Complaint

A woman complained about the care her 90-year-old mother received while a resident in a rest home. The woman was concerned that her mother fell twice, and that it was only as a result of her insistence that her mother received the correct treatment. Following the first fall, the resident was assessed by a registered nurse and a general practitioner, as she was complaining of hip pain. However, it was not until 10 days later that she was X-rayed and diagnosed with a fractured neck of femur. The second fall occurred when she was being showered. She was examined by the general practitioner, who diagnosed a fractured coccyx, recommended gentle mobilisation, and prescribed Panadol for pain relief. A week later the complainant was called by her brother, who had been visiting their mother, because he was concerned about her condition. The complainant arrived at the home, found her mother disorientated and distressed, and insisted that the rest home manager call a doctor. The resident was admitted to hospital, where it was found that she had multiple pelvic fractures, and was hypotensive and dehydrated. With the consent of the family, the hospital provided comfort cares only, and she died a short time later.

14 July 2006

Ms A

Dear Ms A

Complaint: A Rest Home /Ms D /Dr E
Our ref: 05/10483/WS

Thank you for your response to my provisional decision regarding your complaint about the care provided to your mother by a rest home. You stated, "I still feel the doctors could have done better." You also reiterated your concerns about Mr C's ability to communicate effectively. You should have been advised on 18 July 2005 that your mother was deteriorating. You continue to be "haunted" by the events of that weekend. You clarified some points, and I have made changes to the report to reflect this.

The information obtained in the course of this investigation shows that, although some aspects of the care they provided could have been done better, overall Ms D and Dr E acted in the best interests of your mother. Accordingly, I confirm my previous decision to take no further action in relation to Ms D and Dr E.

In my provisional opinion, I advised Mr C that, in my view, he failed to treat your mother with dignity and respect when she was undressing in the shower room and when he recorded in the Progress Notes, "[W]hen will that girl ever be happy?" I advised Mr C that in relation to these matters he breached Right 1(1) of the Code of Health and Disability Services Consumers' Rights (the Code). In response, Mr C accepted that his comments in the records were inappropriate, but he said that he

always treated your mother with "utmost" dignity and respect. My decision that the overall appropriateness of the care the rest home provided to your mother was reasonable is unchanged. However, I am still of the view that Mr C, as the home's manager, breached Right 1(1) of the Code. The reasons for my decision are set out below.

Complaint

On 14 July 2005 you submitted a complaint to the Manager, HealthCert, Ministry of Health, about the care your mother, Mrs B, received while a resident at the rest home. Ms Lomax forwarded the complaint to the Health and Disability Commissioner on 15 July 2005.

In your letter of complaint you stated that you believe the rest home was "negligent in their duty of care" towards your mother in respect of three incidents. I have summarised these incidents as follows:

- *March 2005*
  Your mother had been complaining of pain in her hip and knee for two weeks before she was seen by Dr E, and he diagnosed muscular pain. On 18 March 2005 the pain in your mother's hip increased significantly and she required wheelchair assistance. Registered nurse Ms D examined your mother and found no abnormality in her hip. At your request, an ambulance was called and, on review at a public hospital emergency department, your mother was found to have a fractured neck of femur.

- *14 June 2005*
  On 14 June 2005, your mother fell in the shower and sustained sore buttocks and a knock to the head. Ms D examined her and reported her findings to Dr E. The following day you found your mother to be in considerable pain and asked for Dr E to review her. Dr E examined your mother and diagnosed a fractured coccyx. He advised pain relief and rest.

  Following your mother's fall in the shower, you gave Mr C notice of your intention to move your mother to another facility. Your mother was concerned about reprisal from Mr C.

- *18 June 2005*
  On 18 June 2005, you visited your mother after concerns were raised by your brother about her ability to recognise him, and to communicate. On arrival, you found your mother to be confused and in pain, and insisted that a doctor be called immediately. The on-call doctor attended and advised that your mother be admitted to hospital. On admission, your mother was found to have a broken pelvis. She was dehydrated and anaemic. Your mother passed away three days later.

As Commissioner, I commenced an investigation on 15 December 2005. The following issues were identified for investigation:

The Rest Home

- *The appropriateness of the care provided by the rest home to Mrs B from 7 to 18 March 2005.*

- *The appropriateness of the care provided by the rest home to Mrs B from 14 to 19 June 2005.*

Registered Nurse Ms D

- *The appropriateness of the care provided by registered nurse Ms D to Mrs B in response to her hip pain between 7 and 18 March 2005.*

- *The appropriateness of the care provided by registered nurse Ms D to Mrs B following her fall on 14 June 2005.*

Dr E

- *The appropriateness of the care provided by Dr E to Mrs B on 7 March 2005.*

- *The appropriateness of the care provided by Dr E to Mrs B following her fall on 14 June 2005.*

Information has been provided by you, Mr C, Ms D, general practitioners Dr E and Dr F, and the District Health Board. I asked my clinical advisor to review the file and provide advice on the treatment and care provided to your mother.

Information gathered

The rest home has been regularly audited by the Ministry of Health and is compliant with its certification. The home is accredited by an approved auditing agency and is a member of the Association of Residential Care Homes Incorporated.

Your mother was aged 90 years when these events occurred. Her medical problems were hypothyroidism, bipolar disorder, and recurrent urinary tract infections, and she was deaf. Dr E provided regular medical services to your mother and visited the retirement home every second Monday. He would also attend if there was an urgent or emergency issue.

March 2005

On 7 March 2005, Ms D recorded in the daily progress notes that your mother had been complaining of pain in her left hip for three days. Ms D arranged for Dr E to review her as a part of his routine visit to the home that day. Dr E recorded:

> "7/3/05 C/o [complaining of] L [left] hip pain 3-4 days Worse on walking. Marked rotational movts [movements] restriction. ?OA [oesteoarthritis] ?muscular Rx [prescription] Panadol and review"

Dr E stated that there was no report of your mother having fallen or any other accident. When he examined your mother he could find no evidence of any injury. He found that she had marked restriction of rotational movement, but there was no shortening or external rotation of the left leg. Shortening and external rotation is a sign of hip fracture. Your mother was walking quite well on her walking frame. Dr E considered that the likelihood of a fracture was "extremely remote" and the most likely diagnosis

was a flare-up of the osteoarthritis of her hip or a strained muscle. He considered an X-ray at that time unnecessary and prescribed regular Panadol for pain relief.

The nursing notes for 16 March record that your mother was still complaining of pain in her left hip. Ms D noted that she would arrange for her to be seen by Dr E on Monday 21 March, and that she was to continue having Panadol four hourly.

On 17 March, Ms D again noted that your mother was complaining of a painful left hip and wanted to have her hip X-rayed. Ms D recorded that you wished to be present when Dr E saw your mother.

When you visited your mother on 18 March you were informed that she had been observed to be in severe and sudden hip pain while walking from the lunch room. She required assistance and a wheelchair to get back to her room. You told Ms D that your mother was "not a wimp about pain". Mr C telephoned Dr E to inform him about your mother's condition. You insisted that Mr C arrange an ambulance to take your mother to hospital for an X-ray.

Ms D wrote a letter of referral to the public hospital providing a medical summary and including a list of your mother's current medications.

The ambulance staff noted that although there was no obvious deformity of your mother's left leg when they loaded her into the ambulance, her leg became obviously shorter and rotated during the trip, indicating a possible fracture of the neck of the femur. An X-ray confirmed the fracture and your mother was admitted for surgical repair of her hip fracture.

Dr E believes that your mother may have had a spontaneous fracture of her hip, as there was no history of injury in the two weeks leading up to her fracture being diagnosed. She was getting around well on her walker at this time, and was not in severe enough pain to warrant consideration of an X-ray. He considers that the management he and the rest home provided to your mother in relation to her hip fracture was appropriate.

Your mother recovered well from her surgery and was discharged back to the rest home. Ms D compiled a care plan to address her needs. Dr E reviewed her regularly and provided guidance to the rest home staff for the treatment of her anaemia, mild heart failure and mild renal failure.

June 2005

On the morning of 14 June 2005 your mother fell when she was being assisted to shower by one of the carers. She was helped to her room and examined by Ms D, who recorded in the nursing notes:

> "[Mrs B] slipped and fell in shower room at 0830 hrs [hours] today. No evidence of hip/back pain just bruised buttocks. [Mrs B] shocked by incident and needing TLC [tender loving care]. Will need to be mobilised asap [as soon as possible] to prevent stiffening of joint(s) Please observe and report."

Ms D also completed an "Incident/Accident Report Form" and has recorded "walker went one way; [Mrs B] slipped and slid down onto her bottom off seat". Ms D recorded her examination of your mother and noted a contusion to the left side of the forehead; Ms D checked your mother's hips and back and confirmed that she had no pain in the hips or back but pain in the buttocks. Your mother was able to walk, although she was shocked by the fall. Later that morning Ms D dressed a minor abrasion on your mother's elbow.

Mr C provided a copy of the rest home's policy regarding showering and bathing residents. The policy states:

> "**TWO MAIN RULES WHEN BATHING, SHOWERING OR WASHING A RESIDENT ARE:-**
>
> ***NEVER LEAVE A DEPENDENT RESIDENT UNATTENDED IN A SHOWER OR BATH AND PRIVACY***"

The Incident Form, completed by Ms D, noted the actions to be taken to prevent a re-occurrence. Ms D instructed staff that Mrs B was to be escorted to and from the shower at all times, and that they needed to ensure that her "walker is in reach and has a good steady stance before walking".

At lunchtime Ms D walked your mother to the dining room and back from lunch. Ms D noted in the progress record that your mother was pale and still shaken, and Ms D undertook a set of observations. Your mother's pulse and blood pressure recordings were normal but she had mild shortness of breath. Ms D telephoned Dr E and discussed the results of her examination. Dr E decided that a visit by him that day was not required, but advised Ms D to continue with your mother's regular pain relief, and to report any changes in her condition. Ms D revised the care plan to instruct staff on measures to ensure your mother did not fall again. Ms D stressed the need for your mother to mobilise to reduce stiffening joints. Ms D completed the relevant ACC documentation.

Mr C left a message on your answering machine to inform you of the incident. He said that your mother had had a fall but that "it was not a big deal". When you returned the call, Mr C told you that Dr E had not examined your mother, but had been informed of her fall and the details of Ms D's assessment, and would see her the next morning. Mr C reassured you that your mother was fine but shaken and bruised.

The following morning Ms D re-examined your mother and redressed her elbow. Ms D noted her actions in the progress notes, and stated that Mrs B had a sore coccyx and lower spine.

Shortly after Ms D's examination you visited your mother and found her to be in considerable pain. You requested that a doctor be called. Dr E attended and examined Mrs B.

When Dr E arrived, your mother was sitting in a chair and you were present. He asked her to walk to the bed for an examination. Dr E examined her hips and found that hip

movement was satisfactory, but she was extremely tender over the coccyx area. Dr E diagnosed a fractured coccyx. He advised Ms D to continue the regular Panadol for pain relief, use an air cushion for comfort when sitting, and ensure gentle, slow mobilisation.

On 16 June, Ms D noted that your mother was still sore but had relief from the cushion. She was eating and drinking well. Ms D checked your mother's wound and applied a new dressing.

On 17 June, Ms D assessed your mother and found her to be feeling better but still in some pain and feeling tired.
On 18 June, Mr C noted that your mother was "a little more confused than usual" during the morning. Staff told him that they had difficulty getting her to take fluids during the day, but she had a comfortable night. The following day he noted that although she breakfasted, showered and dressed as normal, the confusion was still present. Mr C advised the carers to provide your mother with regular fluids in small amounts to maintain her hydration.

Your brother visited after lunch and commented to Mr C about your mother's confusion. Your brother did not stay long because your mother fell asleep during his visit. Mr C stated:

> "After son visited, […] (staff) said [I] needed to look at [Mrs B's] tummy as it was protruded. I enquired when she had last had a bowel motion but […] was unsure.
>
> After tea, [Mrs B] had two huge bowel motions (both formed, of light colour and no evidence of any darkness of blood present). Just as [Mrs B] was finishing the door bell rang. I answered the door – it was [Mrs B's] daughter [Ms A]. I walked up to [Mrs B's] room with [Ms A] because I knew the girls were toileting [Mrs B]. … [Ms A] went into [Mrs B's] room and I left them to it. Five minutes later […] said that [Ms A] wanted to see me. I went to the room and [Ms A] indicated to me that [Mrs B] was distressed. …
>
> [Mr C recalled that he reassured you about your mother having just had a bowel motion.]
>
> [Ms A] said she would feel better if a doctor would see her mother, so I went to the office and phoned the After-Hours doctors. They indicated that they were 1½ hours away and asked if we still wanted a visit. … I went up to the room and as I walked through the doorway [Mrs B] was calling out in her sleep. I quickly indicated to [Ms A] that this was something new and we had not had this during the day. [Ms A] indicated that she wanted a doctor. ...
>
> 7.45pm — Emergency [doctor] arrived. I let him read [Dr E's] notes then took [the doctor] to [Mrs B's] room. … I asked doctor to check [Mrs B's] chest as I had been told by [Ms A] that she had a rattley chest. [The doctor] indicated chest was clear. Told him about fluid intake – he said she could be a little dehydrated. I told [the doctor] that this calling out was new to the day. The confusion was there. Told him about the bowel motions. He also commented on the tenderness of her stomach. After the examination Dr said that he felt something was going on and

> she needed some tests. Best way to send her to hospital. He felt there could be a start of some form of infection. We phoned the ambulance. [The doctor] spoke to the on-call registrar at [the public hospital]. [Mrs B] and [Ms A] left in the ambulance."

On admission to the public hospital, a geriatric registrar reviewed your mother and found her to be alert but distressed. She was tender in the pubic area and he prescribed pain relief and an X-ray of her pelvis. The X-rays showed three fractures to her pelvis. A CT scan showed no further abnormalities, but an electrocardiograph showed that she had sustained some heart damage. Your mother's level of consciousness deteriorated during her assessment. Following a discussion with the registrar, the family decided against a resuscitation order and agreed that the hospital staff provide comfort cares only.

Mr C said that the following day he received a call from your partner to advise that your mother was "not in good shape". She was very anaemic, dehydrated, had pneumonia and was expected to live only a short time.

Your mother died a short time later.

Clinical advice

My clinical advisor reviewed the information obtained and advised:

> "In my opinion, it is probable that [Mrs B] had sustained a hip fracture from about 4 March 2005. This would most likely be from an unwitnessed or unrecorded fall. Such a hip fracture may have been impacted and thus allowed her to maintain a reasonable degree of mobility on her walking frame. It is possible that about 16-18 March when the left hip pain increased, that the previously impacted fracture destabilised. The classical signs of shortening and external rotation of the affected leg may not have become apparent until close to the time of sudden increase in pain. Nevertheless an observant geriatric nurse in a rest home setting should be aware of such possibilities.
>
> When [Dr E] had examined [Mrs B] on 7 March he identified 'marked restriction of rotational movements' in association with this new hip pain. In my opinion, the suddenness of the onset of symptoms should have alerted him to the possibility of a fracture or rapid deterioration of an arthritic hip and X-ray should have been undertaken. If a decision to defer X-ray was made then a definite review should have been planned to review progress or further deterioration.
>
> It is also my opinion that assessment of Mrs B on 15 June after she had fallen onto her buttocks should have included a pelvic examination. Given that Mrs B is now known to have had bilateral superior and inferior rami fractures plus a left iliac wing fracture [pelvic fractures], I would consider that 'compression and springing' examinations of the pelvis, in a lady with normal consciousness at that time, would have elicited signs of specific pelvic pain and warranted X-ray examination.
>
> It is my opinion that it is clinically reasonable to make a diagnosis of coccygeal fracture without an X-ray."

Summary

March 2005
Your first concern about the care provided to your mother occurred in March 2005. You believe that over a period of two weeks your mother complained of hip pain, and nothing was done until you insisted on an X-ray, and that an ambulance be called. The X-ray at the public hospital confirmed that your mother had sustained a fractured neck of femur and required surgery.

The information gathered shows that Ms D recorded that your mother first complained of pain in her left hip on about 4 March. She arranged for Dr E to assess her on 7 March. There had been no report of your mother falling or sustaining any other injury to her hip. Dr E could find no evidence of any injury when he examined your mother, and he considered that her pain could be caused by an exacerbation of her osteoarthritis and accompanying muscular pain. He asked the staff to give your mother Panadol four hourly to control her pain, and to encourage her with gentle movement. Ms D monitored your mother over the next week, and on 17 March arranged for Dr E to see her at his next visit on 21 March. However, the next day your mother experienced a sudden and severe episode of pain when she was walking from the lunch room. Dr E was notified and arranged for her to be admitted to the public hospital for further assessment. At the public hospital she was found to have a fractured neck of femur.

My clinical advisor advised that Ms D's incident report was of an acceptable standard, and the information she passed to Dr E about your mother was appropriate.

The records show that Ms D and Dr E performed the appropriate examinations on your mother when her painful hip first came to their notice. There were no clinical signs of injury and therefore no indication at that time that an X-ray was required. The ambulance report supports this, as the shortening and deformity of her leg, indicative of a hip fracture, only became apparent en route to hospital. As my advisor stated, it is not uncommon for the elderly to have undiagnosed, impacted hip fractures that are only identified when an unusual movement causes them to destabilise some time after the initial injury.

My clinical advisor stated that Dr E's advice to "observe and report any changes and to make sure regular analgesia was given" was acceptable treatment.

June 2005
The second incident was when your mother fell in the shower on 14 June 2005 and sustained sore buttocks and a knock to the head. You were unhappy about this occurring and gave Mr C notice of your intention to move your mother to another facility. Your mother was concerned that this would result in Mr C taking reprisal action.

The record of the incident states that the walker "went one way; [Mrs B] slipped and slid down onto her bottom off seat". It appears from this description that the caregiver was attempting to stand your mother up onto the walker after her shower. The incident was promptly reported, and Ms D assessed your mother for injury. Dr E was notified and his interim treatment plan of her obvious injuries was carried out.

You were notified that your mother had fallen. When Dr E saw your mother later that day, he diagnosed a fractured coccyx and advised staff on the conservative management of her symptoms.

I appreciate your concern that your mother suffered a second fracture in three months, and that you attribute this to lack of care. Your mother was a very elderly lady, recovering from hip surgery and at high risk of falling. Staff caring for the elderly need to be aware that even flooring specially designed for wet areas is not always safe. Particular care needs to be taken when transferring a resident using a mobility aid from the wet to dry areas of the shower room.

19 June admission
The third incident that you complained about occurred on Sunday, 19 June when caregiving staff found your mother to be confused and in pain. Your concern was that the rest home staff took no action until you insisted that a doctor be called immediately. The on-call doctor attended and advised immediate transport to hospital, where your mother was found to have a broken pelvis, and to be anaemic and dehydrated. She subsequently passed away.

Mr C and his staff were aware that your mother's condition had deteriorated on 18 June. They were concerned that she remain hydrated, and were encouraging her with fluids. Although her confusion had increased, she was still able to manage her usual daily routines. In the late afternoon on 19 June the caregiving staff reported to Mr C that your mother had a distended abdomen, but this appeared to resolve when she passed a bowel motion. Mr C checked that the motion was normal.

You had arrived by this time, in response to a telephone call from your brother, who was concerned. You requested that Mr C call a doctor to check your mother, and this was done. The on-call doctor decided to admit your mother for further assessment because he was concerned that she could be developing an infection.

The question arises whether Mr C should have acted sooner when the increased confusion was noted on the morning of 18 June, particularly in light of your mother's fall and blow to the head four days earlier. Mr C is not a qualified health professional, although he does have considerable experience in care of the elderly. He should have been aware that confusion associated with recent head injury might indicate that, at the very least, a review by a health professional qualified in care of the elderly was warranted. On the other hand, it does appear that your mother's condition deteriorated very rapidly on that Sunday. The duty doctor stated that your mother's confusion is likely to have begun four to eight hours before he saw her on the evening of 19 June.

Final opinion

No Breach — Nurse D and Dr E
You told my Office on 22 June 2006 that you are not convinced that Mr C, Ms D and Dr E fulfilled their duty of care to your mother. In my view, although Ms D and Dr E could have been more alert to your mother's symptoms in March 2005, and to the possibility of a hidden hip injury, the service they provided to your mother in relation to her hip fracture was reasonable in the circumstances. I note my clinical advisor's comments that Dr E could have been more thorough in his examination of your

mother after her fall on 14 June 2005. This may have led to an accurate assessment of the full extent of her pelvic fractures. However, it is unlikely that the treatment would have been different. In my view, the measures taken by Ms D in response to this incident were appropriate. Your mother's injuries were promptly assessed and a plan was put in place to prevent a recurrence. Overall, I consider that the care provided to your mother was appropriate, although some aspects of Ms D's and Dr E's care could have been improved.

Responses from Nurse Ms D and Dr E
Ms D stated that as a result of these events, she gave clear instructions to all the staff at the rest home about reporting any change in a resident's physical condition. She also directed that all residents are to be fully assisted when showering. Mr C organised a Labour Department educator to come in and instruct the staff on safe lifting and ACC requirements on falls/injury. An advocate visited the home and spoke to the staff about the Code of Rights. These education sessions were compulsory for all staff.

Ms D reviewed the rest home policies in light of the information provided by the Labour Department advisor and the advocate. She also reviewed her own practice in relation to documentation. In February 2006, a Ministry of Health approved auditing agency audited the rest home. Ms D asked the auditor to review their policies and procedures, and requested advice on how the documents could be improved. The auditor advised that the changes made to the policies and procedures were appropriate. Ms D stated:

> "The passing of [Mrs B] is the very first in nature for me and has left an enormous impact on me. Not just in a professional sense, but also personally as a mother and daughter. …"

In relation to his visit to your mother on 15 June 2006 following her fall in the bathroom, Dr E stated:

> "[T]he only site of pain presented to me was in the coccyx area and the left hip. I admit that I should have performed a compression and springing examination, to check for a pelvic fracture, perhaps forgetting that in old people multiple pathology is common, and I failed to look further than the obvious clinical coccygeal fracture. This whole situation has certainly helped to increase my radar to explore for more possibilities than are immediately apparent at first sight."

I am satisfied that Ms D and Dr E have learnt from the issues highlighted by my report, and have reviewed their practice accordingly. Accordingly, I will not take any further action in relation to Ms D and Dr E.

Breach — The Rest Home
My investigation also examined the appropriateness of the care provided to your mother by the rest home. Although the clinical care appears to have been appropriate, I am concerned about some aspects of the rest home's services — in particular, Mr C's attitude. I asked Mr C to respond to my provisional opinion that he failed to treat your mother with dignity and respect.

Mr C believes that he always treated your mother with "utmost dignity and respect", as he does all residents at the rest home. He said that Mrs B was not a good mixer and liked to be left on her own in her room. He agrees that it is totally unacceptable for any staff member to shout at a resident. He said that he and his staff take pride not only in the high quality care they provide, but also in the way they address and deal with problems, "as and when one arises".

Mr C denies that there was any unpleasantness when you spoke to him about your mother's concerns regarding his presence when she was showering. He said that he wanted you to discuss this with Ms D, because she was responsible for planning resident care, and the discussion took place in the privacy of the bottom lounge. Mr C believed that at the end of the discussion you were happy with the explanation and left the rest home in "good spirits".

As a result of your complaint, Mr C has changed the procedure for collecting laundry from the shower rooms. The caregivers now remove the clothing for washing from the shower room after the resident has been escorted back to his or her room or the lounge. He prefers to employ female caregivers, as the majority of the residents at the rest home are female. Only female caregivers or registered nurses shower female residents.

Mr C stated that the rest home has a strict policy that families are kept informed of any accident suffered by their family member in care, or deterioration in health. A message had been left for you that your mother had suffered a fall on 14 June 2005, had been examined by the registered nurse, that there did not appear to be a serious problem, and that you would be kept advised of developments.

Mr C accepts that the comments made in the Progress Notes were inappropriate and unprofessional. He agrees that this is inexcusable and states that it has been fully addressed to ensure it does not occur again.

Mr C stated:

> "Despite the allegations made by [Ms A], I hereby formally take this opportunity to pass on my humble apologies to her for any misunderstanding and for any distress that she may have been under as a result. We have ensured on our part that any area of concern has been fully and satisfactorily addressed, as documented above. We wish [Ms A] our sincere good wishes for the future."

I have carefully considered Mr C's response. I acknowledge his acceptance that his comments in the Progress Notes were inappropriate, and that your mother, and possibly other elderly women at the home, could be upset to have a male person in the vicinity when they were undressed and being showered. I am pleased that Mr C has made changes as a result of my comments, and has apologised for any distress he has caused. I also commend him for having an advocate talk to his staff about the Code of Rights as they apply to the residents at the rest home. However, it remains my view that (at least in relation to the entry in the Progress Notes) he did not treat your mother with respect and dignity and breached Right 1(1) of the Code.

I will send a copy of my final report to the Ministry of Health and the District Health Board (which funds rest homes in the area).

Thank you for bringing your concerns to my attention.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

Cc Manager, Healthcert, Ministry of Health
The District Health Board
Nursing Council of New Zealand
Medical Council of New Zealand