Caregiver, Ms D

A Rest Home/Hospital Trust

A Report by the

Deputy Health and Disability Commissioner

(Case 05HDC18417)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Complainant
Mr B	Consumer's son /Enduring Power of Attorney
Mrs C	Consumer (dec)
Ms D	Provider/Caregiver
Ms E	Registered nurse
Mr F	Chief Executive, Rest Home/Hospital Trust
Ms G	Executive Officer, Rest Home/Hospital Trust
Ms H	Manager, the Home
Ms I	Nurse Consultant
Ms J	Caregiver
Ms K	Caregiver
Ms L	Planning & Funding Manager, District Health Board
The Trust	Rest Home/Hospital Trust
The Rest Home/Hospital	Rest Home/Hospital complex
The Home	Rest Home/Hospital within complex

Complaint

On 19 December 2005, the Health and Disability Commissioner (HDC) received correspondence from Ms L, Planning & Funding Manager, a District Health Board, concerning a complaint from Ms A and Mr B about the services provided to their mother, Mrs C, while she was a resident in a hospital and rest home facility (the Home) at the rest home/hospital complex (the rest home/hospital).

The following issues were identified for investigation:

The Rest Home/Hospital

- *The adequacy and appropriateness of the care provided to Mrs C on 3 December 2005, when it is alleged she was physically and verbally abused at the rest home/hospital.*

Ms D

- *The adequacy and appropriateness of the care provided by Ms D to Mrs C on 3 December 2005, when it is alleged Mrs C was physically and verbally abused at the rest home/hospital.*[1]

The investigation commenced on 27 January 2006. It took over a year to complete owing to difficulties in identifying and contacting Ms D, delays in responses from the parties involved, and new information being provided after my provisional opinion was issued.

Information reviewed

- Interviews with:
  - Ms A
  - Ms D
  - Mr F
  - Ms G
  - Ms H
  - Ms J
  - Ms K
  - Ms L
- The recording of the interaction between caregiver Ms D and Mrs C
- Two reports from Ms I, a consultant with extensive experience in aged care
- Mrs C's records from the Trust
- Telephone calls with Ms E
- Responses to first provisional opinion (2 March 2007):
  - Letter from Ms D dated 23 March 2007
  - Meeting with Ms A on 27 April 2007
  - Letter from Ms A, with attachments, dated 20 May 2007

[1] The issues identified for investigation refer to the care provided to Mrs C on 3 December 2005. The original complaint letter and the recording referred to the night of 3 December but during the investigation it became clear that the events under investigation actually occurred during the early hours of 4 December.

- Responses to second provisional opinion (6 July 2007):
  - Letter from Ms D dated 20 July 2007
  - Letters from the Trust dated 3 and 24 August 2007
  - Meeting with the Trust management 15 August 2007

Information gathered during investigation

Background
The rest home charitable trust owns and manages the facilities at the rest home/hospital complex, including the Home (which has 30 hospital beds and 41 rest home beds). References to the rest home/hospital complex and the Home in this report include the rest home charitable trust.

Mrs C, aged 79 years, had Parkinson's disease. She was admitted to the Home on 17 January 2004. She was initially assessed as needing rest home level care, but in late 2005 this was changed to hospital level care. Prior to residing at the Home, she had had a total right hip joint replacement, but continued to have recurrent hip dislocations.[2] Mrs C's care plan from the Home in January 2004 records:

> "[Mrs C] does not like bullying, or being talked down to. She does not like being treated like a child or being shouted at. She does not like lack of patience or being told regularly to hurry up.
>
> [Mrs C] is very realistic about her current health and future and talks openly about this. [Mrs C] does not cope with anger well and gets upset and flustered. Her concentration gets low and she forgets to be careful."

The records also show that Mrs C could be uncooperative, refusing to sit, dress, walk or participate in activities, and if she did not want to be disturbed she would yell at her caregivers. Mrs C needed to be carefully supervised while walking, as she was unsteady on her feet and prone to falling. Mrs C's care plan (dated 30 November 2005) also states that she should be toileted three hourly or on request, and that she should wear pads. Depending on her degree of cooperation, sometimes two caregivers were needed to take her to the toilet.

Mrs C's daughter and son made a number of complaints on behalf of the family about the care provided to their mother during her time at the Home in 2004/05. Staff attempted to respond to each complaint, investigating the complaints and taking action to address the family's concerns.

[2] Mrs C's medical records show that her hip had dislocated seven times. However, Ms A states that her mother's hip had dislocated 13 times before December 2005.

In December 2005, the family became further concerned when Mrs C started talking about feeling unsafe and saying she was being slapped. As a result, Ms A placed a sound-activated recording device in her mother's room to record her interactions with her caregivers. The family allege that the device recorded a caregiver verbally and physically abusing Mrs C during the night of Saturday 3 December 2005. Chief Executive Mr F met Mr B and Ms A on 10 December, and raised the issue of the incident recorded. Mr F commenced an investigation and, at the same time, organised a consultant, Ms I, to conduct a review of the care provided at the Home.

Recording

Ms A provided HDC with an audio recording from the sound-activated device. The family believes it reveals physical and verbal abuse of their mother on the night of 3 December 2005. On the recording a loud female voice can be heard saying to hurry as she had to get back to her work. I have carefully listened to the recording and heard the following:

> "Female 1: Go, go (unknown sounds follow)
>
> Female 1: Sit down (unknown sounds follow twice)
>
> Female 1: Why did you take that off? Faster, faster, faster.
>
> Female 1: First, sit down, sit down on the bed … on the bed (unknown sound)
>
> Female 1: Oh for God's sake sit down, sit, sit … drink, drink, drink, drink so I can go and do my work.
>
> Female 1: Go on drink, you are not the only one here!
>
> Female 2: (Unrecognisable word)
>
> Female 1: (Unrecognisable word) (unknown sound)
>
> Female 2: (Unrecognisable words) (unknown sound)."

There are sounds that the family has interpreted as a series of slaps, and a number of other unidentifiable sounds. The recording is 49 seconds in length. The time shown on the recording provided is 1.33am on Sunday, 4 December 2005. Unfortunately, the accuracy of this timing cannot be corroborated, as the machine was turned off, which reset the time shown. This timing would, however, fit in with Mrs C being toileted between 1.30 and 2am.[3]

[3] This information appears on Mrs C's Restraint Release & Safety Chart.

Events of 3 December 2005
On the night of 3 December 2005, caregivers Ms D, Ms J and Ms K were on duty, under the supervision of a registered nurse, Ms E. They commenced work at 11pm and finished at 7am the next day.

Ms J and Ms D were working on the upstairs floor of the Home where Mrs C's room was located. Ms K worked downstairs and Ms E worked between floors but spent more time downstairs helping Ms K. The Trust's Registered Nurse Job Description outlines the responsibilities of the position as including the following:

- Caregivers receive guidance and direction when delivering care to residents. The care is monitored and evaluated.
- The competence of staff is monitored in the delivery of care that is safe and appropriate.

Ms D
Ms D was interviewed by HDC staff on 30 November 2006. Ms D confirmed that she had been working on 3 December 2005. She had not heard the tape and subsequently said she does not want to. However, she acknowledged that it must have been her voice on the recording. She stated that she had read a transcript of the recording, which she said was very "different from what really happened that night". Ms D stated that, at first, she could not remember the incident with Mrs C at all but "the more [she] read the script, the more [she] remember[ed] what really happened".

Ms D said that at 11pm she received the handover report from the enrolled nurse, who told her that Ms A had requested that her mother be toileted every hour throughout the night to keep her dry. Incontinence pads were not to be used. Ms D said that she did not agree with the instruction. She explained that the previous night (2 December), while working downstairs, she had heard screaming and upon investigation found the caregivers "doing the hourly toileting". Ms D said that she told Ms J what she had witnessed the previous night and that she would not toilet Mrs C hourly. Ms G, the Executive Officer, said that any instructions about hourly toileting would be in Mrs C's records. However, there is no such instruction in her records or nursing care plan. Furthermore, there is no record of Mrs C screaming on the night of 2 December.

Ms D stated that they went into Mrs C's room about midnight and she was asleep. Ms D said that she put on the light, and Mrs C started screaming, "telling us to get out, get out of her room, so we left". There is no record of this behaviour on Mrs C's "Behaviour Chart".

Ms D said that she checked Mrs C throughout the night but she was always asleep. The records show that Mrs C was checked about every half hour, and toileted between 1.30 and 2am and again between 5.30 and 6am. This record was signed by Ms D.

Ms D stated that at about 5.30am, she and Ms J went into Mrs C's room to take her to the toilet before going to the hospital part of the Home. When they woke Mrs C, she

started screaming and refused to get out of bed. Ms D said that she knew it would take time, so she told Ms J to go to the hospital and she would come to help her when she had toileted and changed Mrs C.

Ms D said that while she was trying to explain why Mrs C had to go to the toilet, Mrs C pointed to the recording device and told Ms D that her daughter had put the recording device in the room to "get you people". Ms D said that she had not met Ms A, and Mrs C pointed out her daughter Ms A in a picture of her family hanging on the wall. Mrs C said again, "She's taping you and she will get you people."

Ms D said that she did not understand Mrs C's comments, as she was there to help. She said that Mrs C continued to protest, screaming at her to "get out". Ms D said that as she put Mrs C's feet on the floor, Mrs C slapped her across the face. Ms D asked Mrs C why she had done that and Mrs C replied, "For waking me up."

Ms D said that Mrs C started sliding down to the floor as she was pulling her up from the bed. Ms D said, "Not on the floor, not on the floor." She fetched a toilet chair and manoeuvred Mrs C to the toilet. Mrs C then refused to sit on the toilet and started voiding onto the floor. When Ms D stood Mrs C onto her feet, the toilet seat fell, making a banging sound. Mrs C refused to stand, saying she wanted to sleep on the floor. Eventually Ms D was able to position Mrs C near the bed, but she refused to sit on the bed.

Ms D said that Mrs C asked her for a drink of water and then would not drink it, and slapped the glass out of her hand. Ms D said that she was conscious that because she was spending so much time with Mrs C, Ms J was changing all of the other hospital patients without assistance.

Ms D denies that she slapped Mrs C or spoke harshly to her. Ms D said that she had other people to care for and felt that Mrs C was taking too much of her time. Ms D said that she always spoke loudly to residents because they were often hard of hearing and did not follow her instructions. She did not report Mrs C slapping her because many of the residents hit out at caregivers when they were disturbed, and the incident was "normal" and not out of the ordinary.

Ms D said that Mrs C was screaming while she was getting her up off the bed, and she queried why this was not on the recording. She said that she was in the room for a considerable period of time but the recording is very short, and that the "full story" would have been apparent had the recording been of the whole night.

Ms A queried Ms D's recollection of her mother screaming, pointing out that when Mrs C's Parkinson's medications were depleted she was unable to shout or lash out. She said that Mrs C had a soft voice and was unable to shout or scream. The records show that Mrs C was becoming progressively more uncooperative and agitated from 28 November 2005, and was said to be "shouting and yelling" on 8 December 2005. However, there was no documentation of her screaming or yelling on 2/3 December,

and there is no evidence in the nursing notes or care plans that Mrs C was required to be toileted hourly throughout the night.

Documentation
There is no record in Mrs C's progress notes of the above event. The Trust policy on documentation is that all residents must have their care documented once every 24 hours unless there is an exceptional event, which is to be recorded at the time. In relation to Mrs C, her care is recorded at 2pm and 9.23pm on 3 December 2005 and once the following day.

Other staff
Caregivers Ms J and Ms K were interviewed by HDC staff on 10 August 2006. Ms K had not heard the recording. She said that she did not know about the incident until sometime later, and could not remember the night of 3 December 2005, but confirmed that she had worked downstairs that night.

Ms J said that she had heard part of the recording on a television programme, and that it sounded like Ms D's voice on the recording. She conceded that she could not remember whether she had been in Mrs C's room during the night of 3 December, and confirmed that she had not been present when the events on the recording took place.

On 18 May 2007 Ms E, the registered nurse on duty on 3 December 2005, spoke to HDC staff. Ms E did not remember anything unusual happening that night. The only thing she recalls is that some time later two caregivers did not turn up for work one night. Rumours circulated that there was some sort of investigation and something about a tape recorder, but it was not clear what the investigation was all about.

Ms E does not recall Mrs C yelling or screaming, but said that Mrs C would retaliate if anyone was aggressive towards her or tried to hurry her. She was a determined lady who knew her own mind and could stand up for herself. Ms E clearly remembers Mrs C dislocating her hip. It happened numerous times, and sometimes occurred simply when she crossed her legs. When this happened, she would be taken to hospital by ambulance for relocation under a light general anaesthetic. Ms E said that she did not spend a lot of time with Ms D, but recalls that she did not have any complaints about her.

The Trust's investigation
On 10 December, Mr B telephoned Mr F about the recording, and they arranged to meet. On 12 December, Mr F met with the family and listened to the recording. The minutes of this meeting, recorded by Mr F, state that the family:

"…

1. Claimed that there is verbal and/or physical abuse;
2. That your Mother is abused by neglect, i.e. not properly cared for, no activities, not taken out for a walk etc.

3. That things were not being followed up as had been outlined in the Care Plan re care of your Mother;
4. You also raised the issue of an incident report concerning your mother dated 12/12/05."

Mr F initiated an investigation of the incident. Ms D was suspended pending a full investigation. Ms J was moved to the dementia unit, pending the investigation, and reinstated to the Home in January 2006. Mr F also arranged for an external consultant, Ms I, to carry out a full review of the complaints processes and of Mrs C's care at the Home. Between 14 and 21 December 2005 Ms I conducted a review at the Home and identified some areas that could be improved on, including elements of a culture focusing on the needs of staff rather than those of the residents.

Mr F suggested that Ms A and Mr B contact HDC if they were "not happy with these procedures". The family believed that, at the meeting, there was agreement to have a "hidden surveillance camera" installed in their mother's room to record all interactions with her caregivers. Mr F made no reference to this in the minutes and did not install a camera in Mrs C's room. The family felt that Mr F had not kept his promise. They complained to the District Health Board (as the funding authority) and, on 17 December 2005, they moved Mrs C to another rest home facility.

On 23 December 2005, Mr F and Ms G met with Ms D and her support person. The Trust had requested a copy of the recording but, at the time of the meeting, had not received it. In a letter dated 23 December 2005, Mr F informed Ms D:

> "I have heard that recording, and we have appointed an independent investigator who has spoken with the family and listened to the tape recording also.
>
> The [Trust's] investigator's account of the recording is as follows:
>
> > 'An abrupt loud [female] voice was heard growling to hurry up on the toilet as she had to get back to her work. There was a sound the family interpreted as a series of slaps which sounded like three hand claps or slaps. There was no sound following from the other person in the room. This interaction was inappropriate in a care situation and fits within definitions of psychological abuse [harassment and intimidation].'
>
> From what I heard on the tape, I agree that the investigator's report accurately describes what happened. The voice appears to be yours. You said she was not the only one needing help.
>
> My initial impression of what was said; the way it was said; and to whom it was said was that it was completely unacceptable and a breach of the standard of care that we are required to provide, and that our employees are required to provide on our behalf."

This letter also contained notice of suspension pending a disciplinary hearing in January 2006. Ms D did not return to work after the 23 December meeting, and did not attend the disciplinary meeting in January. Ms D advised that she simply tendered her resignation after the 23 December meeting. She was formally dismissed by the Trust on 13 February 2006.

The Trust's investigating team interviewed Ms J on 11 January 2006. Ms G, Ms H and Ms J's support person also attended. Ms G told Ms J that the voice on the recording had been identified as belonging to another caregiver. Ms J denied hearing Ms D speak to residents in an abusive or aggressive manner, and said that she did not have any concerns about the staff with whom she worked on night duty. She said that she relied on them to help her at night because she worked only one night a week.

Police

On 30 March 2006 Ms A laid a formal complaint of assault with the New Zealand Police. However, the charge of common assault was withdrawn by Police because there was insufficient evidence to meet the threshold for a prosecution. The Police were unable to identify the voices or alleged slapping noises on the recording.

Ms D's employment record

The Trust provided Ms D's employment records. Ms D commenced work for the Trust on 30 May 2001, and worked one night duty shift a week and at other times when needed. At the commencement of her employment she was given a job description for the caregiver position, which included the responsibility to meet the needs of residents with "patience, understanding, dignity and respect". There was no mention in the records provided of any complaints made about Ms D.

Ms D attended an induction programme that included education in dementia, stroke, back care and mobility, and continence management. She was signed off as having completed the course satisfactorily on 6 June 2001. She attended night duty in-service education in October 2003 and was offered further courses in November 2004 and 2005 but did not attend. The 2005 course included sessions on employment issues, dealing with sudden death, dementia (including behaviour management), physiotherapy and CPR (cardiopulmonary resuscitation).

The Trust advised that annual in-service training is compulsory for all staff; however, it is difficult to ensure that part-time staff attend training. The "Educator" follows up all staff members who fail to attend training and provides them with copies of the handouts and videos, which include a video on the Code of Rights. Ms D was not followed up when she failed to attend training on 21 November 2005, as she was suspended shortly thereafter as a result of the incident on 3 December 2005.

Previous complaint about Ms D

On 20 May 2007, Ms A provided evidence of a previous complaint she had made about Ms D. On 17 March 2004 Ms A had written to Ms G about a fall her mother had had during the night of 12 March 2004. Ms A explained that Mrs C fell while in the

toilet, and was put back to bed by two caregivers in a very rough and careless manner. Later that night Mrs C rang her bell for help getting back into bed and was berated by one caregiver for wasting time.

One of the caregivers involved was identified by management as Ms D. There was no contemporaneous report of the fall, and medical assistance was not sought to assess Mrs C for injury. The registered nurse's notes from 13 March 2004 state that Mrs C asked to put in a Concern Form about the caregivers the night before having handled her "extremely roughly" and spoken to her "very roughly". An incident report was completed on 13 March 2004 by the registered nurse, and the matter investigated.

In an email from Ms H (Manager of the Home) to Ms G (Executive Officer) on 19 March 2004, Ms H outlined a meeting she had had with Ms D in relation to the incident. Ms H reported that Ms D was reprimanded for not reporting or documenting the fall. Ms D was also told that "raising her voice", as she did to Mrs C, would not be tolerated. Ms H wrote that she mentioned to Ms D that "this was not the only incident of her raising her voice to residents" and "this will stop". Ms D apologised for not reporting or documenting the incident but denied raising her voice to Mrs C. Ms H suggested that Ms D should attend a morning or evening shift to work alongside one of the Team Leaders.

Ms H, in a statement dated 23 August 2007, explained that it was Ms D's colleagues on the night shift of 13 March 2004 who had told her that "[Ms D] had raised her voice to [Mrs C] and that this was not the only incident of her raising her voice to residents". Ms H also explained that she spoke to RN Ms E after the meeting on 19 March 2004 and asked her "to review [Ms D's] conduct and keep [her] advised of any issues". Ms H stated that RN Ms E was a senior and experienced nurse and a "very good supervisor for the caregivers in her team", and she "had every confidence in her ability to supervise [Ms D] and provide on-the-job training if needed". Ms H claimed that she spoke to RN Ms E the week after the 19 March meeting and confirmed that Ms D "had carried out her duties on her night shift properly and had moderated her voice and acted appropriately with residents". Ms H noted that she "did not hear of any further problem with [Ms D] from any other staff member or resident".

Ms D, by letter dated 20 July 2007, gave her version of the events surrounding this complaint, as follows:

> "I received a phone call to come in and talked to [Ms H]. She told me the reason of the meeting, that [Mrs C] told her daughter that she had a fall in the toilet and there were two caregivers attended to her and the one in white told her not to ring the bell and kept yelling at her. I told [Ms H] my version of the incident. I was doing my round and I found [Mrs C] between her bed and her bedside table she was on her knees, I rang the bell and [the other caregiver] that was working with me that night came and we took her to the lavatory gave her some water and put her to bed. I was questioned on not calling the nurse. My response was it was not a fall, so I did not think at the time that it was necessary to call the

> nurse. I was asked again about the caregiver who was in white who told [Mrs C] not to ring the bell, I told her that I was wearing my uniform which is not white obviously and I never told [Mrs C] the whole time not to ring the bell. I asked them to talk to [the other caregiver] and get her version of the story and she was the one who was wearing a white polo t-shirt. I told them that [Mrs C] was never on the floor and if she had a fall they should be able to see bruises from the result of her fall. I told [Ms H] that I am not going to comment on anything regarding the other care giver that I worked with that night, and for them to talk to her."

Ms D said that Ms H encouraged her to talk about anything that was a concern at work, to "report everything even though it does not seem important and to use the help of the registered nurse". She said that after the meeting, she "never heard from anyone" and "was never under monitor at all".

In a letter to Ms A dated 24 March 2004, Ms G reported the outcome of the Trust's investigation and gave an assurance that the matter had been dealt with. Ms G documented this in Mrs C's notes. When interviewed by HDC staff on 3 August 2006 in relation to this investigation, Ms G said that she was not aware of any other such complaints about Ms D. Ms G and the Trust subsequently clarified that the question was understood as relating to the allegation of physical abuse. Had Ms G understood the question encompassed any complaints about Ms D, steps would have been taken to investigate and provide this information.

Subsequent events
Mrs C died in 2007. She spent the last months of her life at home, being cared for by her daughter.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 1

Right to be Treated with Respect

(1) Every consumer has the right to be treated with respect.

RIGHT 3

Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

Opinion: Breach — Mrs D

Under the Code of Health and Disability Services Consumers' Rights (the Code), Mrs C had the right to be treated with respect (Right 1(1)) and in a manner that respected her dignity and independence (Right 3).

Under no circumstances is it acceptable for a health care provider to hit, slap or in any other way physically intimidate a person in his or her care. However, it is unclear what actually happened between Ms D and Mrs C overnight on 3 December 2005. Ms A is firmly convinced that Ms D slapped and verbally abused her mother. Ms D denies that she ever slapped or was abusive to Mrs C.

Ms D was working in the Home on the night of 3 December 2005, and Mrs C was in her care. Ms D accepts that it was her voice on the recording. However, Ms D does not believe that it is a full account of events. She contends that she spent a considerable period of time with Mrs C, taking her to the toilet, changing her nightdress and bed, and giving her a drink of water. Mrs C was generally uncooperative and Ms D was working without assistance. Even if Ms D is mistaken in her recollection of the amount of time she spent with Mrs C, it is clear that the 49 seconds recorded could not have been the full interaction. Sound-activated recorders do not always record everything, but would be expected to pick up louder sounds made by Mrs C and anyone else in the room that night.

The recording is very brief and of poor quality. I note Ms D's concern that the recording does not provide a full picture of the events during the whole night. Mrs C could not recall the events, and there were no independent witnesses in attendance. On the recording, two voices can be heard. I am satisfied that the quieter voice is Mrs C, and the louder voice is Ms D.

The timing of the recording cannot be established. Ms D toileted Mrs C between 1.30 and 2am and again between 5.30 and 6am. It appears that Ms A's voice recorder was activated at 1.33am, but that cannot be substantiated. However, the time has very little bearing on the real issue, which is the lack of respect shown by Ms D toward Mrs C.

Ms D said that she knew about the recording device. Mrs C pointed it out to her not long after being woken to go to the toilet. Ms D believed that she had nothing to fear in having their conversations recorded because she was speaking to Mrs C as she spoke to all the other residents. She explained that she spoke loudly to residents so that they could hear her and understand what she wanted them to do. She needed Mrs C's

cooperation because her colleague was working alone with the other hospital level residents.

Ms D has denied that she spoke harshly to Mrs C or hit her. She has a loud excitable voice and has previously been told by one of the Trust managers not to speak so loudly. She was in a hurry to finish with Mrs C and was becoming frustrated at the time she was taking.

In these circumstances, I cannot conclude that the banging or clapping sounds heard on the tape, of which there are several, are slaps. Without any further corroborating or forensic evidence it is impossible to state, even on the balance of probabilities, that those sounds are Ms D slapping Mrs C. Ms D has offered a possible explanation. She said that the toilet seat fell, and also that Mrs C hit her. Again it is not possible to determine whether this was the case. I do not have sufficient evidence to conclude that Ms D physically abused Mrs C. Therefore I can take no further action on this matter.

However, it is clear from the recording that Ms D shouted at Mrs C and spoke to her in a manner that was disrespectful. The manner in which Ms D berated Mrs C and ordered her to obey commands demonstrates a failure to treat Mrs C with the respect and dignity she was entitled to. Ms D's shouting and the way she spoke to Mrs C amounts to verbal abuse and indicates a general lack of respect, regardless of the fact that she states that this was not her intention. Such behaviour is unacceptable. In my opinion Ms D did not treat Mrs C with respect and did not provide Mrs C with services in a manner that respected her dignity. Accordingly, Ms D breached Rights 1(1) and 3 of the Code.

Breach — The Trust

As an organisation providing health and disability services to the residents in its facilities, the Trust has a duty to comply with the Code. In addition to any direct liability for a breach of the Code, as an employer the Trust is responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. However, under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from breaching the Code. Thus the Trust had a duty to take appropriate action to ensure Mrs C was provided with a safe environment and that her rights under the Code were not breached.

Vicarious liability
The Trust has a written policy on "Neglect and Abuse" in the Policies and Procedures Manual, and Ms D's job description stated that she had a responsibility to treat residents with "patience, understanding, dignity and respect".

Ms D had a complaint made about her in March 2004, which alleged that Ms D did not treat Mrs C with respect and did not provide services in a manner that respected her dignity. Mrs C complained that she had fallen in the toilet and was "rough handled" back to bed, and spoken to aggressively.

Ms H (Manager of the Home) and Ms G (Executive Officer) were aware of this complaint. Ms H met with Ms D on 19 March 2004, and reprimanded her for not reporting or documenting the incident. Ms D was also reprimanded for speaking loudly and aggressively (although Ms D denied this). There was also a suggestion that Ms D should attend a shift to work alongside one of the Team Leaders, but this does not appear to have occurred. In response to my second provisional opinion, Ms H stated that she also asked RN Ms E, who was a "very good supervisor for the caregivers in her team", to keep her advised of any issues regarding Ms D's conduct. RN Ms E does not recall this specific request; however, she does not dispute that the request may have been made (as management sometimes asked her to keep an eye on a particular caregiver).

As outlined in Opinion 05HDC04892 (August 2006), employers of health care providers have a duty to monitor and maintain the competence of their employees, and to respond decisively to any complaints or concerns about an employee's practice. In my view, once concerns were raised about the way Ms D treated residents, the rest home had an obligation to take action to protect Mrs C and other residents from the risk of a repetition of such behaviour. The Trust acted decisively and appropriately by holding a disciplinary meeting, but Ms D apparently lacked insight into the inappropriateness of her behaviour. In these circumstances the Trust needed to take further steps to ensure that Ms D had modified her behaviour after the reprimand. Some form of monitoring and training should have occurred.

Some further steps were taken. A registered nurse, who had responsibility for monitoring the competence of staff in delivering care, was asked to review Ms D's conduct. However, there is no evidence of any review or monitoring of Ms D's performance. Furthermore, given that RN Ms E had clinical responsibility for residents in four rest home areas, I have doubts about the extent to which she would have been able to specifically monitor or review the conduct of a particular caregiver in the course of her usual duties. I also note that Ms D did not believe she was being monitored as a result of the March 2004 complaint, and it appears that she did not attend a daytime shift as suggested by Ms H. Formal monitoring (such as resident feedback or unannounced observations) should have occurred.

In light of the concerns raised, it was also important that the Trust ensure that Ms D attended appropriate training. Caring for elderly people can be challenging, particularly

when the elderly person is uncooperative or suffers from dementia. I accept that it may be difficult for part-time staff to attend training. However, to ensure that vulnerable consumers receive appropriate care by staff in rest homes, caregivers must be trained in a number of areas, including ways to manage challenging behaviour and the importance of treating residents with respect. Ms D took part in an induction programme and attended night duty in-service education in October 2003, which included training in acceptable employee behaviour. However, Ms D did not attend the training sessions offered in 2004 and 2005. The Trust states that annual in-service training is compulsory for all staff, and staff members who fail to attend training are followed up and provided with information. However, I have been provided with no evidence that this occurred in relation to Ms D.

In summary, from at least March 2004 the Trust was aware that Ms D raised her voice to residents. In light of Ms D's failure to acknowledge her inappropriate conduct, further steps were required to ensure that she behaved appropriately towards residents in the future. Action should have been taken to monitor Ms D's manner with residents, such as implementing a formal supervision or performance monitoring programme. The Trust should also have ensured that Ms D underwent training in managing challenging resident behaviour and treating residents with respect. I am not satisfied that the Trust took all reasonably practicable steps to prevent its employee, Ms D, from breaching the Code. Nor do I consider that it is unduly onerous to require an organisational provider of health and disability services to ensure that staff caring for vulnerable residents are properly trained and monitored — particularly when concerns have been raised about disrespectful behaviour on the part of an employee/ caregiver. Accordingly, it is my opinion that the Trust is vicariously liable for Ms D's breach of the Code.

Direct liability

As outlined above, Ms D did not treat Mrs C with respect, nor provide services in a manner that respected her dignity, on the night of 3 December. When this came to the attention of the Trust, appropriate action was taken by suspending Ms D and instigating a full investigation into the incident.

The manner in which Ms D provided services to Mrs C was not in accordance with the Trust's written policy on "Neglect and Abuse" or the Trust's Caregiver job description. At the commencement of employment, Ms D was given a copy of this job description, which included a responsibility to meet the needs of residents with "patience, understanding, dignity and respect". Ms D also attended the compulsory induction programme upon commencing employment, and was given the opportunity to attend annual in-service training. Notwithstanding the concerns raised above about the ability of registered nurses to carry out a specific review of a particular caregiver's performance, the Trust's Registered Nurse Job Description clearly stated that the registered nurses on duty had a responsibility to monitor and evaluate the care provided by caregivers.

Accordingly, except in relation to points raised in relation to vicarious liability above, I am satisfied that the Trust provided Mrs C with an appropriate standard of care on the night of 3 December 2005 and therefore did not directly breach the Code.

Actions taken

The Trust
The Trust has provided HDC with three-monthly reports on the implementation of Ms I's review report. In her report dated 15 September 2006, Ms I stated that "considerable efforts are being made to implement and bed in changes to the operation and culture in order to achieve high standards of clinical and personal care for the residents of [the Home]". Staffing levels have been increased and further staff training has been provided. Ms I advised that the only issue remaining was the employment of good staff at all levels, which is a problem the Trust shares with the rest of the health sector.

On 24 August 2007, the Trust advised that it "will endeavour to become a lead agency promoting the need for training standards for the industry and attempt to influence the current working parties being established to work on this by working through its national peak organisations, Healthcare Providers NZ and the New Zealand Council of Christian Social Services".

Ms D
In response to this investigation Ms D provided an apology to Mrs C and her family for breaching the Code of Health and Disability Services Consumers' Rights. Ms D stated:

"… I'm sorry that my tone of voice was raised in a manner that was disrespectful and sounded harsh. You do not deserve this and no one else either. I want you and your family to know that I never mistreated you or disrespect you in any shape or form. I felt that I did my best looking after you and I'm still defending myself of being accused of hitting you. I'm asking you and your family to forgive me if I may [have] sounded rude and I am genuinely sorry. …"

Recommendations

I recommend that Ms D, if she intends to work as a caregiver again:

- review the way she speaks to residents in light of this report, and modify the tone and tenor of her communication

- undertake training that focuses on effective communication with the elderly
- inform any future healthcare employers of the findings of this investigation.

I recommend that the Trust:

- ensure that staff compliance with its compulsory in-service programme is regularly reviewed. Employees who fail to attend training should be followed up in writing, with a reminder of the obligation to attend training sessions and details of alternative training dates or facilities. A copy of this correspondence should be retained on the employee's file;
- review its systems for monitoring or reviewing staff performance where concerns have been identified; and
- confirm to HDC by **8 October 2007** that these recommendations have been fulfilled.

Follow-up actions

- A copy of this report will be sent to the Ministry of Health and the District Health Board.
- A copy of this report, with details identifying the parties removed, will be sent to HealthCare Providers NZ and Age Concern and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.