Iona Home and Hospital

(Presbyterian Support Otago Incorporated)

A Report by the

Aged Care Commissioner

(Case 20HDC01116)

Health and Disability Commissioner

Te Toihau Hauora, Hauātanga

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Complaint and investigation

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Commissioner.

2. This Office received a complaint from Ms B and Mrs C about the services provided to their father, Mr A, at Iona Home and Hospital, an aged residential care facility operated by Presbyterian Support Otago (PSO). The following issues were identified for investigation:

- *Whether Presbyterian Support Otago Incorporated provided Mr A with an appropriate standard of care in 2019 and 2020.*
- *Whether Ms D provided Mr A with an appropriate standard of care in September 2019.*
- *Whether Ms E provided Mr A with an appropriate standard of care in September 2019.*
- *Whether Ms F provided Mr A with an appropriate standard of care in September 2019.*

3. The investigation primarily focused on incidents involving several caregivers in September 2019.

4. The parties directly involved in the investigation were:

Ms B	Complainant/consumer's daughter
Mrs C	Complainant/consumer's daughter
Iona Home and Hospital (Iona)	Aged residential care facility
Presbyterian Support Otago Incorporated	Aged residential care service
Ms D	Senior caregiver
Ms E	Caregiver
Ms F	Caregiver

5. The following people are also mentioned in the report:

Ms G	Manager
Ms H	Activities Coordinator
Ms I	Clinical Manager
RN J	Registered nurse (RN)
RN K	Registered nurse

6. Independent clinical advice was obtained from RN Megan Sendall (Appendix A).

7. Sadly, Mr A passed away following HDC's receipt of Ms B's complaint. I offer my sincere condolences to Ms B and Mrs C for his passing.

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Information gathered during investigation

Introduction

8. This report concerns the care provided to Mr A, a man in his eighties who resided at Iona Home and Hospital. In particular, the report concerns the behaviour of caregivers who attended Mr A on 18 and 19 September 2019, as seen on video footage captured by a hidden camera installed in Mr A's room by his family.

Background

9. Mr A moved into Iona's dementia unit on 1 August 2019 after being referred from the Royal District Nursing Service. This followed concerns from his wife that his dementia was progressing and that she was no longer able to care for him at home. Mr A's diagnoses included Alzheimer's dementia, peripheral vascular disease[1] (resulting in a left leg above-knee amputation in 2017), and suspected cancer of the colon or prostate. Mr A used a wheelchair or a prosthetic leg with a walking frame to mobilise.

10. Mr A's initial nursing assessment was completed by RN K on 1 August 2019. The assessment recorded that Mr A was not independently mobile and was a high falls risk. He required one-person assistance to mobilise to a wheelchair or to put on and take off his prosthesis and to steady him while walking. He used continence products and required assistance with toileting and personal cares.

11. Mr A was also noted to have short-term and long-term memory loss with cognitive difficulties, with the initial assessment recording that Mr A did not recognise his daughter (Ms B) and was unable to recall his wife's name. The assessment described Mr A as 'not oriented to time, person and place'. No specific behavioural challenges were described but it was noted that other residents entering his room and going through his possessions could be a 'trigger'.

12. Mr A's care plan[2] indicated that he was prone to confusion, had difficulty following directions, and therefore required assistance with personal cares. The care plan specified that Mr A required guidance and assistance in dressing and undressing both his upper and lower body. In addition, it specified the need to attend to Mr A's personal cares in a way that did not rush him and reduced his frustration/agitation and maintained his privacy and dignity. A nursing note from 3 August 2019 recorded an incident during which Mr A had become 'physically and verbally aggressive' when staff attempted to assist him with toileting following a fall. Later that day, a caregiver note recorded that toileting was one of Mr A's 'biggest triggers' for aggression.

13. On 5 August 2019, a further nursing note recorded: '[I]t appears that [Mr A] is still resisting assistance from staff.' There were subsequent discussions between nursing staff and Ms B on how best to manage assisting with personal cares, and how to prevent triggers/agitation

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[1] A slow and progressive circulation disorder caused by narrowing, blockage or spasms in a blood vessel.

[2] HDC was provided with the version last updated on 20 December 2019. Typically, the care plan was evaluated every six months.

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related to certain methods. Aggressive and/or agitated behaviours, such as raising his voice and threatening to hit out at staff, were noted frequently in Mr A's clinical records during August and the beginning of September 2019.[3]

14. On 26 August 2019, RN K recorded in Mr A's progress notes that she informed Ms B that there had been a (possibly accidental) incident where Mr A was swinging his arms and hit a caregiver. On 5 September 2019, RN J noted that Mr A's cognition had deteriorated since admission, which made cares difficult to complete, and that Ms B was aware of this.

Incident reports

15. On 22 August 2019, an incident report was completed by caregiver Ms E, who reported that Mr A had hit her across the left shoulder when attempting to transfer him from the commode[4] chair to the bed. Ms E recorded that she informed a nurse of this event. RN J recorded that Mr A became tired and frustrated easily due to dementia and had difficulty following instructions. However, no further recommendations were documented, and the incident was recorded as having been closed by RN J on 30 August 2019.

16. No incident form was completed for the events relating to 26 August 2019.

17. On 31 August 2019, Ms E completed another incident report, which noted that Mr A had swung and hit her across the chest when she was supporting him with his toileting needs. Ms E recorded that she had informed a nurse about the incident. Clinical Manager Ms I noted that a behaviours of concern chart was initiated, and that RN J was to discuss the incident with Ms B. A copy of the behaviours of concern chart was not provided to this Office. The incident was then closed by Ms I on 5 September with a comment to '[c]ontinue to monitor for cause of behaviour'.

18. On 14 September 2019, another caregiver completed an incident report that noted that Mr A had become 'agitated' during cares and had hit and grabbed her by the right arm. The caregiver recorded that she had informed a registered nurse of the behaviour and telephoned Ms B to 'come in to calm [Mr A] down'. The incident form noted that staff had reported Mr A's behaviour as becoming 'increasingly more physical[ly] abusive', that staff were 'distressed' by having to attend to Mr A's 'unpredictable' physical behaviour, and that Mr A required a needs assessment[5] for reassessment of his level of care. The investigation was signed off by Ms I on 16 September 2019 with a plan to discuss the issue with Mr A's family, and a note that strategies were in place to minimise these events, although the strategies were not specified.

19. PSO told HDC that usually, incident reports are investigated by a registered nurse and then signed off by the Clinical Manager.

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[3] Evidence of this was documented on 8 August, 22 August, 24 August, 25 August, 26 August, 5 September, 12 September, 14 September, and 16–20 September 2019.

[4] A portable toilet.

[5] It is not known whether a needs assessment occurred.

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Meeting with family and commencement of investigation

20. On 17 September 2019, Ms B attended a meeting with the Ms G, and Ms I and RN J to discuss Mr A's increasing aggressive behaviour and his verbal outbursts towards staff since his admission. Ms B told HDC that she was advised that Mr A might need small amounts of morphine to 'curb his behaviour'. RN J noted that managing the pain in this way might help with the behaviour. Ms B told HDC that she informed Iona staff that Mr A was 'not naturally an aggressive person' and that this type of behaviour was 'totally out of his character'.

21. Ms B said that she was concerned that no consideration was given to the possibility that the way Mr A was being treated by staff could be a cause of his behaviour.

22. Ms B stated that on 18 September 2019, she and Mr A's other daughter, Mrs C, installed a hidden CCTV camera in Mr A's private room. The camera was installed without the knowledge or awareness of staff. Ms B told HDC that the reason for installing the camera was to observe Mr A's interactions with staff and to determine the reason for the 'dramatic change' in his behaviour. Footage of Mr A's room was recorded during the night of 18 September and the morning of 19 September 2019, including several interactions between Mr A and his caregivers.

23. On 19 September 2019, Ms B raised a complaint with Ms G alleging that caregivers at Iona had behaved abusively towards Mr A.

24. On 20 September 2019, PSO sought a copy of the footage from Ms B and commenced an investigation into the family's concerns about the abusive behaviour. The investigation was led by an independent external reviewer. PSO told HDC that the scope of the investigation did not include examination of the staffing and team structures or the culture of the workplace but was instead to determine whether the allegations of abuse could be substantiated. The investigation report was completed on 27 October 2019, and the final summary was shared with Mr A's family on 9 December 2019.

25. PSO's investigation found that the allegations made against the staff in the footage were substantiated. PSO told Ms B that it was 'extremely sorry for failing to safeguard the wellbeing of [Mr A] from 1 August 2019 up until the beginning of the investigation'.

26. PSO acknowledged that its investigation 'took too long' and noted that although the investigation was commenced quickly, it was several months before it was concluded and Mr A's family were notified of the outcome. PSO explained that the delay occurred because the external reviewer was already committed to work with another organisation for a period during the investigation. However, PSO said that in retrospect, it could have engaged another appropriately qualified person to undertake the review to ensure that it was completed in a timely way.

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18 September 2019 — incident with Ms D and Ms F

Video footage

27. HDC was provided a copy of the video footage recording the interactions of caregivers Ms D and Ms F with Mr A on the night of 18 September 2019.

28. The footage shows that at 9.08pm on 18 September 2019, Mr A was sitting on the bed in his room with Ms D present. At approximately 9.10pm, Ms D brought a vacuum cleaner into the room and took a commode to Mr A's bedside. She told Mr A that she needed to change the sheets of his bed as they were wet. During the next several minutes, Ms D repeatedly asked Mr A to 'come sit on' the commode. Ms D did not offer or provide any assistance to help Mr A to mobilise. Mr A's response to these requests was inaudible, but the footage shows him leaning towards the side of the bed against the wall and fiddling with the sheets. Mr A appeared to be uncomfortable and to be struggling to understand Ms D's request.

29. At approximately 9.15pm, Ms F entered the room and spoke briefly with Ms D before Ms F started to vacuum the room. Mr A was now leaning over the bed and looking around his feet and under the bed. At approximately 9.18pm, Ms F asked Mr A to reposition himself so that she could remove the sheets. Mr A complied, and the sheets were removed. Over the next several minutes, Ms D and Ms F repeatedly instructed Mr A to mobilise in an attempt to transfer him from the bed to the commode so that the sheets could be changed.

30. At approximately 9.23pm, Mr A stood and swivelled, and moved to the commode without assistance. He then asked the caregivers: '[W]ho is pulling that [clothes? closed?].' It is not clear from the footage what Mr A was referring to. After a few moments, Ms D raised her voice and said to Mr A: 'Now sit there and just behave.'

31. At approximately 9.27pm, Ms D stood behind Mr A and said: 'Stand up [Mr A] so I can pull your pants up please.' She then loudly repeated 'pull your pants up'. Mr A appeared confused and said something inaudible. Ms D then moved in front of Mr A, pointing her finger at his face, and Mr A raised his hand. Ms D said: 'Don't raise your fist. Cut it out. Pull your pants up. That's all I wanted.' Mr A then attempted to speak while Ms D was speaking; however, the exchange was inaudible.

PSO's investigation findings

32. PSO's investigation described the footage as showing Ms D 'shouting and speaking loudly [at Mr A] in an aggressive and abrupt tone' over a period of eight minutes, gesturing at him 'angrily' with her finger and 'failing to adequately communicate or explain' to him what was happening. PSO described Ms D's behaviour as abusive in terms of the loudness and level of aggression.

33. PSO also noted that Ms F was not seen to stop Ms D or say anything to Ms D about her behaviour. There was no evidence that Ms F reported the incident or raised concerns about Ms D's behaviour and, instead, it was found that Ms F repeated Ms D's behaviour to Mr A on 19 and 20 September.

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34. PSO concluded that the allegations of abuse towards Mr A were substantiated, and that the behaviour of both Ms D and Ms F were not in line with its Enliven Philosophy[6] and Code of Conduct.

Information provided to PSO by Ms D

35. Ms D acknowledged to PSO that her behaviour towards Mr A on 18 September was 'wrong', and she said that she 'deeply regretted' what happened. Ms D stated that during that week she had worked for six days without a break. PSO acknowledged this and said that it was possible that the rostering issues had contributed to the incident.

36. Ms D told PSO that Ms B had told her to be firm with Mr A and to use words like 'get your butt into bed'. Ms B told PSO that she had asked Ms D to be assertive with Mr A in getting him into bed but denied using any specific words for Ms D to use.

Information provided to PSO by Ms F

37. Ms F told PSO that she is 'extremely regret[ful]' of what happened to Mr A on 18 September 2019. She stated that she shook her head 'a couple of times' at Ms D to indicate that she was not happy with her shouting at Mr A.

38. Ms F told PSO that she did not document or report the incident as she felt 'fearful and intimidated' by Ms D. Ms F explained that previously Ms D had told her to be more assertive with Mr A and had expressed dissatisfaction at Ms F taking a softer approach. Ms F said that she felt that she needed to defer to Ms D, 'who sees herself as a boss'.

39. PSO staff acknowledged that Ms D was 'a strong personality with a loud voice' but found no specific evidence that Ms D intimidated or bullied Ms F. However, PSO accepted that it was possible that Ms F felt intimidated by Ms D.

40. PSO said that Ms F acknowledged that there was 'plenty of support and opportunity' for her to report the incident and was aware that she should have done so. PSO did not provide details of the support available; however, PSO said that Ms F had opportunities to raise her concerns on 20 and 24 September, but instead raised other issues.

Information provided to PSO by Ms G and Ms I

41. Ms G and Ms I told PSO that Ms F had admitted to repeating Ms D's behaviour on 19 and 20 September. Ms G said that this meant that Ms F had pointed her finger and shouted at Mr A, in order to be 'assertive' as Ms D had recommended to her. However, Ms F admitted that this did not work and resulted in Mr A hitting her. In response to the provisional opinion, Ms F denied pointing her finger or yelling at Mr A.

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[6] PSO's aged-care services are provided under the name 'Enliven'. The Enliven Philosophy refers to principles of caring, enabling, and supporting people to be healthy and happy and have choices so that they can make decisions for themselves, be connected to their family/whānau, friends, and community, and receive the practical support they need.

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42. An incident report completed for 20 September outlined that Mr A had hit Ms F, but no incident report was completed for 19 September.

Information provided to HDC by Ms F

43. In response to the provisional opinion, Ms F told HDC that a month or two before the incident of 18 September, Mr A's care plan was changed, and she was instructed by the unit nurse that on the afternoon shift, only the senior caregivers would care for Mr A because of his high needs. Ms F said that she was 'happy' with this decision because she felt that she did not have adequate training to care for a resident with 'such high needs'.

44. Ms F told HDC that during the incident of 18 September, she got down on her hands and knees and spoke softly to Mr A, 'showing empathy and kindness', and also asked Ms D if she could try a technique she had used with other residents. Ms F reiterated that she shook her head with disagreement as she had found Ms D's yelling alarming.

45. Ms F said that she did not report Ms D's behaviour because she was shaken by the experience. She stated that 'nothing was ever done' regarding previous complaints made about Ms D by other staff members, and she believed her complaint would 'fall on deaf ears'.

Earlier incident involving Ms D

46. In addition, PSO investigated an allegation from Ms H that Ms D had spoken abusively towards Mr A on 9 September 2019. Ms H told PSO that she had witnessed Ms D repeatedly shouting at Mr A to move when he was found to be blocking a corridor with his wheelchair. Ms D told PSO that she did not agree with Ms H's recollection of the incident and was unsure of the number of times she asked Mr A to move. PSO concluded that on the balance of evidence, the allegation was substantiated and that it was likely that Ms D had raised her voice.

PSO's comments to HDC

47. PSO told HDC that it is common for a senior caregiver to assume a leadership role in this kind of setting, and that Ms D had 'a great deal of mana'. PSO explained that Ms D's education, experience, and skills made her the logical choice to be this leader. PSO reflected that the roster pattern and the fact that no registered nurse was based in the unit during the late afternoon, evening, and night contributed to a situation that allowed Ms D to overstep her boundaries.

19 September 2019 — early morning incident with Ms E

Video footage

48. The footage shows that at 5.49am on 19 September 2019, Mr A was sitting on the side of the bed with his legs off the edge, fiddling with his sheets and blankets. At approximately 5.52am, a caregiver, Ms E, entered Mr A's room. Ms E took the sheets off Mr A so that she could place a continence product on him. She pulled the continence product halfway up Mr A's legs, then told Mr A to 'pull [his] pants up' and left him to pull up the product the rest of the way.

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49. Mr A fiddled with the continence product for several minutes and appeared confused. Ms E repeatedly told Mr A to pull up the product, including stating, 'Pull them up or not, I don't care', and 'Hurry up'. At approximately 5.57am she attempted to assist Mr A to pull up the continence product. Ms E can be heard saying: 'Cover yourself up please, I don't need to see all of that. Pull your pants up [Mr A].' Eventually, the product was placed successfully.

PSO's investigation

50. PSO's investigation found that the footage showed Ms E 'instructing' rather than assisting Mr A, and that her behaviour in repeatedly requesting that Mr A pull up his pants showed a lack of empathy and care towards him. PSO described Ms E's behaviour as 'disrespectful and at times patronising'. PSO also noted that Ms E left Mr A alone to put on his continence product when he appeared to need assistance, and that this escalated his behaviour, making it more difficult to settle him.

51. PSO concluded that Ms E's behaviour was not in line with its Enliven philosophy or Code of Conduct.

Information provided to PSO by Ms E

52. Ms E acknowledged to PSO that she had not behaved appropriately towards Mr A, and that she should have remained calm, slowed down, and spent more time with him. She explained that Mr A was more likely to sit and fiddle without instruction, and that she was wary of attempting to assist with the continence product because previously Mr A had hit her when assisting. She stated that she discussed Mr A and his behaviours with Ms D and expressed her concerns.

53. Ms E told PSO that she did not feel appropriately trained to manage dementia patients. She stated that she had received de-escalation training but did not find this beneficial for Mr A and the behaviours he was displaying. PSO provided HDC with an education summary that indicated that Ms E had attended dementia training days at Iona during 2015 and 2019 (prior to the incident) and had completed a Dementia Limited Credit Programme during 2016.[7] Ms E had also attended other training sessions.[8]

54. Ms E said to PSO that she did not get her allocated breaks during the eight-hour shifts that she worked. She stated that on the morning of the incident, she had been working on her own and had not had a break. She also said that she had experienced migraine headaches during the night because of stress around how to manage Mr A, but she had felt obligated to work despite not feeling well. She stated that she was under a lot of stress and was emotionally drained and exhausted from working with Mr A.

[7] A programme that supports caregivers working in or entering the dementia residential field by teaching the essential knowledge and skills required for working with consumers affected by dementia. Learning and assessment for this qualification occurs in the workplace.

[8] Other relevant training sessions attended by Ms E included 'Code of Rights' training in 2018 and 2021, 'Philosophy of Care' training in 2014 and 2015, and 'Restraint Minimisation' training in 2021.

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55. PSO acknowledged that rostering issues may have contributed to the incident and that there was evidence that Ms E 'was not at her best'. PSO acknowledged that this may have affected Ms E's decision-making.

56. Ms E also told PSO that incidents involving Mr A had been reported either via incident forms, in progress notes, or verbally, but there had been no response or follow-up from the registered nurses or management. However, PSO's investigation found that there was evidence that incident reports were investigated, and that steps were taken to manage Mr A's behaviour. PSO did not provide any further details of the steps taken.

Information provided to HDC by Ms E

57. Ms E told HDC that she recalled telling Ms D a few days prior to 19 September 2019 that she was 'not coping' and 'did not want to be at work and crying'. Ms E said that on 19 September she had a migraine, and she acknowledged that she should have called in sick.

58. Ms E told HDC that she was the only caregiver within the dementia unit on the night shift of 19 September and was responsible for 14 residents. She stated that she had no breaks during this shift and was emotionally drained, and her tiredness affected her ability to deal with the situation.

59. Ms E said that several staff had declined to care for Mr A or had been removed from his care because of difficulties in providing care. Ms E also told HDC that she was increasingly cautious and anxious because of the incidents where Mr A had hit her, and that his behaviour was unpredictable. She said that this affected the manner in which she assisted Mr A on 19 September, but she did not knowingly withhold support or assistance from him. She stated that she repeated her requests and had tried several different ways to assist Mr A in pulling up his pants over 17 minutes, including being gentle and encouraging, but this was not successful.

60. In relation to the tone of her voice, Ms E said that she was emulating another caregiver whom she had observed working effectively with Mr A, and the tone may have come across as condescending, but this was not her intention.

61. Ms E acknowledged that she had received de-escalation training but said that she did not find this helpful in managing Mr A's behaviour. She stated that staff needed better recommendations, guidance, or support on how to manage Mr A's escalating behaviour and how to protect themselves, especially following the completion of the incident reports.

Further information

Workplace culture

62. PSO undertook a review of the workplace culture at Iona following its investigation into the abuse allegations from Mr A's family. PSO told HDC that the staff interviewed as part of this review overall 'enjoyed coming to work, loved the residents they worked with and appreciated their colleagues'. However, PSO noted that some staff felt that issues or conflicts they raised were 'not managed as well as they could have been'. Regarding factors

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that potentially prevented staff from reporting bad behaviour, one staff member in the dementia unit commented that they did not want to be seen as 'narking' on another staff member. However, this staff member also stated that they would not be afraid to speak out if they saw anyone treating residents badly.

63. HealthCERT told HDC that it did not receive any section 31[9] notifications from Iona Home and Hospital.

Education

64. PSO said that caregivers were well trained to undertake their roles. However, PSO acknowledged that 'clearly some [staff] were not able to put their learning into practice[,] especially when it came to issues around understanding residents' rights, advocacy, managing behaviour etc'.

65. PSO said that at the time of the events, nine out of its 12 caregivers had completed their Dementia Limited Credit Programme. Six caregivers had also completed the 'Walking in Another's Shoes' training programme.

66. PSO told HDC that it provided its staff with education on the following topics over August and September 2019: 'Whanaungatanga — Cultural training', 'Courageous conversations in the workplace', 'Manual handling', and 'Enliven Values and Philosophy'.

67. PSO said that at the time of the events, a new registered nurse had just been appointed in the lead role. Whilst she had worked at Iona for some time and had worked with people with dementia previously, she had not worked within a dementia unit. The nurse acknowledged that she would have benefited from a more detailed orientation to her role and responsibilities.

Resourcing

68. PSO said that when compared with the wider sector nationally, staffing for the dementia unit fell within the median quartile range.

69. PSO said that the dementia unit does not have a registered nurse rostered on during the afternoon, evening, or night shifts, which is not uncommon. However, a registered nurse would always be working within another unit in Iona's facility and could be called upon for assistance. The Aged Residential Care contract with Health New Zealand|Te Whatu Ora states that there must be at least one caregiver on duty in the Dementia Unit at all times; however, it does not specify that a registered nurse is required.

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[9] Section 31(5) of the Health and Disability Services (Safety) Act 2001 requires certified providers to notify the Director-General of Health about any health and safety risk to residents or a situation that puts (or could potentially put) the health and safety of people at risk.

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Relevant standards

70. The New Zealand Health and Disability CORE standards[10] in place at the time of events stated:

> 'Standard 1.3 Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence
>
> Criteria The criteria required to achieve this outcome shall include the organisation ensuring:
>
> …
>
> 1.3.3 Consumers shall be addressed in a respectful manner by their preferred name.
>
> 1.3.6 Services are provided in a manner that maximises each consumer's independence and reflects the wishes of that consumer.
>
> 1.3.7 Consumers are kept safe and are not subjected to, or at risk of abuse and/or neglect
>
> …
>
> Standard 3.6 Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.
>
> Criteria The criteria required to achieve this outcome shall include the organisation ensuring:
>
> …
>
> 3.6.4 The consumer receives safe and respectful services in accordance with current accepted good practice, and which meets their assessed needs, and desired outcomes.'

Response to provisional opinion

Ms D

71. Ms D was provided with a copy of the provisional report and given an opportunity to comment on the report. Ms D confirmed to HDC that she had no comments.

Ms F

72. Ms F was provided with a copy of the provisional report and given an opportunity to comment on the report. Ms F told HDC that the incident of 18 September 2019 was a terrible experience, and she regrets not feeling strong enough to leave the room to get a registered nurse. Ms F said that she now works elsewhere and will never return to work as a caregiver. Other comments provided by Ms F have been integrated elsewhere in the report.

Ms E

73. Ms E was provided with a copy of the provisional report and given an opportunity to comment on the report. Ms E told HDC that she accepted that her communication was 'disrespectful and inappropriate at times' towards Mr A. Ms E acknowledged that she should

[10] New Zealand Health and Disability Services (CORE) Standards (NZS 8134:2008).

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have remained calm and tried other techniques when communicating to Mr A. Further, Ms E stated that she has expressed her sincere apologies to Mr A and his family. Other comments provided by Ms E have been integrated elsewhere in the report.

Mr A's family

74. Mr A's family was provided with the 'information gathered' section of the provisional report and a meeting was held with the family to discuss the report. The family expressed disappointment with PSO's management and the culture at the care home. The family would like the providers to be held accountable and emphasised that they did not want any other residents to endure what their father experienced.

75. The family stated that there were some gaps in the information gathered. However, they accepted that further attempts to gather information would delay the investigation process, and that any new information may not necessarily change HDC's final decision. The family expressed a desire for closure and said that they are reassured by the follow-up actions to be taken by HDC in response to the investigation. This includes the sharing of the investigation report with the agency that completes certification audits on PSO, publication of the investigation report, and monitoring of the recommendations.

PSO

PSO was provided with a copy of the provisional report and given an opportunity to comment on the report. PSO told HDC that it accepted the findings.

Opinion: Ms D — breach

Introduction

76. Ms D was one of two caregivers (along with Ms F) involved in the incident of 18 September 2019. As a healthcare provider, Ms D had a responsibility to comply with the Code of Health and Disability Services Consumers' Rights (the Code). After reviewing all the information on file, it is clear that Mr A did not receive care from Ms D that was safe, respectful, or consistent with his needs. Ms D's actions were inconsistent with her responsibilities as a caregiver, and it is my view that individually she was accountable for her conduct. In forming my decision, I have considered independent clinical advice from aged care advisor RN Megan Sendall, and I refer to this throughout my opinion.

Lack of respect — breach

77. The footage of the incident on 18 September 2019 shows Ms D speaking in a rude and aggressive manner towards Mr A. She repeatedly spoke loudly to Mr A, gestured angrily, and failed to communicate or explain to him what was happening, despite Mr A appearing confused.

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78. RN Sendall described Ms D's language as 'sometimes threatening and at other times bullying' towards Mr A, and as demonstrating 'abusive behaviour'. PSO's investigation similarly described Ms D's behaviour as 'abusive'.

79. RN Sendall said that the way in which Ms D communicated with Mr A was 'never acceptable' and advised that her behaviour amounted to a significant departure from the accepted standard of care.

80. I accept this advice. Ms D spoke to Mr A in a harsh tone and behaved rudely and aggressively towards him, and I agree with the above descriptions of Ms D's behaviour as abusive. Every consumer has the right to be treated with respect, and previously this Office has highlighted the critical importance of providing respectful care to those who are vulnerable, dependent on their caregivers, and less able to advocate for their own interests.[11]

81. I consider that the footage shows Ms D demonstrating a highly concerning lack of respect for Mr A, and I agree with RN Sendall that the conduct Ms D displayed is never acceptable. I further note that Ms F told PSO that Ms D had directed her to be assertive with Mr A and expressed dissatisfaction when Ms F took a 'softer' approach. I consider that this indicates that the approach Ms D displayed towards Mr A in this footage may not have been an isolated lapse of judgement.

82. I am particularly concerned about Ms D's behaviour given Mr A's vulnerability as a person with a complex medical history within a supported living environment. Mr A's family trusted staff to treat Mr A with respect and dignity and to enable him to accomplish basic daily tasks, and I consider that Ms D's behaviour violated this trust. Furthermore, there was a marked imbalance of power between Mr A, who had dementia, and Ms D, an experienced caregiver. People with dementia can be particularly vulnerable to abuse due to their incapacity to advocate for themselves, which can make it harder to establish whether abuse is taking place, and by whom.

83. I acknowledge that Ms D told PSO that Mr A's family had advised her to be assertive with him when getting him into bed. There is disagreement between Ms D and Ms B regarding what specific words Ms D was advised to use. Ultimately, I do not find it necessary to make a factual finding on this matter, as I do not consider that Ms B anticipated or intended to endorse the rude, disrespectful, and aggressive approach demonstrated by Ms D in the footage of this incident. If Ms D believed that an 'assertive' approach required her to act in this way, I find this very concerning.

84. I acknowledge that Ms D has since expressed regret to PSO for her actions. I also acknowledge that PSO found during its investigation that Ms D had worked seven shifts in the week leading up to the incident without a break, due to short staffing. I am concerned by this, and comment further below on the responsibility of PSO regarding what happened. However, while I have taken into account that Ms D was likely under additional pressure at

[11] See complaint investigation 18HDC00859.

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the time, I do not consider that this justifies her behaviour, nor does it significantly mitigate her departure from the accepted standard of care.

85. For the reasons set out above, I consider that Ms D failed to provide respectful care to Mr A, in breach of Right 1(1) of the Code.

Transfer of Mr A — breach

86. Mr A had a complex medical history. His care plan noted that he was not mobile independently, was a high falls risk, and required assistance when mobilising, dressing, and undressing. In addition, Mr A's care plan stated the importance of acting in a way that reduced his agitation and did not rush him.

87. The footage of the incident of 18 September 2019 shows Ms D repeatedly asking Mr A to leave the bed and 'come sit on' the commode so that the sheets could be changed. Ms D did not provide any physical assistance to Mr A, and Mr A appeared to be uncomfortable and struggling to understand her request.

88. After reviewing the footage, RN Sendall observed that safe techniques for transferring Mr A were not followed. She advised that the way in which Mr A was transferred from the bed to the commode (by instructing Mr A to stand and swivel) was not recommended practice and did not meet PSO's moving and transfer guidelines. RN Sendall considered that this amounted to a moderate departure from the accepted standard of care.

89. RN Sendall also noted that Mr A was repeatedly asked to perform tasks that he found challenging, and he did not receive the gentle support and assistance he needed to complete the requested tasks. RN Sendall advised that this amounted to a moderate departure from expected practice.

90. I accept this advice, and I am critical of the standard of care Ms D provided to Mr A during his transfer from the bed to the commode. While often it is desirable and appropriate to encourage and support independence, given Mr A's medical history, care plan, and high risk of falls, it was unsafe and inconsistent with Mr A's needs to encourage him to mobilise independently. Based on RN Sendall's advice, I consider that Ms D should have provided Mr A with supportive physical assistance in a gentle and patient manner. I note that Ms D's instructions to Mr A to pull up his pants also did not align with his care plan, which stated that he required assistance in dressing and undressing his lower body.

91. I acknowledge that Ms D was not the only caregiver present in the room during the incident of 18 September 2019, and I discuss Ms F's involvement separately below. However, I note PSO's statement that Ms D was a senior caregiver with a strong personality, who had assumed a leadership role over her fellow caregivers due to her education, experience, and skills. Given this team dynamic, and that it was Ms D who first asked Mr A to move and requested that he pull up his pants, I consider that Ms D bears primary accountability for the inappropriate care provided to Mr A in this instance. Accordingly, I find that Ms D did

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not provide services in a manner consistent with Mr A's needs, in breach of Right 4(3) of the Code.

92. PSO told HDC that it has undertaken a review of its workplace culture and identified areas that could be strengthened. I will discuss the changes made by PSO in this area since these events, and the actions I will be taking to follow up the matter, later in this report.

Additional allegation of abuse on 9 September 2019 — no breach

93. I note that PSO also investigated an additional allegation made against Ms D by Ms H.

94. Ms H alleged that Ms D had been verbally abusive towards Mr A on 9 September 2019, by shouting at him and repeatedly asking him to move when his wheelchair was blocking a corridor. Ms D denied this allegation. During my investigation of this complaint, I have received no other information that substantiates Ms H's allegation.

95. Whilst PSO upheld Ms H's allegation, the absence of evidence available to me on this point means that for the purposes of this investigation, I cannot make a finding that this happened.

Opinion: Ms F — breach

Introduction

96. Ms F was one of two caregivers (with Ms D) involved in the incident of 18 September 2019. As discussed in the preceding section, I consider that Ms D held primary responsibility for the substandard care provided to Mr A, as she was the senior caregiver at the time of events. Nonetheless, I am critical about Ms F's conduct during this incident.

Failure to intervene — breach

97. The footage for the incident of 18 September 2019 shows that Ms F did not intervene to stop Ms D's aggressive and abusive behaviour towards Mr A or raise any concerns with Ms D about her manner of communication.

98. Ms F told PSO that she regrets what happened and that during the incident she shook her head at Ms D a couple of times to indicate that she was not happy with her shouting at Mr A. Ms F is not seen to be shaking her head in the footage, but I note that Ms F is not always visible. However, even if Ms F did shake her head, I consider that this would have been insufficient action in any event.

99. After reviewing the footage, RN Sendall advised that the 'general engagement between [Ms F] and [Mr A] was not supportive, kind or effective'. RN Sendall noted that it was concerning to see Ms F witness bullying and inappropriate language from Ms D to Mr A without any meaningful response or intervention. RN Sendall stated that Ms F's 'lack of advocacy and

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compassion was evident' and advised that Ms F's behaviour demonstrated a mild departure from the expected practice.

100. I accept this advice. It is disappointing that Ms F did not speak up or intervene during Ms D's inappropriate behaviour towards Mr A. Mr A was in a vulnerable position and relied on his caregivers for support. As I have stated above, people living with dementia can be particularly vulnerable to abuse due to their incapacity to advocate for themselves, which can make it harder to establish whether abuse is taking place, and by whom.

101. I acknowledge that Ms F told PSO that she felt 'fearful and intimidated' by Ms D and that she needed to defer to Ms D as she saw herself as a boss. PSO's own investigation did not find any specific evidence that Ms D intimidated or bullied Ms F but acknowledged that it was possible. I accept that if this was the case, this could to some extent explain a lack of intervention at the time. However, I note that Ms F had further opportunities to raise her concerns on 20 and 24 September but did not do so (discussed further below). While I consider that Ms D bears primary responsibility for showing disrespectful behaviour towards Mr A, I am critical that Ms F's lack of intervention and failure to advocate for Mr A contributed to this situation.

102. For the reasons set out above, I consider that Ms F failed to provide respectful care to Mr A, in breach of Right 1(1) of the Code.

Failure to complete incident report — adverse comment

103. Following the incident of 18 September, Ms F failed to report what had happened to senior staff or management.

104. PSO's position description for a caregiver states that caregivers must act 'as an advocate for residents by reporting issues or concerns to the Registered Nurse or Manager', and that all employees are expected to report issues that may cause harm to others in the organisation, in compliance with health and safety standards. Similar requirements are outlined under section 32 of the Aged Care Services Collective Agreement (dated 2019–2020) and PSO's Code of Conduct policy. By failing to report this incident, Ms F did not comply with the above policies and standards, and I am critical of this.

105. Ms F said that she had intended to report Ms D and had written a letter about Ms D with the intention of handing the letter to Ms G. However, PSO's investigation found that this did not occur. Although Ms F was working on a night shift on 19 September, she had contact with RN J on 20 September, and with Ms G on 24 September, when she had the opportunity to raise these issues. By not utilising opportunities with staff to raise her concerns and/or report the incident, Ms F did not act professionally and again failed to advocate for Mr A's wellbeing.

106. I acknowledge Ms F's view that 'nothing was ever done' regarding previous complaints made about Ms D by other staff members. However, this does not absolve Ms F from her professional responsibility to report inappropriate behaviour, and I am concerned about Ms

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F's failure to advocate for Mr A. I am also critical of the culture at Iona, which I discuss further below.

107. For the safety and wellbeing of both consumers and providers of health care, it is of paramount importance for an organisation to foster an environment that embraces open disclosure. Staff must feel empowered to advocate for patients and speak up regarding more experienced colleagues if they observe them acting wrongfully. I discuss the matter of the workplace culture at Iona under my opinion on PSO.

Transfer of Mr A — adverse comment

108. The footage for the incident of 18 September 2019 shows that at approximately 9.18pm, Ms F asked Mr A to reposition so that she could remove the sheets. Mr A complied, and the sheets were removed. During the next few minutes, Ms F joined Ms D in repeatedly instructing Mr A to mobilise in an attempt to move him from the bed to the commode. When Mr A eventually stood and swivelled to sit on the commode, Ms F did not assist him to mobilise.

109. As discussed earlier in this report, RN Sendall advised that instructing Mr A to stand and swivel was not a safe transfer technique and did not meet transfer guidelines. RN Sendall considered that this amounted to a moderate departure from expected practice. RN Sendall further advised that Mr A was repeatedly asked to perform tasks known to be challenging for him, and that all caregivers in the footage failed to provide the gentle support and assistance Mr A needed to complete the requested tasks. RN Sendall concluded that this also was a moderate departure from expected practice.

110. I accept this advice, and I am critical of Ms F for joining Ms D in transferring Mr A in an unsafe manner that was not in line with expected practice. Nonetheless, considering my view that the primary responsibility for this incident lies with Ms D as the more experienced caregiver who assumed a position of leadership between herself and Ms F, I consider that this mitigates against a finding that Ms F breached the Code.

Behaviour towards Mr A on 19 and 20 September — no breach

111. Ms G and Ms I told PSO that Ms F had repeated Ms D's behaviour towards Mr A on 19 and 20 September. Ms G told PSO that Ms F had admitted to pointing her finger at Mr A and shouting at him, to be 'assertive'. Ms F had told Ms G and Ms I that her behaviour had caused Mr A to hit her.

112. Ms I did not specify what Ms F's behaviour was on 19 and 20 September. Further, Ms F told HDC that she did not yell or point her finger at Mr A.

113. An incident form confirms that Mr A hit Ms F on 20 September. However, no incident forms were completed for 19 September.

114. Ms F did not admit this behaviour directly to PSO when interviewed, and there is no video footage to verify Ms G and Ms I's statements.

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115. Based on the above information, I am unable to make a finding as to whether Ms F acted inappropriately towards Mr A on 19 and 20 September.

Opinion: Ms E — breach

Introduction

116. Ms E was the sole caregiver involved in the incident on 19 September 2019. Both Mr A's initial nursing assessment and care plan specified that he had cognitive difficulties that made it difficult for him to follow directions, and that he required assistance with personal cares.

117. As a healthcare provider, Ms E had a responsibility to comply with the Code. After reviewing all the information on file, it is clear that Mr A did not receive care from Ms E that was safe, respectful, or consistent with his needs. Ms E's actions were also inconsistent with her responsibilities as a caregiver, and it is my view that she was individually accountable for her conduct.

Lack of respect — breach

118. The footage for the incident on 19 September 2019 shows Ms E putting a continence product halfway up Mr A's legs and then repeatedly asking Mr A to pull up the product the rest of the way. Ms E displayed impatience by raising her voice and asking Mr A to 'hurry up' before eventually assisting Mr A in pulling up the continence product. She also used demeaning language, telling Mr A, 'Pull them up or not, I don't care', and 'Cover yourself up please, I don't need to see all of that'.

119. PSO's investigation found that Ms E's behaviour showed a lack of empathy and care towards Mr A and described her communication as 'disrespectful and at times patronising'. Ms E acknowledged that she should have remained calm and tried other techniques when communicating with Mr A.

120. RN Sendall noted that Ms E's repeated instructions using a negative tone lacked insight into Mr A's lack of response. RN Sendall said that it appears that Ms E did not consider the extent of Mr A's cognitive decline and the support he needed. RN Sendall described Ms E's multiple requests to Mr A to pull up his pants and the statement, 'Pull them up or not, I don't care', as inappropriate and abusive. RN Sendall advised that Ms E's conduct amounted to a moderate departure from expected practice.

121. I accept this advice and agree with both PSO's and RN Sendall's descriptions of Ms E's behaviour as inappropriate.

122. Ms E said that she had been stressed and had been suffering from migraines prior to the incident. I acknowledge this and the fact that Ms E was working alone, had not taken a break during the night of 19 September 2019, and felt obligated to work despite not feeling well.

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Ms E also felt that she was not adequately trained to manage dementia patients, which led to her becoming emotionally drained and exhausted from attempts to work with Mr A.

123. PSO told HDC that it accepted that rostering challenges may have played a role in these events. PSO said that it is taking action to strengthen the education and training provided to staff on dementia care. I discuss these concerns and the changes PSO is making to address these later in this report.

124. I note that Ms E had completed several incident forms reporting that Mr A had shown physically aggressive behaviour towards her, and I will discuss PSO's response to these incidents below. I acknowledge this and the challenge that comes with looking after people with dementia.

125. While the above factors may help to explain Ms E's actions, I consider that they do not excuse the inappropriate nature of her conduct on 19 September.

126. In retrospect, Ms E acknowledged that her behaviour was 'disrespectful and inappropriate', and she has expressed her sincere apologies to Mr A's family. Ms E also acknowledged that her tone may have come across as condescending but said that this was not her intention.

127. It is of paramount importance that caregivers provide respectful care to those who are vulnerable and dependent upon their cares, and under no circumstances is it acceptable to act as Ms E did towards Mr A. Accordingly, I find that Ms E failed to provide respectful care to Mr A, in breach of Right 1(1) of the Code.

Lack of assistance — adverse comment

128. As noted above, Ms E repeatedly asked Mr A to pull up his pants, which resulted in confusion for Mr A, and several minutes passed before Ms E decided to assist him with the task. RN Sendall was critical of Ms E's action of repeatedly asking Mr A to perform a task that he found challenging. RN Sendall advised that Ms E did not consider the extent of Mr A's cognitive decline and the support he needed, and that she should have provided gentle assistance. On a similar note, PSO's investigation found that Ms E instructed rather than assisted Mr A.

129. Ms E told HDC that she had tried many different approaches to verbally encourage Mr A to put on his pants, but her tiredness affected her ability to manage Mr A better. Ms E said that Mr A's behaviour was unpredictable, which also made her increasingly cautious about the way she assisted him. She said that she did not knowingly withhold support or assistance from him.

130. I acknowledge Ms E's comments that she was tired and that she was not deliberately trying to withhold assistance from Mr A. However, I consider that these explanations do not excuse Ms E's conduct. Ultimately, I accept RN Sendall's advice and PSO's investigation finding. I note that both Mr A's initial nursing assessment and care plan specified that he had cognitive difficulties. This made it difficult for him to follow instructions and meant that he required

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assistance with personal cares. I consider that by withholding the support Mr A needed, Ms E did not provide care in line with Mr A's nursing assessment and care plan, and I am critical of this.

Opinion: Presbyterian Support Otago — breach

131. As the operator of Iona Home and Hospital and as a healthcare provider, PSO has a duty to comply with the Code and was required to provide Mr A with services of an appropriate standard. While I consider that the individual caregivers involved are responsible for their inappropriate conduct, I have also examined PSO's role as the organisation with overall responsibility for ensuring Mr A's wellbeing.

Adequacy of care planning — adverse comment

132. PSO had an obligation to meet the Health and Disability Services (NZHDSS) CORE Standards and the Age-Related Residential Care Services Agreement (ARRC agreement) in place at the time of events. Under the NZHDSS and the ARRC agreement, PSO had a responsibility to ensure that Mr A had an adequate care plan. Care plans summarise a person's health needs, goals, and current treatments, which in turn guide caregivers to support older people.

133. RN Sendall advised that Mr A's care plans were developed sufficiently following appropriate assessment on admission. The care plan was completed to meet Mr A's individual needs and included family consultation/preferences for care, and these were reviewed at regular intervals with ongoing nursing and medical input. RN Sendall advised that the caregivers and nursing staff followed the care plans to the best of their ability given the complexity of Mr A's diagnosis and physical and cognitive limitations.

134. However, RN Sendall advised that the overall provision of care fell short of industry standards when abuse was not identified by the organisation. I accept this advice. Although Mr A's care plans had regular input, it is my opinion that the care plans did not focus on Mr A's behaviours of concern sufficiently, and on how these behaviours could be de-escalated. The inadequate care planning compounded by a substandard care home culture meant that the caregivers were not able to provide respectful care that met Mr A's needs. I now discuss the culture within the care home.

Care home culture — breach

135. The NZHDSS require PSO to ensure that those under their care receive adequate and appropriate services that meet their assessed needs and desired outcomes.[12] Standard 1.3 of the NZHDSS requires providers to ensure that consumers are treated with respect and receive services in a manner that has regard for their dignity and safety. This duty includes a responsibility to operate the care home in a manner that instils in its staff a culture of

[12] Standard 3.6.4 of the New Zealand Health and Disability Services (CORE) Standards (NZS 8134:2008).

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treating residents with respect. It is clear from the preceding sections of this report that the care Mr A received fell short of these standards. He did not receive safe and respectful treatment during the incidents that took place on 18 and 19 September 2019, and he did not receive care in a manner consistent with his needs.

136. The video footage shows that the abuse of Mr A was not an isolated incident, but rather repeated actions involving three caregivers. While there is individual accountability for these actions, in my view the widespread failures reflect a culture of disrespect by caregivers at PSO towards those under their care, and a culture of non-compliance with organisational policies.

137. RN Sendall advised that PSO had a responsibility to prevent issues of abuse through appropriate selection of staff, training, rostering, oversight, and performance monitoring. I accept this advice. As a group provider it is PSO's responsibility to ensure that staff display appropriate behaviours towards residents and to take adequate steps to maintain oversight of this.

138. PSO provided evidence that it had given its staff relevant training prior to these incidents, including on topics of managing challenging resident behaviours, managing people with dementia, preventing elder abuse and neglect, and having courageous conversations in the workplace. However, the actions of three caregivers suggest that staff did not understand these topics to a sufficient degree. I also note that Ms E said that she felt she was not adequately trained to manage dementia patients, which led to her feeling exhausted from having to work with Mr A. PSO acknowledged that 'clearly some [staff] were not able to put their learning into practice'. In addition, PSO said that most staff in the unit had considerable experience working with people with cognitive impairment.

139. I note that PSO has acknowledged that it failed to safeguard Mr A adequately. Further, I note that no incident reports were completed on 18, 19 or 20 September 2020 (other than one incident report completed by Ms F). As such, I am also concerned that staff do not have a proper understanding of the importance of incident reporting.

140. In my view, the widespread and repeated nature of these actions by caregivers at PSO reflects a pattern of poor care and a failure to comply with policy and legal standards, for which ultimately PSO is responsible. Accordingly, I find that PSO breached Right 4(2)[13] of the Code.

Resourcing limitations — adverse comment

141. I note that all three caregivers raised concerns about staffing issues within the care home.

142. Ms F spoke of a situation where she had been on her 'own for 2 hours with 14 residents. A number of them with high needs'. Ms E said that on a night shift it was usual for a caregiver

[13] Right 4(2) states: 'Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.'

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to be allocated 14 residents over an eight-hour period, and she never got any allocated breaks. Ms E said that this led her to become exhausted, stressed, and emotionally drained, and that even when she was sick, she had felt obligated to work. Lastly, Ms D said that prior to 19 September 2019, she had been working for seven consecutive days without a break. This included a double shift on 14 September from 10am to 11.15pm. PSO said that efforts were made to obtain cover for this shift, but these were unsuccessful, and Ms D said she felt obliged to complete this double shift and had 'no choice'.

143. PSO said that at the time of the events, there were 11 permanent care workers within the dementia unit of the rest home. Whilst PSO's investigation scope did not cover staffing structures, it said that when compared to the wider sector nationally, staffing levels for the Mackay unit had fallen within the median quartile range. Nonetheless, PSO has acknowledged that issues with the roster pattern may have contributed to a situation that allowed Ms D to overstep her boundaries.

144. PSO said that no registered nurse was based in the dementia unit during the late afternoon, evening, or night shift, which is not unusual across the sector, and under these circumstances it was common for a senior caregiver to assume responsibility. PSO acknowledged that the level of nurse supervision contributed to the incident.

145. The employment agreement between caregivers and PSO states that PSO is responsible for ensuring that it will arrange hours so that employees do not exceed 40 hours in a week, and that employees are entitled to have two ten-minute rest breaks and thirty-minute unpaid meal breaks. However, it appears that this was not followed in Ms E's and Ms D's case.

146. I acknowledge that there is a significant shortage of registered nurses and caregivers across aged care and that Iona's current staffing levels were within New Zealand's median quartile range. However, it is PSO's responsibility to ensure that it operates safely. I am concerned that the safety and wellbeing of the staff at Iona was not being protected, and therefore the subsequent impact this had on the residents' wellbeing. I remind PSO of its responsibilities under the Health and Safety Act 2015 and the ARRC Agreement, to provide a safe environment to its employees.

Delay in investigating changes in Mr A's behaviour — adverse comment

147. PSO was aware that Mr A's behaviour was becoming more challenging prior to the incidents on 18 and 19 September 2019. Incident forms had been completed on 22 August, 31 August, and 14 September, which noted that Mr A had hit staff. Evidence of physical outbursts had also been documented within the progress notes throughout August and September 2019. However, little information was provided to HDC in terms of how these incidents were managed other than what was discussed during the meeting with Ms B on 17 September.

148. On 17 September 2019, staff met with Ms B to discuss the increased physical aggression and verbal outbursts from Mr A towards staff since his admission. Ms B told HDC that she was advised that morphine might be used to curb Mr A's behaviour, and she was concerned that

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no consideration was given to the possibility that the way Mr A was being treated by staff could be a cause of his behaviour.

149. Following this, on 18 September 2019, Mr A's family installed a hidden camera in his room because Mr A's behaviour had been 'completely out of character'. The footage taken during the night of 18 September 2019, and on the morning of 19 September 2019, revealed members of staff acting in an abusive manner towards Mr A, which his family brought to the attention of PSO.

150. I acknowledge that drawing a link between a resident's behavioural changes and staff abusive conduct is not always straightforward. However, as noted by RN Sendall, industry education draws connections between the challenging behaviours of residents and staff management of residents, and I am concerned that it appears that PSO did not consider this or take any action to investigate the potential causes of Mr A's behavioural changes at an earlier stage.

151. The statements provided by the caregivers indicate that Mr A's behaviour was known and expected. It is also apparent that Mr A's behaviour was causing distress to staff, although staff did not appear to complete incident reports routinely on every occasion where there was an incident.

152. RN Sendall advised that the delay in investigating the potential causes of the deterioration in Mr A's behaviour, and identifying the abuse, resulted in the overall provision of care to Mr A falling short of aged-care industry standards. I accept this advice.

153. Based on RN Sendall's advice that it is recognised that the challenging behaviours of residents can be linked to the manner in which staff interact with residents, I consider that the above background warranted PSO exploring whether there was connection between Mr A's challenging behaviour and the conduct of his caregivers. I have not been provided with any evidence by PSO indicating that these connections were explored prior to Ms B raising her concerns.

154. Whilst reluctance by staff to report abusive behaviour may have made it more challenging for PSO to draw a link between Mr A's behaviour and the abuse, PSO had a responsibility to ensure that Mr A received safe and appropriate services, and I am critical of the delay in initiating an investigation of the reasons behind his change in behaviour.

Subsequent investigation of abuse allegations — no breach

155. RN Sendall advised that PSO responded appropriately once it became aware of the footage of the incidents of 18 and 19 September 2019 and the family's allegations of abuse. RN Sendall stated that the investigation was conducted using suitably skilled and qualified personnel, including an external reviewer, and noted that PSO apologised to Mr A's family for the time taken to complete the investigation and respond with the findings.

156. RN Sendall summarised PSO's investigation into the incidents as follows:

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> '[PSO's] actions throughout and following the complaint of abuse, investigation, and employment process, demonstrate they acted appropriately albeit their own acknowledgement of investigation completion delays. Investigation outcomes were analysed, and corrective action completed. A full, genuine and complete apology was made to the family when care provision fell short of PSO's standards, values and family expectations … [T]he organisation responded appropriately and genuinely to the incident of abuse and followed due process to manage risk. Improvements related to education, training and orientation has been completed alongside improved clinical oversight.'

157. I accept this advice, and I am reassured by RN Sendall's view that PSO suitably identified the factors that may have contributed to the potential for abuse, such as rostering, and areas for improvement such as staff training and oversight. PSO acknowledged that its investigation process took too long, and that Mr A's family was not notified of the outcome for several months. I now discuss the changes made by PSO as a result of these events.

Changes made

158. On 9 December 2019 PSO advised Mr A's family that it was taking the following steps at Iona as a result of its investigation into their concerns:

- A Clinical Coordinator who has extensive experience in the area of dementia and is a 'Spark of Life' master practitioner[14] is working with staff at the dementia unit to assist them by identifying different practices and techniques to improve the quality of care for residents. This is to be supplemented with follow-up education sessions by the Clinical Nurse Advisor during 2020.
- All staff in the dementia unit will go through further training on PSO's Enliven Philosophy and Residents' Code of Rights.
- Staff will attend training around Elder Abuse delivered by Age Concern.
- PSO will undertake a review of workplace culture and identify areas that could be strengthened.
- PSO will re-establish the Dementia Continuous Quality Improvement Work Stream and use this as a vehicle to provide support to staff and educate staff working with residents with cognitive impairment.
- PSO will undertake a review of the support mechanisms PSO has in place for staff.
- PSO will review the Enliven Philosophy of Care training module to include the issues raised in Mr A's care as examples (maintaining anonymity).

[14] The Spark of Life International Master Leadership Programme is a course run by Dementia Care International that provides training on best practice management of people with dementia.

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- PSO will modify care worker education on behaviour to include more observation, role playing, and coaching.

159. On 28 January 2022, PSO advised HDC of the following further changes:

- A budget was established to introduce the 'Eden Alternative'[15] model of care to PSO's aged residential care facilities.
- The planned review of workplace culture was carried out, identifying areas that could be strengthened. It was noted that some staff felt that the issues or conflicts they raised were not managed as well as they could have been, prompting the development of a new module education course for senior nurses. De-brief sessions were held so that staff could discuss how they were feeling and how they could support each other and re-build team relations. This education is ongoing.
- Rather than re-establishing the Dementia Continuous Quality Improvement Work Stream, a decision was taken by PSO to complete the Alzheimers NZ 'Dementia Friendly Recognition programme' and achieve the 'Dementia Friendly Award and Accreditation'. This is an organisation-wide approach that ensures that all the services PSO provides are made as easy as possible for people with memory loss to access (including residents and their families). Work had commenced with the establishment of a working group from across PSO, and environmental audits had been completed or scheduled in all 22 of PSO's workplaces. The project will culminate in an audit and update of PSO's policies/procedures, services, and facilities in late 2022 to ensure they are 'Dementia Friendly'.
- Following a review early in 2021, PSO updated and re-issued posters and resources aimed at encouraging staff to report bullying, not be a bystander, and to intervene when they see bullying occurring. PSO also took part in Pink Shirt Day 2021 to promote workplace bullying prevention. PSO is working on a training package in relation to bullying awareness and prevention, covering harassment, discrimination, and being inclusive.
- The Enliven Philosophy of Care training module has been reviewed and updated to include the issues raised in Mr A's care as examples (maintaining anonymity).
- Caregiver training, education, and documentation on behaviour management has been updated several times to include more observation, role playing, and coaching. Training regarding behaviour is also provided in different settings, including formal training sessions, but also 'just in time' training and discussion at handovers and staff meetings where individual residents are discussed.
- Significant effort has been undertaken in upskilling nurses and senior nurses in both leadership and clinical issues, with additional training provided for nurses who have

[15] A philosophy of care that focuses on moving away from the institutional hierarchical (medical) model of care into a constructive culture of 'home', where residents direct their own lives.

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leadership roles as part of their duties. Topics included building an effective team, conflict resolution, and dementia management.

160. In response to the proposed recommendations, Ms D:

- Provided a formal written apology to Mr A's family for the breaches and deficiencies identified in the report.
- Completed the HDC online learning 'Module 1: How the Code of Rights improves health and disability services'.

Recommendations

161. I make the following recommendation to Ms F:

a) Provide a formal written apology to Mr A's family for the criticisms of her care outlined in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Ms B and Mrs C.

162. I make the following recommendations to Ms E:

a) Provide a formal written apology to Mr A's family for the breaches and deficiencies regarding her care identified in this report. The apology is to be provided to HDC within three weeks of the date of this report, for forwarding to Ms B and Mrs C.

b) Complete the HDC online learning 'Module 1: How the Code of Rights improves health and disability services' and provide evidence to HDC that the module has been completed, within three months of the date of this report.

163. Having considered the changes made by PSO since these events, I make the following recommendations to PSO:

a) Provide an update on whether the 'Eden Alternative' model of care has been introduced to PSO's aged residential care facilities, or (if not) when the model will be introduced. As part of this update, PSO is to provide an explanation of how the rollout of this model has helped to address (or will help to address) the issues raised in this report regarding workplace culture, managing challenging resident behaviours, and providing respectful care. This information is to be provided to HDC within three months of the date of this report.

b) Provide evidence of ongoing training, education, and support since 1 January 2022 for staff regarding managing challenging resident behaviours, preventing elder abuse, addressing workplace bullying, and resolving conflicts between staff. This information is to be provided to HDC within three months of the date of this report.

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c) Provide the results of the audit and update of PSO's policies/procedures, services, and facilities in late 2022 to ensure that they are in line with Alzheimers NZ's 'Dementia Friendly Recognition Programme'. As part of this, an explanation should be provided for any ongoing deficiencies identified, including details of any corrective actions being undertaken to address these. This information is to be provided to HDC within three months of the date of this report.

d) Use an anonymised version of this report as a basis for staff training, focusing particularly on the breaches of the Code identified, and provide evidence of that training to HDC within six months of the publication of the anonymised report.

Follow-up actions

164. A copy of this report with details identifying the parties removed, except Iona Home and Hospital, Presbyterian Support Otago Incorporated, and the independent clinical advisor on this case, will be sent to HealthCERT, Health New Zealand|Te Whatu Ora Southern, and Te Tāhū Hauora|Health Quality and Safety Commission and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from RN Megan Sendall on 19 February 2021:

'Assessment of care provided to [Mr A] was conducted through review of documents supplied by Presbyterian Support Otago (PSO) to the office of the Health and Disability Commissioner. They include patient records alongside complaint documentation.

Considerations for this review, relate to care provision by PSO to [Mr A] in particular key areas requested for advice as follows:

1. The adequacy of care planning for [Mr A] and the overall compliance with the requirements of the care plan.
2. The appropriateness of PSO's management of:
   a. [Mr A's] falls risk; and
   b. Incidents where [Mr A] became agitated and/or aggressive towards staff.
3. The overall management of [Mr A's] care during the COVID-19 lockdown in March–May 2020, including whether GP or other input into [Mr A's] care should have been obtained during this period.
4. The adequacy of investigations into [Mr A's] potential urinary symptoms prior to his hospital admission in June 2020.
5. Any other matters considered warranting comment.

Advice includes:

a. The accepted standard of care/practice.
b. Any identified departure from the standard of care or accepted practice and how significant this is considered to be.
c. How this is viewed by my peers.
d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

1. <u>The adequacy of care planning for [Mr A] and the overall compliance with the requirements of the care plan.</u>

[Mr A's] care plan was developed following appropriate assessment following admission and reviewed at intervals. The plan was completed to meet [Mr A's] individual needs and included family consultation/preferences for care. Nursing and medical assessments were ongoing. Additional considerations for review of care planning, include [Mr A's] family's interpretation of engagement and involvement. Coupled with this, the organisation's ability to deliver key aspects of the plan.

In my opinion, there are many challenges regarding the transition between the loving individual care previously provided by families in the resident's home environment and group care provided by employed staff in a residential community setting. It is often difficult for the new resident and their family to adjust to their change in circumstances, loss of independence and provision of group care. It is challenging for staff to meet the

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expectations of loving families who have developed a routine and have provided individual care that they feel meets their loved one's needs in these circumstances.

The change in environment is a major factor for the new resident. Establishing new routines and trying to continue established patterns of activity require adjustment by all participants. The initial care plan developed is sufficiently detailed for staff to provide suitable care in this instance.

Other considerations for the review of care planning, include the family's expectations to continue with all [Mr A's] daily activities prior to admission. Also the organisation's ability to work with the family to find a balance of possible/achievable care delivery and support alongside activities that increased risk in a communal setting.

It is my belief the organisation provided rationale to the family and [Mr A] for the organisation's inability to continue caregiver support from the community and specific exercises requiring equipment. Rationale from allied health consultants related to exercise, walking, and standing also added to the progress note entries and provided insight into what could be achieved. Regular review was completed of functional support. Observations recorded around [Mr A's] willingness to walk, as well as his advancing cognitive change and general decline, indicate walking wasn't always possible or achieved as identified in his care plan. Staff kept on trying to support [Mr A's] independence and mobility.

Overall, in my opinion, the organisation's ability to provide care identified in the care plan was achieved. Care plans are living documents which are changed and responded to in relation to multiple factors and influences daily. [Mr A's] progress notes indicate sufficient information was gathered to reflect any change required to care for him. It is noted the family found documentation gaps following review of facility documentation. In response to this, the organisation initiated service improvement activities. Ongoing review of documentation following corrective action, evidenced documentation had improved. Regardless of historic documentation gaps, progress notes indicate care was provided to meet care goals in most care planning areas. The exception being the area related to the allegations of abuse and on occasion challenging behaviour.

The overall provision of care itself following [Mr A's] entry to service fell short of industry standards when abuse was not identified by the organisation. It is appreciated that this is difficult to identify however industry education draws connections between residents' challenging behaviours and staff management of residents. Following the family's covert video recording of activities in [Mr A's] room, the family were justified in bringing this matter to the organisation's attention and requesting action.

PSO responded appropriately and launched an investigation using suitably skilled and qualified people. The organisation acknowledged the time frame for completing the complaint and responding with the findings to the family was too long and apologised.

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Learnings about this complaint process identified improvements with communication engaged in the complaint procedure.

The standard of care provided to [Mr A] in September 2019 did not meet the organisation's standards. Their actions throughout and following the complaint of abuse, investigation, and employment process, demonstrate they acted appropriately albeit their own acknowledgement of investigation completion delays. Investigation outcomes were analysed, and corrective action completed. A full, genuine, and complete apology was made to the family when care provision fell short of PSO's standards, values, and family expectations.

In summary, it is my opinion that care planning was developed appropriately and that care and nursing staff followed care plans to the best of their ability given the complexity of [Mr A's] diagnosis, physical and cognitive limitations. Staff recorded their attempts to provide care identified in the care plan and solutions to complete cares under challenging conditions to meet family expectations.

In addition, it is my opinion, the organisation responded appropriately and genuinely to the incident of abuse and followed due process to manage risk. Improvements related to education, training, and orientation have been completed alongside improved clinical oversight.

There are no recommendations for the improvement of care planning.

2. **The appropriateness of PSO's management of:**
   a. **[Mr A's] falls risk; and**
   b. **Incidents where [Mr A] became agitated and/or aggressive towards staff.**

a. Falls risk:

[Mr A's] assessments indicated he presented a high risk of falls. Major contributing factors included his amputee status, elimination requirements, advanced cancer diagnosis and cognitive change. Practical solutions were implemented by staff arranging his room to meet [Mr A's] needs and prevent him falling. Actions of staff who were seeking ways to support [Mr A] are recorded alongside communication with family to implement their suggestions.

Staff were presented with a major challenge to balance the support [Mr A] required to maintain independence and maintain mobilisation alongside his increasing cognitive change, sleep and rest challenges, advancing cancer on a background of pain.

I believe the organisation provided adequate assessment, care, sought external advice, and opportunities for family engagement in the management of [Mr A's] mobility requirements during a period of time when [Mr A's] health was declining. Although [Mr A] fell on several occasions, the risk of falling versus the ability for [Mr A] to continue to mobilise at will, was challenging. One on one care to lower the risk of falls, is not available at this level of care or indeed in a communal setting. I believe staff did their best to

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prevent falls for this gentleman in this complex situation. The organisation provided evidence of appropriate staffing to meet industry guidelines for this level of care.

There are no recommendations for the organisation's management of falls.

Response to Agitation:

The family reported [Mr A] was agitated at home mostly during the evening prior to admission. There were documented times when [Mr A] was frustrated with staff attempts to deliver care in keeping with his diagnosis of Alzheimer's Disease, identified triggers and change of environment. [Mr A's] care plan documented staff actions to mitigate times of frustration and deliver loving care. There were also recorded times when staff clearly did not meet the organisation's expectations or care plan requirements to deliver loving care. Corrective action was taken, and oversight of care increased. The family were involved, and apologies were made.

Overall, there is evidence to suggest staff cared for [Mr A] in a way that supported his autonomy whilst delivering timely care to minimise times of frustration. In my opinion, it is very difficult to eliminate this entirely. Improvements to orientation, training, education, and external advice have improved PSO's service.

There are no further recommendations for the organisation's management of agitation further to those completed and monitored following the outcome of the September 2019 family complaint.

3. **The overall management of [Mr A's] care during the COVID-19 lockdown in March–May 2020, including whether GP or other input into [Mr A's] care should have been obtained during this period.**

Communication recorded between the facility and family indicated there was frequent communication between parties. It is noted that this was an extremely challenging time for all residents in community care during COVID-19 lockdown. With visits from family and friends restricted, and outings curtailed, staff were charged with additional work to manage the daily living and recreational needs of residents. It is also noted that this was a challenging time for family and staff working to maintain effective communication between parties for all residents during a high-risk period. External review of Aged Residential Care facilities, including secure units, was undertaken during this period by District Health Board and Ombudsman teams.

Following review of nursing and medical records, my belief is that care continued for [Mr A] appropriately under less-than-ideal circumstances. There were two occasions when [Mr A's] property was not managed carefully, and this was not recorded as per organisational requirements. PSO acknowledge their staff failure to follow policy related to these events, have completed corrective action and apologised. The loss and damage of personal items, in my opinion, was not a symptom of care provision to [Mr A]. I believe that trust and faith in the facility was probably not re-established following the substantiated claims of abuse soon after [Mr A's] admission.

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General practices were utilising alternative measures during COVID-19 lockdown to provide care rather than onsite visits. In most cases this worked well as RNs onsite reported and managed any change in condition and any expected resident decline. RNs continued to assess, monitor, and document residents' health. It is my belief that staff continued to provide care as per care plan requirements.

The family's concern surrounding [Mr A's] welfare and care in a time of restricted visiting is appreciated. The family noted [Mr A] looking well during a ZOOM session during this time.

There are no recommendations for improvement related to [Mr A's] care during lockdown.

4. **The adequacy of investigations into [Mr A's] potential urinary symptoms prior to his hospital admission in June 2020.**

[Mr A] was seen by his GP in a timely manner following his admission to the facility. He received ongoing medical assessment and support. It is noted that [Mr A] had an advanced cancer diagnosis. [Mr A's] GP was aware of his medical diagnosis and discussed options for care and ongoing management with his family. Medical and nursing records include family consultation in the development of a plan of care including discussion around the necessity for ongoing medical investigations. [Mr A's] comfort and symptom management was identified as an important goal. [Mr A] was seen by the local Hospice Palliative Care Nurse specialist following admission.

The nature of [Mr A's] ongoing abdominal discomfort in 2020 is noted and medication administration records confirm the administration of regular analgesic. There is also documentation around alternative medication suggestions from the family which were discussed by the family and GP. The rationale provided by the GP for not administering these was outlined.

[Mr A's] bladder symptoms were described by the GP as consistent with advanced cancer. Records documenting [Mr A's] final admission to [the public hospital] conclude there was no evidence of urinary retention. Although [Mr A's] urine was cloudy on admission and antibiotics were administered there were no symptoms of sepsis present. Documents reflect staff recording [Mr A's] symptoms appropriately. Clinical and medical care were regularly provided.

Facility staff and [Mr A's] GP confirmed [Mr A] had a reduced urinary output most likely resultant from reduced oral input and loose bowel motions. A urine sample was not taken in [the public hospital] and infection was not confirmed. The assessment of symptoms prior to admission to [hospital] by PSO staff and the GP indicate [Mr A's] generally declining health was a result of advanced cancer on a background of Alzheimer's.

In this review I believe there were adequate assessments made of symptoms prior to hospitalisation by PSO staff and the GP. [Mr A] had advanced cancer and his symptoms

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reflected this. His requirements for care were increasing beyond the home's ability to provide them. Transfer to hospital was appropriate.

There are no recommendations for improvement regarding the organisation's assessment and management of urinary symptoms during [Mr A's] time in care, in particular prior to admission to [hospital].

There are no other issues identified for comment.

Megan Sendall RN'

The following further advice was obtained from RN Megan Sendall on 31 October 2022:

'This review relates to care provision recorded video footage by Presbyterian Support Otago (PSO) staff to [Mr A].

Advice includes:

1. The manner and behaviour of each of the caregivers during their interactions with [Mr A], and whether this was in accordance with expected standards;

2. Whether care was provided to [Mr A] in a manner that was safe and suitable to his needs. As part of this please address:

a. Whether appropriate techniques were used for manual handling, transfers and mobilisation

b. The adequacy of assistance provided to [Mr A] to perform his tasks (such as getting dressed)

c. Any other matters of a clinical matter.

3. If the new information provided changes any aspects of your initial advice.

4. Any recommendations for improvement.

For each question, advise:

a. The accepted standard of care/practice

b. Any identified departure from the standard of care or accepted practice and how significant this is considered to be

c. How this would be viewed by my peers

d. Recommendations for improvement that may help to prevent a similar occurrence in the future.

1. The manner and behaviour of each of the caregivers during their interactions with [Mr A], and whether this was in accordance with expected standards;

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Caregiver A [Ms E]):
It was observed during review of video footage recorded on September 19, 2019, at 17.52 hours, that [Ms E] behaved in a way that was inappropriate. She repeated instructions without insight into [Mr A's] lack of response using a negative tone. It appeared [Ms E] did not consider the extent of [Mr A's] cognitive decline and the support he needed. [Ms E] made multiple requests to [Mr A] to put on his "pull ups" and said "Pull them up or not, I don't care" and left the room. This is inappropriate and abusive.

Caregiver B [Ms F]:
[Ms F] was observed entering [Mr A's] room on October 8, 2021, at 2110 hours without greeting or explanation. There was a moment when [Ms F] is observed saying a supportive phrase, "Good man" which was encouraging. However, the general engagement between [Ms F] and [Mr A] was not supportive, kind, or effective. It was concerning to see [Ms F] in another video clip, witness bullying and inappropriate language from [Ms D] to [Mr A] without any response or intervention. Her lack of advocacy and compassion was evident.

Caregiver C [Ms D]:
[Ms D] was observed using harsh and inappropriate language to [Mr A], sometimes threatening and at other times bullying him. This is never acceptable. [Ms D] demonstrated abusive behaviour.

In my opinion, all three caregivers provided care below expected standards.

Furthermore,

- [Ms E] demonstrated a moderate departure from practice.
- [Ms F] demonstrated a mild departure from practice and,
- [Ms D] demonstrated a significant departure from expected standards of care.

2. **Whether care was provided to [Mr A] in a manner that was safe and suitable to his needs.**

a) Safe techniques for transferring [Mr A] were not followed. The recorded assist transfer from bed to commode during which [Mr A] was instructed to stand and swivel, did not meet transfer guidelines.

b) [Mr A] was repeatedly asked to perform tasks that he found challenging. Independence is always encouraged and supported. However, in my opinion, all three CGs failed to provide the gentle support and assistance [Mr A] needed to complete the requested tasks.

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For both areas of concern, I believe my peers would share my concern that there was a moderate departure from expected practice. Areas of improvement relate to staff training and oversite.

I have reviewed my previous advice and considered your initial questions again. I believe the answers provided identified the organisation had acted appropriately. I considered the organisation's response again and believe this was appropriate. There was evidence of external third party management of the investigation and resultant performance issues.

It is clear, following review of the video footage, that three CGs did not provide appropriate loving care to [Mr A]. The organisation provided their response details once abuse issues were raised and identified improvements to staff culture. I believe they have responded appropriately. The organisation identified areas of improvement they felt contributed to the potential for abuse, i.e. rostering. It has been extremely difficult to fill rosters in facilities in the last two years and finding shifts where staff can work happily is positive. In this case following an investigation, the organisation felt that partnering a lead CA with a strong personality with another staff member was a less than optimal solution. However, this is often the case and does not always produce a negative outcome.

Although the organisation has the weight of responsibility to prevent issues of abuse through appropriate selection of staff, training, roistering, oversight and performance monitoring, there are times when staff must take responsibility for their own actions.

I believe in this instance the CAs must do so.

Megan Sendall RN'

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