nurse [Mrs C], provided [Mr A] with reasonable treatment and care between April and August 2008.*
- *Whether [Mrs C] adequately informed [Mr A] or his enduring power of attorney about his condition and treatment, and responded appropriately to complaints about his care.*
- *Whether registered nurse [Ms D] provided [Mr A] with reasonable treatment and care between April and August 2008.*
- *Whether registered nurse [Mr E] provided [Mr A] with reasonable treatment and care between April and August 2008.*
- *Whether registered nurse [Ms F] provided [Mr A] with reasonable treatment and care between April and August 2008.*
- *Whether registered nurse [Ms G] provided [Mr A] with reasonable treatment and care between April and August 2008.*
- *Whether Oceania Care Company (No 1) Ltd t/a Villa Gardens Home and Hospital provided [Mr A] with reasonable treatment and care between April and August 2008.*

This report will begin with an overview of my professional qualifications and clinical experience, followed by a timeline outlining the events surrounding this complaint. Finally, my professional opinion on the case will be provided. The findings, as documented, are a result of reading through the information provided by the Health and Disability Commissioner's Office, my own professional clinical and research experience of working with older adults and their families/significant others, my extensive experience working as a nurse at all levels of the health care environment, and after reviewing the relevant literature related to the ethical and legal obligations of nurses in providing a nursing service to vulnerable older people and their families.

Personal and professional profile

I am a registered nurse, who has a doctoral degree in nursing, a Fellow of the College of Nurses Aotearoa (NZ) and have been nursing for 31 years. I am currently working as a senior lecturer and postgraduate programme co-ordinator in the School of Health and Social Services, Massey University, Albany Campus, Auckland. I teach in postgraduate nursing programmes and my doctoral research focused on delirium in

people over the age of 65 years and the impact this had on families/significant others. My clinical experiences include working with people who have disabilities, acute care, operating theatre and health care of the older person. I am currently on the Management Board of Nursing Praxis in New Zealand and am an Honorary Research Consultant at the University of Queensland, School of Nursing. My research experience and publications are in men's health and well-being, nursing and older people, the social aspects of ageing, health assessment, vulnerable populations and health workforce issues. Finally, I have extensive experience in providing independent advice to the Health and Disability Commissioner related to ensuring consumers of health services receive safe and appropriate standards of care.

Background

[Mr and Mrs A] originally lived [elsewhere] and relocated to reside in [the area] in late 2004. [Mr A] lived with chronic obstructive pulmonary disease and dementia. Immediately on relocating [Mr A] was admitted to the dementia wing of Villa Gardens Home and Hospital. Approximately three months later [Mrs A] joined him at Villa Gardens but she lived in the residential care section of the organisation until her death in January 2007. [Mr and Mrs A] had one daughter, [Mrs B] who is a registered nurse and lived close by. Due to increasing frailty [Mr A] was reassessed in early 2008 as requiring hospital level care and was subsequently moved to the hospital wing of Villa Gardens in April of that year. [Mr A] died in Villa Gardens Hospital [in mid-] 2008. [Mr A's] daughter, Mrs B, alleges that during [Mr A's] stay in the hospital section of the facility he:

- Lost 8kg in weight in 10 days
- Developed pressure areas on his buttocks and heels
- Developed oral thrush and a chest infection that went undiagnosed
- Sustained skin tears that were not treated
- Experienced pain that was inadequately managed
- Did not receive adequate levels of nutrition
- Was left alone and not repositioned for long periods of time
- Was not kept clean and his personal needs were not met.

After [Mr A's] death an autopsy was performed which identified the presence of bilateral pneumonia, advanced cachexia, impaired skin integrity and pressure areas.

Professional advice

I have been asked to advise the Commissioner on whether, in my opinion, Oceania Care Company/Villa Gardens Home and Hospital, [Mrs C], [Ms D], [Mr E], [Ms G] and [Ms F] provided services to [Mr A] of an appropriate standard during the period of 2008.

1. Were the services provided to [Mr A] appropriate?
2. What standards apply in this case?
3. Were those standards complied with?

Finally, as required, I will comment on any other aspects of the care that I deem necessary. The following professional advice is presented as it relates to the above points. I conclude my advice with my opinion on the level of severity associated with the complaint made against Oceania Care Company/Villa Gardens Home and Hospital, [Mrs C], [Ms D], [Mr E], [Ms G] and [Ms F], documented as mild, moderate or severe.

[Mrs C]

1. *Did [Mrs C] take appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mr A]?*

It is important to note that [Mrs C's] last working day at Villa Gardens was approximately the 24th of July 2008. With this in mind, it is my professional opinion that [Mrs C] took the appropriate steps to ensure a suitable level of care was provided to [Mr A] between April 2008 and approximately the 24th July of the same year. In [Mrs C's] statement provided in section E, and alluded to on page 383, she outlines that her key responsibilities as Facility Manager were to concentrate on running the business and all clinical matters, such as ensuring the provision of appropriate standards of nursing assessment and care, were the responsibility of the clinical co-ordinator. Complaints to [Mrs C] from [the family] regarding [Mr A's] care were attended to within the timeframe outlined in Villa Gardens' policy manual and were conveyed to the appropriate clinical people to address. However, this evidence is only presented in section E, [Mrs C's] correspondence to Rae Lamb and is alluded to rather vaguely on page 37 where it states '… It is my understanding that [Mrs C] responded to the formal complaint on 25th April 2008 …'. There is no formal documentation suggesting that this action had been undertaken. 'Having an understanding' implies that there is a level of uncertainty about whether this did occur.

2. *Is there anything else [Mrs C] should have done in the circumstances?*

After addressing the first complaint from the family it is unclear as to whether [Mrs C] made contact with the family to see whether the issues they had raised were appropriately addressed. Doing so would have been an important quality assurance task to have undertaken. All steps in the quality assurance process should have been undertaken, clearly documented and have been provided to me as an expert witness.

[Ms D]

1. *Did [Ms D], as Clinical Co-ordinator, take appropriate steps to ensure that an appropriate standard of nursing assessment and care was provided to [Mr A]?*

From the documentation provided to me it appears [Ms D] was employed to the role of Clinical Co-ordinator on 28th April 2008. After reviewing the clinical care documentation provided to me my expert opinion is that [Ms D] provided an appropriate standard of nursing assessment and care to [Mr A]. This is evidenced

by the comprehensive statement provided by [Ms D] in section C and the care planning documentation provided in section B.

2. *Were there any systemic factors impacting on [Ms D's] ability to ensure appropriate care was provided to [Mr A]? Please comment with specific reference to:*

a) Care planning
It is clearly documented throughout the documents provided to me that Villa Gardens was experiencing difficulties in attracting, recruiting and retaining appropriately qualified people to staff the organisation. However, section B provides evidence that [Mr A's] care plan adequately reflected his needs and was largely kept current. The lifestyle plan starting on page 107 was not required to be reauthorised by the Director of Nursing until October of 2008. There is also evidence that the plan was updated as [Mr A's] condition changed including changes made by [Ms D].

b) Medication
From the documentation provided to me on the whole it appears that prescribed medications were given to [Mr A]. I do note that on page 49 on the 18th April Nilstat for oral thrush was recommended. This is also noted on page 140 in [Mr A's] progress notes however there is no evidence that this intervention was operationalised. I rate this omission as mild in severity.

c) Personal care needs
All personal care needs have been adequately documented indicating that [Mr A's] care needs were attended to.

d) Pain relief
The documentation provided to me indicates that appropriate pain assessments have been carried out and pain relief has been offered to [Mr A] as required.

e) Nutrition
[Mr A's] care plan outlines his nutritional needs including the type of assistance required in order to meet those needs. Section B, page 215 is a report from [the dietitian] to the PSE Team dated the 31st July 2008. This report also makes reference to April 2008 indicating that during the period of April to August 2008, when [Ms D] was the Clinical Co-ordinator, this nurse was aware of [Mr A's] impaired nutritional status. My only criticism is that any older person whose nutritional status is compromised should be placed on a food and fluid chart as well as a 24 hour fluid balance chart. Official monitoring of [Mr A's] input and output was not provided in the documentation during the period of April to August 2008. I rate this omission as mild in severity.

3. *Did [Ms D] communicate appropriately with other providers involved in [Mr A's] care?*

The documentation provided in Section B indicates that [Ms D] did communicate with a variety of other health professionals in relation to [Mr A's] care needs. For example, other registered nurses, care workers, dietitians and doctors.

4. *Is there anything else [Ms D] should have done in the circumstances?*

The role of Clinical Co-ordinator is a senior nursing position. As a nurse leader and experienced health professional, [Ms D] should have had the necessary education and skills to insist that the terms of her orientation period were met. If [Ms D] thought that what she was directed to undertake was not commensurate with the role of clinical co-ordinator then she should have actively taken the necessary steps to ensure the management of Villa Gardens enabled her to fulfill her obligations associated with this role. I rate this inaction as mild.

[Mr E]

[Mr E] claims that as the registered nurse he had very little contact with [Mr A] during his stay in the hospital wing of Villa Gardens. However, as a registered nurse he has the overall responsibility for all patients in his care and at his discretion can delegate tasks to other care workers, for example enrolled nurses and health care assistants. I only have [Mr E's] statement as it appears in section G as evidence because it is difficult to decipher his signature in the progress notes which would have supported his evidence. However, as identified the above section related to [Ms D] it appears that a reasonable and appropriate standard of care was provided to [Mr A] by [Mr E] from April to August 2008.

1. *Did [Mr E] provide an appropriate standard of nursing assessment and care to [Mr A]? Please comment with specific reference to:*

a) Care planning

It appears that the appropriate care planning was provided by [Mr E] between April and August 2008.

b) Medication

From the documentation provided to me on the whole it appears that prescribed medications were given to [Mr A] by [Mr E]. [Mr E] does identify that he did not recall [Mr A] having oral thrush and outlines the process and some treatment options to deal with this issue. However, I do note that on page 49 on the 18th April Nilstat for oral thrush was recommended. This is also noted on page 140 in [Mr A's] progress notes however there is no evidence that this intervention was operationalised by [Mr E]. I rate this inaction in relation to [Mr A's] medication as mild in severity.

c) Personal care needs
From the information provided to me it appears that [Mr A's] personal needs were met by [Mr E] between April and August 2008.

d) Pain relief
It appears that appropriate pain assessments were carried out by [Mr E] from April to August 2008.

e) Nutrition
From the documentation provided to me it appears that [Mr E] did everything possible to ensure that [Mr A's] nutritional needs were met.

2. *Did [Mr E] appropriately document the care?*

From the documentation provided to me it appears that on the whole [Mr E] appropriately documented [Mr A's] care between April and August 2008. However, due to [Mr A's] impaired nutritional status [Mr E] should have documented his food and fluid input on a food chart and his fluid input and output on a fluid balance chart during July and August of 2008. I rate this inaction as mild.

3. *What else, if anything, should [Mr E] have done in the circumstances?*

[Mr E] states in Point 25 page 364 that during [Mr A's] stay at Villa Gardens he actively spoke to the management of the organisation expressing his concern regarding the lack of staff and skill mix. This was appropriate action for [Mr E] as a registered nurse within the organisation to do.

[Ms G]

From the documentation provided to me [Ms G] was involved in [Mr A's] care from the 1st July 2008. I only have [Ms G's] statement as it appears in section D as evidence because it is difficult to decipher her signature in the progress notes which would have supported her evidence. However, as identified the above section related to [Ms D] it appears that a reasonable and appropriate standard of care was provided to [Mr A] by [Ms G] from July to August 2008.

1. *Did [Ms G] provide an appropriate standard of nursing assessment and care to [Mr A]? Please comment with specific reference to:*

a) Care planning
It appears that the appropriate care planning was provided by [Ms G] between July and August 2008.

b) Medication
It appears that [Mr A's] medications were correctly administered by [Ms G] between July and August 2008.

c) Personal care needs
It appears that [Mr A's] personal needs were met by [Ms G] between July and August 2008.

d) Pain relief
It appears that appropriate pain assessments were carried out by [Ms G] and as per her statement no pain relief was required during July and August 2008.

e) Nutrition
[Ms G's] statement confirms [Ms D's] actions as clinical co-ordinator that [Mr A's] nutritional needs were recognised, assessed, the appropriate people consulted in a timely manner and the necessary interventions instigated between July and August 2008.

2. Did [Ms G] appropriately document the care?

As earlier mentioned it is difficult to determine whether [Ms G] appropriately documented [Mr A's] care in the progress notes. However, due to [Mr A's] impaired nutritional status [Ms G] should have documented his food and fluid input on a food chart and his fluid input and output on a fluid balance chart during July and August of 2008. I rate this inaction as mild.

3. What else, if anything, should [Ms G] have done in the circumstances?

In her statement [Ms G] intimates on page 298, section D that she was aware of the staffing issues and was trying to ensure an appropriate standard of care was provided to all older people in the hospital wing of Villa Gardens. She also suggests that these concerns were discussed with [Ms D] which was an appropriate action to take.

[Ms F]

From the documentation provided to me [Ms F] was involved in [Mr A's] care from the 19th June 2008. I only have [Ms F] statement as it appears in section F as evidence because it is difficult to decipher her signature in the progress notes which would have supported her evidence. It also appears that [Ms F's] competence to practise as a registered nurse has been questioned in several witness statements. However, I assert that these allegations are only anecdotal and there is no formal evidence that these were true. Formal mechanisms exist, for example a competence review as outlined in Health Practitioners Competence Assurance Act. As this was not undertaken and there is no formal documentation available I deem that [Ms F] was competent to practise as a registered nurse. In addition, [Ms F] had a competence review undertaken on 10th October 2008; the outcome of which was that she was competent to practise as a registered nurse. Finally, Mrs B alleges that [Ms F] failed to provide appropriate care to [Mr A] on 1st August 2008 (see page 13 section A), however [Ms F] states that she was not working on August 1st 2008 and a copy of the roster has been provided on page 309 section F supporting this assertion.

1. *Did [Ms F] provide an appropriate standard of nursing assessment and care to [Mr A]?*

From the documentation provided to me it appears that [Ms F] provided an appropriate standard of nursing assessment and care to [Mr A] during the period of June through to August 2008.

2. *Did [Ms F] appropriately document the care?*

From the documentation provided to me it appears that on the whole [Ms F] appropriately documented the care provided to [Mr A] during the period of June through to August 2008. However, due to [Mr A's] impaired nutritional status [Ms F] should have documented his food and fluid input on a food chart and his fluid input and output on a fluid balance chart during July and August of 2008. I rate this inaction as mild.

Oceania Care Company/Villa Gardens

1. *Were there adequate clinical governance and quality structures in place at Villa Gardens?*

In all of the documentation provided to me the common themes in relation to [Mr A's] case revolve around inadequate staffing, difficulties attracting, recruiting and retaining staff, poor or inadequate lines of communication, lack of organisational leadership and unwanted negative media attention. While I believe the clinical governance and quality structures were in place at Villa Gardens the operationalisation of these were lacking and inadequate. Consequently, it is my professional opinion that these issues placed undue stress on the registered nurse workforce at Villa Gardens. My position is further supported by correspondence from [the DHB Chair] (see pages 24->25 section A) and [Mr W] (see pages 37->39 section A) to [the family]. [The DHB Chair] identifies that a temporary Manager had been employed to provide clinical governance and leadership at Villa Gardens. [Mr W] all but admits that quality issues at an organizational level were inadequate. I rate this issue as moderate in severity.

2. *Was RN [Ms D] adequately supported?*

It appears from RN [Ms D] statement that she was not adequately supported in her role as clinical co-ordinator. [Mrs C's] statement in section J also intimates that [Ms D] was not able to cope with her workload. It is therefore my professional opinion that Villa Gardens did not adequately support [Ms D] in her role and more could have been done to support her as the clinical co-ordinator. Considering the importance of the clinical co-ordinator in ensuring that quality care is provided I rank Villa Gardens' action in relation to this issue as moderate.

3. *Were RNs [Mr E], [Ms G] and [Ms F] adequately supervised and supported?*

In terms of line management, nurses [Mr E], [Ms G] and [Ms F] report to the clinical co-ordinator re concerns related to the provision of a quality health service. It would then be the clinical co-ordinator's responsibility to address these concerns with the management of the organisation. Equally, it is the clinical co-ordinator who is responsible for the oversight of clinical supervision. As such, it is my professional opinion that Villa Gardens was not directly responsible for ensuring the above nurses were adequately supervised and supported.

4. *What else, if anything, should Eldercare/Oceania have done in the circumstances?*

Comprehensive orientation programmes for all staff should be made available and have been mandatory for all staff at Villa Gardens. Clear support structures for senior staff should have been put in place. The challenges associated with the recruitment and retention of appropriately qualified staff within the residential care sector is not new. Consequently, Villa Gardens should have had the necessary contingency plans in place to address any staffing crisis that may have presented itself.

5. *Please comment on the initiatives designed to improve services at Villa Gardens since these events*

The initiatives provided to me appear appropriate. However, recommendations are only as good as the people who instigate them. The key to improving services at Villa Gardens will be reliant on a competent, stable, well qualified and unified senior management team.

6. *Please provide any further recommendations for improvement.*

I have no further recommendations to suggest."

Dr Stephen Neville, RN, PhD, FCNA(NZ).

Appendix B — Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill

...

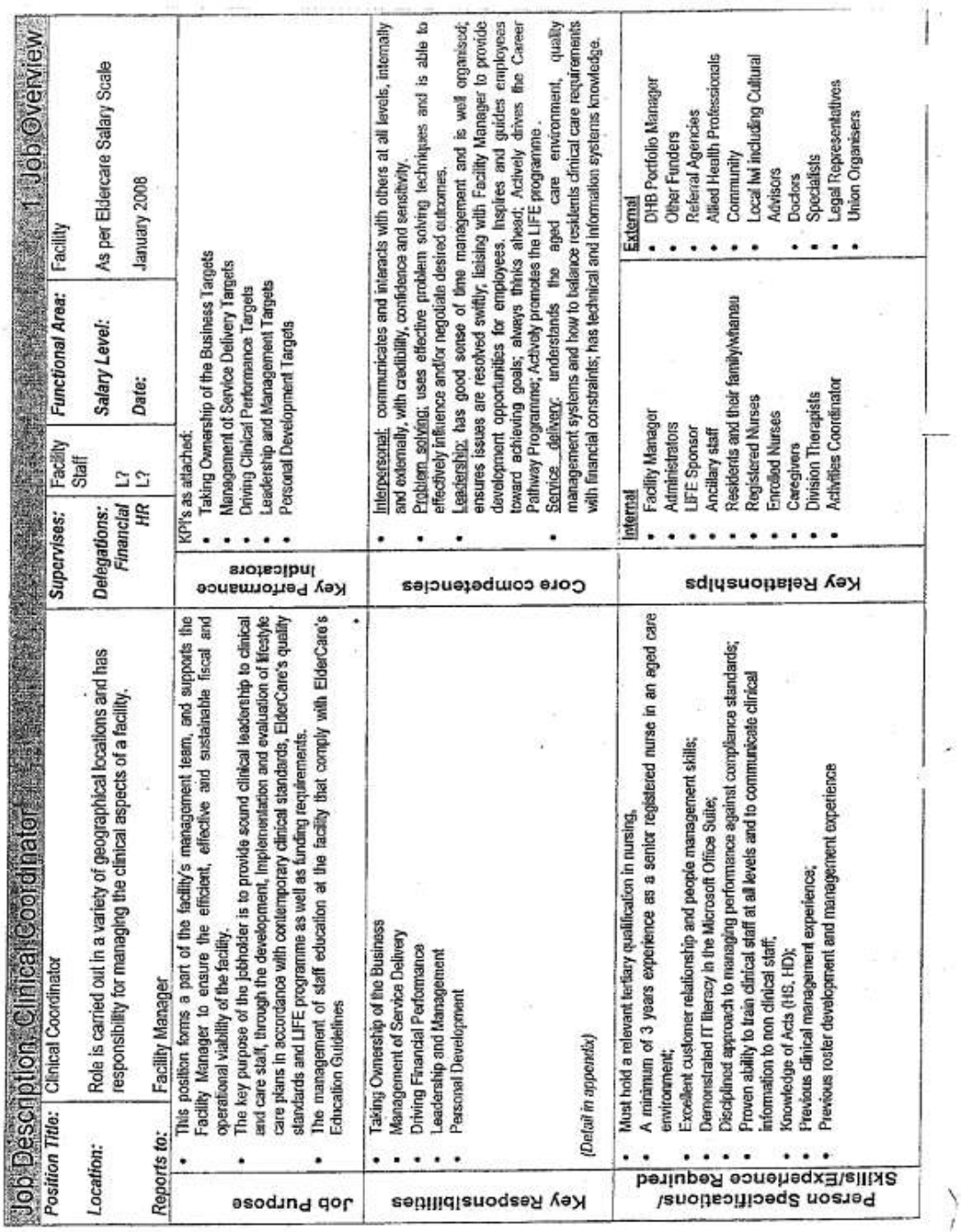
(3) Every consumer has the right to have services provided in a manner consistent with his or her needs.
(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer

RIGHT 10

Right to Complain

(3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.

Appendix C — Oceania Job Description: Clinical Co-ordinator



Job Description: Clinical Coordinator — 1 Job Overview

Position Title: Clinical Coordinator
Location: Role is carried out in a variety of geographical locations and has responsibility for managing the clinical aspects of a facility.
Reports to: Facility Manager
Supervises: Facility Staff
Delegations: Financial L? HR L?
Functional Area: Facility
Salary Level: As per Eldercare Salary Scale
Date: January 2008

Job Purpose

- This position forms a part of the facility's management team, and supports the Facility Manager to ensure the efficient, effective and sustainable fiscal and operational viability of the facility.
- The key purpose of the jobholder is to provide sound clinical leadership to clinical and care staff, through the development, implementation and evaluation of lifestyle care plans in accordance with contemporary clinical standards, ElderCare's quality standards and LIFE programme as well as funding requirements.
- The management of staff education at the facility that comply with ElderCare's Education Guidelines

Key Responsibilities

- Taking Ownership of the Business
- Management of Service Delivery
- Driving Financial Performance
- Leadership and Management
- Personal Development

(Detail in appendix)

Person Specifications/ Skills/Experience Required

- Must hold a relevant tertiary qualification in nursing.
- A minimum of 3 years experience as a senior registered nurse in an aged care environment;
- Excellent customer relationship and people management skills;
- Demonstrated IT literacy in the Microsoft Office Suite;
- Disciplined approach to managing performance against compliance standards;
- Proven ability to train clinical staff at all levels and to communicate clinical information to non clinical staff;
- Knowledge of Acts (HS, HD);
- Previous clinical management experience;
- Previous roster development and management experience

Key Performance Indicators

KPI's as attached:

- Taking Ownership of the Business Targets
- Management of Service Delivery Targets
- Driving Clinical Performance Targets
- Leadership and Management Targets
- Personal Development Targets

Core competencies

- Interpersonal: communicates and interacts with others at all levels, internally and externally, with credibility, confidence and sensitivity.
- Problem solving: uses effective problem solving techniques and is able to effectively influence and/or negotiate desired outcomes.
- Leadership: has good sense of time management and is well organised; ensures issues are resolved swiftly; liaising with Facility Manager to provide development opportunities for employees. Inspires and guides employees toward achieving goals; always thinks ahead; Actively drives the Career Pathway Programme; Actively promotes the LIFE programme.
- Service delivery: understands the aged care environment, quality management systems and how to balance residents clinical care requirements with financial constraints; has technical and information systems knowledge.

Key Relationships

Internal

- Facility Manager
- Administrators
- LIFE Sponsor
- Ancillary staff
- Residents and their family/whanau
- Registered Nurses
- Enrolled Nurses
- Caregivers
- Division Therapists
- Activities Coordinator

External

- DHB Portfolio Manager
- Other Funders
- Referral Agencies
- Allied Health Professionals
- Community
- Local Iwi including Cultural Advisors
- Doctors
- Specialists
- Legal Representatives
- Union Organisers

Names have been removed (except Villa Gardens Home & Hospital, Eldercare, Oceania Care Company and the expert who advised on this case) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Job Description - Clinical Coordinator
2. Key Responsibilities

Key Responsibilities	Specific Actions
Taking Ownership Of The Business	▪ Understands ElderCare's Strategic Plan and is able to assist the Facility Manager to develop a business plan and work programme to achieve facility relevant clinical goals; ▪ Assists the Facility Manager to ensures that the facility meets all reporting deadlines by ensuring that information is shared with the Facility Manager in a timely and appropriate manner; ▪ Establishes networks and maintains effective communication across all clinical areas of the business in conjunction with the Facility Manager; ▪ Assists the Facility Manager to maintain regular communication with the DHB's , NASC assessors and families; ▪ Demonstrates innovation which creates and realises new clinical procedural opportunities; ▪ Deputising the Facility Manager in their absence.
Management of Service Delivery	▪ Ensures facility clinical and care staff comply with ElderCare's systems, structures, processes, policies and procedures and role models compliant practices at all times; ▪ Ensures all professional codes of practice, clinical standards and contractual and legal obligations are complied with; ▪ Ensures effective, safe and sustainable rostering practices are maintained at all times; ▪ Demonstrates knowledge and respect for the requirements of differing age, socio economic and ethnic backgrounds and promotes diversity awareness within the facility; ▪ Provides an environment that promotes resident safety, independence, quality of life and good health and ensures the incorporation of the LIFE programme into the business-as-usual activities; ▪ Supports the implementation, maintenance and monitoring of health and safety systems; ▪ Demonstrates and actively encourages innovation in service delivery; ▪ Promptly and effectively addresses any clinical issues raised and discusses those with residents family members and medical personnel; ▪ Proactively drives multi-disciplinary meeting and outcomes; ▪ Supports the LIFE sponsor to drive the LIFE programme inside of the facility.
Driving Financial Performance	▪ Keeps Facility Manager informed of any clinical care plans that could have a cost implication that needs to be managed; ▪ Ensuring the revenue potential of the facility is maximised through adhering to the Facility Managers planning for occupancy levels, available funding versus individual clients' care costs; ▪ Monitors usage of products in a cost effective way; ▪ Manages bureau and overtime use explaining exceptions and increases to the Facility Manager for the monthly profit and loss statement.
Leadership and Management	▪ Provides vision and purpose to clinical and care staff in a way that they can understand and actively contribute to the realisation of in their role; ▪ Actively coaches and mentors clinical and care staff and encourages peer support and knowledge sharing providing education and training as required; ▪ Actively promotes and supports the development of a performance for results culture and continuous improvement; ▪ Acts as a role model in the areas of personal presentation, professional commitment and clinical management practices; ▪ Improves ownership and worth of their clinical and care team, and builds and encourages an environment that values delivering exceptional service; ▪ Aid the Facility Manager to recruit and retain suitable clinical and care staff to ensure the achievement of set business objectives; ▪ Supervises and direct the work activities and performance of reporting staff. Establishes annual performance objectives and training plans for each staff member and records what has been agreed/ completed on the Performance and Development Review Form in liaison with the Facility Manager; ▪ Manages ElderCare's education programme, also including maintaining relevant records, ensuring that staff are competent to carry out their tasks; ▪ Demonstrates the ability to effectively delegate, make sound decisions and manage up; ▪ Facilitates the career development of the clinical and care staff to enhance service delivery, staff satisfaction and the achievement of key strategic goals. Actively drives the CCP system for all facility staff; ▪ Deals with clinical and family issues in a timely and effective manner and keeps Fa[illegible]y Manager fully informed of issues/resolution and completes

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	appropriate documentation.
Personal Development	▪ Demonstrated commitment to ongoing learning; ▪ Maintaining a learning Portfolio which demonstrates how ongoing learning is influencing how you work, resulting in improvements in the work place.

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Appendix D — ElderCare Policy for Complaints

ElderCare

POLICY FOR COMPLAINTS

STANDARD

Any complaint is documented, followed up and trends analysed so that corrective action is taken to improve the quality of service provided.

This standard is achieved when the following steps are completed:

1. The complainant is informed of their right to access, at any time during the process, an independent advocate who can be provided through the Advocacy Service.

2. All complaints are recorded on a Complaint Form. If the complainant does not wish to document the complaint, the senior staff member documents the complaint recognising the complainant's right to confidentiality. The complaint form includes time and date of complaint occurring, signature and designation of person reporting the complaint. A short explanation of the complaint is included.

3. Reportable complaints may include:
   - unsafe acts or service
   - unexpected, harmful incidents to residents
   - a service not up to standard
   - a service which is late or forgotten
   - patient, resident or relative complaint
   - staff member complaint
   - visiting specialist complaint

4. A complaint form is completed by the staff member, resident or relative who:
   - is involved in the complaint
   - witnesses the complaint, or
   - the complaint was reported to.

5. The complaint form is completed as soon as practicable after the complaint occurs, but before the staff member goes off duty. Residents and relatives have access to complaint forms for completion in privacy and at their convenience.

6. The complaint form is given to the Facility Manager, who considers the complaint and instigates any immediate action necessary.

7. Any complaints considered to be serious in terms of risk to the resident, staff or the organization, including those received from the Health and Disability Commissioner, Ministry of Health or District Health Board, are reported to the Operations Manager and Director of Nursing immediately.
8. All letters arising from serious complaints are proof read by the Operations Manager or the Director of Nursing.

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9. A complaint is acknowledged in writing by the Facility Manager within five working days of receipt, unless it has been resolved to the satisfaction of the complainant.

10. The complaint is investigated by someone without a conflict of interest.

11. Follow up and feedback on any corrective action taken is provided to the complainant as soon as reasonably possible, but not longer than two weeks. If the complaint becomes drawn out, the complainant is updated on progress monthly

12. If the complaint involves a resident and care from another health or medical professional, the complaint is discussed with the health or medical professional and appropriate action taken with due regard for confidentiality.

13. Details of the complaint are recorded the complaint file or log. Complaints are reviewed by the Quality Improvement Team.

14. Trends are reported at the staff QI meeting and monitored in order to develop corrective/preventive action where applicable.

15. Staff and patient confidentiality will be maintained throughout the procedure.

16. The complainant must also be informed of their right to forward the complaint to the Health and Disability Commissioner.

17. The complaints procedure and how to access independent advocacy is made available to all new residents and their families/whanau on admission

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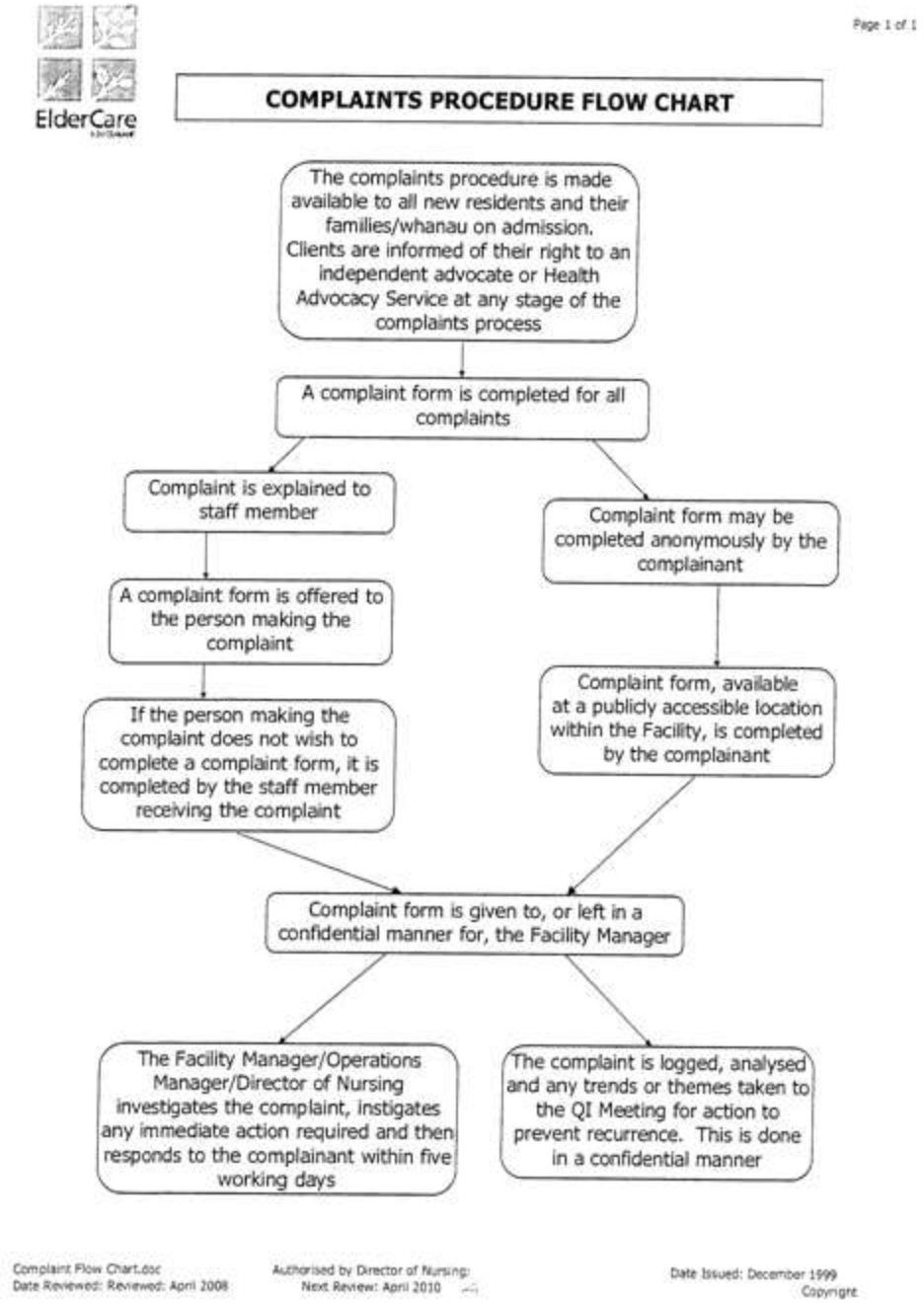

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