Nurse Manager, Mrs D / A Rest Home

A Report by the

Health and Disability Commissioner

(Case 00HDC00047)

Health and Disability Commissioner
Te Toihau Hauātanga, Hauātanga

Parties involved

Ms A	Complainant / Diversional Therapist at the rest home
Mr B	Consumer
Mrs C	Consumer
Mrs D	Provider / Manager at the rest home
Mrs E	Consumer
Mrs F	Consumer
Mrs G	Consumer
Dr H	General Practitioner / Attending General Practitioner at the rest home
Dr I	Psychogeriatrician, Assessment and Rehabilitation Team
Dr J	Psychologist, Assessment and Rehabilitation Team
Mr K	Nurse, Assessment and Rehabilitation Team
Mrs L	Caregiver at the rest home
Ms M	Community Mental Health Nurse, Assessment and Rehabilitation Team
Mrs N	Sister of consumer Mr B
Mr O	Husband of consumer Mrs G
Mrs P	Daughter-in-law of consumer Mrs E
Mrs Q	Sister of consumer Mrs F
Ms R	Social Worker, Age Concern

Complaint

On 23 December 1999, the Health and Disability Commissioner received a complaint from Ms A, a former employee who had worked as a diversional therapist at a rest home, concerning the standard of service provided to the residents of the rest home. The complaint was that:

- *Staff had seen Mr B, who suffers from dementia, touch female residents at the rest home on the breasts and masturbate in front of Mrs C.*
- *There are unconfirmed reports that Mr B is sexually assaulting women residents in their beds.*
- *Mr B is allowed to go for walks unaccompanied outside the rest home.*
- *On Friday 17 December 1999 Ms A brought these matters to the attention of the nurse manager, Mrs D, at a staff meeting, and was told that Mr B could not be transferred until there was someone to replace him.*
- *Mrs D shouts at patients and staff when stressed.*
- *Temazepam has regularly gone missing from the rest home.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

An investigation was commenced on 20 January 2000. The investigation was extended to a Commissioner's own initiative investigation on 10 April 2000 relating to the alleged sexual molestation of Mrs C, Mrs E, Mrs F and Mrs G, residents of the rest home.

Information reviewed

- Clinical records relating to Mr B from the rest home
- Clinical records relating to Mrs C from the rest home
- Clinical records relating to Mrs G from the rest home
- Clinical records relating to Mrs E from the rest home
- Clinical records relating to Mrs F from the rest home
- Clinical records relating to Mr B from the Community Assessment and Rehabilitation for the Elderly Team at the public hospital
- Independent expert advice from Ms Jan Featherston, nurse; and Dr Crawford Duncan, consultant psychiatrist specialising in psychiatry of old age.

Information gathered during investigation

Overview
This complaint concerns the services provided to Mr B while he was a resident at the rest home. Mr B suffered from Lewy body dementia. He also had episodes of inappropriate sexual behaviour. The treatment and care provided to him should have been appropriate to manage his dementia and sexual disinhibition so that even with those disorders, his quality of life was maximised. The rest home also provided care to other residents, who were entitled to be protected from potential harm, including the risk of harm from other residents. Mr B's behaviour should have been managed so that the other residents did not suffer as a result of his behaviour.

Background
In June 1996, 75-year-old Mr B was admitted to a public hospital following a car accident. He was referred to a clinic where he was seen by a neuropsychologist. It was established that Mr B had not been coping well at home, that he had been having hallucinations, and that his memory had gradually deteriorated over the preceding five or six years. Mr B's car accident, the reason for his admission into the hospital in June 1996, was his third such accident. It was arranged for a social worker to visit Mr B at his home on a fortnightly basis. He was also encouraged to accept the home help that he had been offered prior to his car accident. Mr B was seen by psychiatric services following his discharge home. He was readmitted to hospital and diagnosed with dementia, mild Parkinson's disease and hallucinations. As it was considered he required

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assistance and supervision, Mr B was admitted to the rest home, a stage II rest home, on 3 October 1996.

Prior to his admission to the rest home, Mr B was prescribed temazepam (a night time sedative). Mr B's notes record that he did take some time to settle at night and that he would sometimes wander within the rest home. In November, Dr H, a general practitioner who attends the rest home on a weekly basis to treat the residents, discontinued the temazepam and commenced Mr B on Serecid (used to treat anxiety).

Dr H informed me that on 28 November 1996, the owner of the rest home at the time, informed him that a female resident had accused Mr B of exposing himself to her. Mr B denied the allegation to Dr H. The owner contacted the social worker who had referred Mr B to the rest home, who confirmed that there had been no previous reports of similar behaviour by Mr B. There were no further incidents reported to Dr H until December 1997 when Mr B was found to have wandered into another resident's room. According to Mr B's records, Dr H requested that he be carefully observed and recommenced Mr B on Serecid, which had earlier been discontinued. The notes provided to me do not state when the Serecid was discontinued or for what reason.

1997–1998

Mr B's notes record that during 1997 he was, at times, agitated and abusive to staff. He was also reported as having periods of confusion. Staff discussed the residents' behaviour at their daily staff meetings and were requested to observe and report on Mr B's behaviour. Mr B continued to behave erratically and, in February 1998, Dr H referred Mr B to the Assessment and Rehabilitation team "in the light of fresh observations by staff of [Mr B] being found occasionally in the wrong room at night".

Dr I, psychogeriatrician, who was involved in Mr B's care and provided information to my investigation, was sent a copy of my opinion and commented:

> "I understand that the Assessment and Rehabilitation team's contact with [Mr B] in 1997 was the first. It is unclear … as to whether he did or did not have a history of inappropriate sexual behaviour before his placement at the rest home."

Dr I saw Mr B on 5 March 1998. Dr I recommended that Mr B's Serecid be decreased over a period of time. She requested that a 'behaviour chart' be commenced to monitor Mr B's behaviour, and she referred him to a psychologist within the Assessment and Rehabilitation team to attempt to modify Mr B's behaviour. Dr I also provided the rest home with information on sexuality in dementia.

A behaviour chart was commenced by staff at the rest home. The chart appears to have been kept for a period of approximately six weeks, during which time there were no reported instances of inappropriate behaviour by Mr B. Dr J, a psychologist of the Assessment and Rehabilitation team, visited Mr B at the rest home. She advised Dr H, in a letter dated 9 April 1998, that staff had informed her there had been no further "episodes of aggression" and that staff felt the issues had resolved. Dr H advised me that

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as Dr J discharged Mr B from any further follow-up, he assumed that the Assessment and Rehabilitation team could no longer assist staff with the care of Mr B.

Mr B continued to receive care at the rest home. In May 1998 a staff member saw Mr B with Mrs C backed against a wall. Both Mrs D and Dr H talked to Mr B about the matter, but he had no recollection of the event. Dr H commenced Mr B on clonazepam (a sedative) twice daily. Mr B developed urinary incontinence, a known side effect of clonazepam, and his evening dose of clonazepam was subsequently reduced. Staff reported that the reduced dose had good effect; however, on 28 July Mr B was found kissing Mrs G and touching her on the breast. Mr B had put Mrs G's "hand on him". A staff member wrote: "Please get him out of this house before it's too late." The following day Mrs D spoke to Mr B and left instructions to staff that he must not go near other residents. Over the next few days (2 to 8 August) Mr B is recorded as confused, abusive and withdrawn. On 8 August he left the rest home unaccompanied to go to the local store.

There are gaps in Mr B's notes provided to me by the rest home and it is difficult to ascertain what further, if any, incidents occurred. However, in December he was recorded as "being very aggressive towards […]", and "showing a lot of aggression towards [Mrs G] (pushing and trying to hit her) and [Mrs C]".

1999

On 19 January 1999, Mr B's access to the kitchen at the rest home was restricted and he was recorded as being very aggressive about the restriction. On 5 February Mr B was found exposing himself to Mrs C and Mrs F. On 7 February, he was found trying to get his hand up "[Mrs C's] nightwear". On 9 February, Mr B left the rest home unaccompanied. Mrs D discussed Mr B's "language, agitation, physical abuse and exposure" with Dr H. She requested that staff continue to observe Mr B.

On 5 and 7 March, Mr B left the rest home unaccompanied for periods of half an hour. He was noted to be "aggressive towards […] and abusive with staff" on 5 March.

On 12 March 1999, Dr H made an urgent re-referral of Mr B to the Assessment and Rehabilitation team. Dr H advised me that he requested support from the Assessment and Rehabilitation team "to use chemical castration for [Mr B] as behavioural techniques were useless given his increasing dementia". Dr I (from the Assessment and Rehabilitation team) commenced Mr B on Risperidone (an antipsychotic). Mrs D requested that staff write up a special chart for incidents.

Dr H informed me that Mr B did not respond to the risperidone treatment and that it had to be discontinued because of side effects. Dr H further advised that Mr B's health continued to deteriorate and he became "increasingly frail, slow and less mobile, and staff continued as before to monitor his occasional lapses in behaviour". Mr B was also seen by Mr K, a nurse with the Assessment and Rehabilitation team, who visited Mr B at the rest home and made follow-up phone calls. Mr K reported to Dr H, in his letter dated 5

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May 1999, that Mr B's behaviour appeared to have settled down and that staff at the rest home appeared to be coping well with Mr B.

Dr I commented:

> "Sometimes a mental health community team will take over the care of a particular patient. At other times, especially if, as in this case, they have confidence in the GP and the caregivers, then they will merely advise and expect that the primary caregivers will re-contact the secondary service if the advice is unhelpful or the problem gets worse.
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> …
>
> It is clear that the [Assessment and Rehabilitation] team did not particularly get involved with [Mr B] and obvious in retrospect that the team should have. A complication especially in 1999 was the resignation of most of the long term [Assessment and Rehabilitation] team and the employment of locums.
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> …
>
> [T]he [Assessment and Rehabilitation] team was not at that point working on a consultation-liaison model, which is ideal, rather than an assessment and advice-giving approach.
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> …
>
> Ideally, [Mr B] should have gone into a Stage III home. However, there were only 204 such beds in all of [the city] at that time. These were constantly full."

Mr B's notes record intermittent incidents of his approaching other residents. On 28 April, 1 July and 23 July he is recorded as having "bailed up" Mrs G during the afternoon shift. On 20 December Mr B was found stroking the right breast of Mrs E. He is also recorded as being verbally abusive to staff and swearing at staff and other residents.

Mrs D requested that staff continue to observe Mr B very carefully.

Complaint to Mrs D

Ms A was working as a diversional therapist at the rest home. She informed me that at a staff meeting in December 1999 she raised with Mrs D her concerns about Mr B's behaviour. Ms A suggested that Mr B be transferred to an all male rest home. She alleged that Mrs D responded angrily and said that Mr B could not be transferred until there was someone to replace him.

Mrs D denied that residents are kept at the rest home until a replacement is found. She advised me that if she thought it was in a patient's best interests to be moved to another establishment that would be done as soon as possible and in conjunction with advice from Dr H and the Assessment and Rehabilitation team.

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Ms A also advised me that she had been informed by a caregiver (Mrs L) that Mrs L had seen Mr B touching women inappropriately; she had seen him masturbating in front of Mrs C and there were unconfirmed reports that Mr B had been sexually interfering with women while they were in bed.

Mrs L informed me, in February 2000, that Mr B's behaviour had deteriorated and that he had recently become more aggressive. She further stated that it was a while since Mr B had masturbated, although one staff member had informed her recently that Mr B had masturbated and ejaculated in the lounge. With regard to other residents, Mrs L informed me that one of the female residents informed her that Mr B had asked her to touch him. This incident occurred several years previously, soon after Mrs L commenced work at the rest home. Mrs L had last seen Mr B touch a resident's breast in December/January (1999/2000). She informed me that it was her opinion that Mr B was "interfering sexually with the bedridden patients". She further advised that she had spoken to Mrs D about Mr B's interfering with female residents.

Although Mr B's notes record some instances of his having approached female residents, there are no corresponding entries in the notes of the female residents concerned. There were no 'incident reports' concerning these events in the documents provided to me.

Referral to Age Concern
Ms A contacted the Elder Abuse unit of Age Concern in December 1999, after she ceased working at the rest home, regarding her concerns about Mr B. Age Concern made an urgent referral to the Assessment and Rehabilitation team. The referral letter stated that "[Ms A] has advised us that [Mr B] masturbates in front of other residents and also ejaculates in front of them. We believe that [Mr B] has also fondled the breasts of women residents …". The Assessment and Rehabilitation team could not take any immediate action because of staffing problems and advised Age Concern that it might like to take the matter to Health Services for the Elderly. (It appears, however, from documents provided to me by the Assessment and Rehabilitation team, that as a result of the complaint to Age Concern, the Ministry of Health became involved in the matter and instructions were eventually given to remove Mr B from the rest home.)

Mr B's notes record that on 20 January 2000 his behaviour was discussed with Dr H and that a referral was to be made to the Assessment and Rehabilitation team. On 21 January 2000, Dr H again referred Mr B to the Assessment and Rehabilitation team, requesting that Mr B be transferred. Dr H stated in his letter that the manager of the rest home (Mrs D) considered it was time for Mr B to be placed in an all male rest home.

Mr B was seen by Ms M, a nurse from the Assessment and Rehabilitation team, on 9 February 2000. She informed Dr H that Mr B had admitted molesting female residents and that Mr B believed this behaviour had decreased.

Mr B was transferred to another rest home on 25 February 2000. Mr B's sister, Mrs N, informed me that she received a telephone call on 25 February 2000 to inform her that

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Mr B was to be transferred to second rest home that day. She had not been contacted prior to this time to inform her about Mr B's transfer.

Mr B's sister

Mrs N also provided information to me concerning her brother while he was a resident of the rest home. She said that she was unhappy with the standard of care at the rest home and that in November 1999, she contacted Ms M of the Assessment and Rehabilitation team requesting that alternative accommodation be found for Mr B. Mrs N made a second request to Ms M in December and was informed that Mr B was due to be re-assessed in March 2000. Mrs N also informed me that Mr B had repeatedly told her his money was going missing. Mrs N checked Mr B's bankbook and found that there had been regular withdrawals. However, she conceded that because of Mr B's dementia it was difficult to take seriously some of the statements he made.

The documents provided to me by the Assessment and Rehabilitation team contain no record of Mrs N's contact with the team.

Other residents of the rest home

Relatives of some of the residents at the rest home were approached during my investigation to obtain information concerning the matters raised by this complaint.

Mrs G

Mr O, the husband of Mrs G, informed me that his wife had told him about one of the male residents who she described as a "creep", and that the man constantly bailed her up in the corridor. Mr O made a complaint to Mrs D about this. Mrs D informed Mr O that she would warn the man about his behaviour. Mr O could not recall when he made his complaint to Mrs D.

Mrs D did not provide any information to me about this event, nor was there any reference to the discussion in the notes sent to me by the rest home.

Mrs E

Mrs P, the daughter-in-law of Mrs E, was informed that Mr B had been seen touching Mrs E on her breast. Mrs P advised that she was concerned her mother-in-law may have provoked Mr B when he touched her breast. Mrs P also informed me that she was of the view the rest home provided good care to her mother-in-law.

Mrs F

Mrs Q, the sister of Mrs F, informed me that she was not aware of any incidents where a male resident of the rest home may have interfered with her sister. Mrs Q also informed me that her sister had dementia and that she did get involved in fights because of this. Mrs Q recalled one occasion when her sister had a scratch on her face and that, when asked about it, Mrs D did not provide a direct answer.

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Mr B is allowed to go for unaccompanied walks outside the rest home
An allegation was made that Mr B was allowed to go walking on his own and that, in the circumstances, he might be a threat to people in the community.

Mrs D informed me that due to Mr B's physical deterioration and limitations he was very unsteady on his feet and that he had not left the rest home unaccompanied since October 1999. She further stated that the rest home is a Stage II rest home and that residents who are capable of leaving and returning to the home may do so provided they advise staff of their intentions.

In her response to my provisional opinion, Mrs A stated that she worked at the rest home between March and December 1999 and during that time Mr B was allowed to go out walking and draw out money for spending. She said that she once took him on an outing and observed that he was steady on his feet.

From a review of Mr B's notes, it appears that during the early time of his stay at the rest home he went on outings to his friend's and he went out with his sister. Also, there were occasions when he left the Rest home without informing staff. There is no record of Mr B acting inappropriately when away from the rest home.

Medication management
Ms A suggested that temazepam regularly went missing from the rest home. She advised me that she had "heard unofficially" about this. She did not provide any further details.

Mrs D informed me that a pharmacy dispenses the residents' medication, in the 28-day Webster Pack system. The packs are made up by the pharmacy and delivered to the rest home. The staff who are responsible for the administration of the medication take the pack to the resident and "pop" the appropriate blister from the pack directly to the residents. When the packs are not in use they are locked in the medicine cupboard and are checked by the manager or registered nurse daily. The medication sheets instruct staff to record if the medication was not given, denoting "R" for refused medication, "N" for nausea and vomiting, and "A" for absent.

Mrs D further informed me that only two residents had been prescribed temazepam and their records for the previous six months (August 1999–early February 2000) do not show any missing tablets. She strongly denied the allegation that temazepam had regularly gone missing.

Mrs D shouts at residents and staff
In response to the complaint that Mrs D shouts at staff and patients when stressed, Mrs D informed me that it is not in her nature to shout at anyone. She denied the allegation that she shouted at any of the residents.

Dr H informed me that, in his view, Mrs D's care of residents at the rest home was exemplary. He stated that she had "consistently shown a deep caring and compassion for those elderly in her care".

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No other information was provided to me during my investigation about Mrs D shouting at staff or residents.

Independent advice to Commissioner

Nursing advice
Ms Jan Featherston provided the following independent expert nursing advice:

> "I have been asked to provide professional advice in relation to [Mr B] and residents of [the rest home] and whether services were provided with reasonable care and skill.
>
> In providing this advice I reviewed the supporting information.
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> - Letter to the Commissioner from [Ms A] received 23 December 1999, marked with an 'A'. (3 pages)
> - Letter of response to the Commissioner, from [Mrs D], manager, [at the rest home], dated 9 February 2000, marked with a 'B'. (3 pages)
> - Clinical records relating to [Mr B] at [the rest home], marked with a 'C'. (40 pages)
> - Letter of response to the Commissioner, from [Dr H], dated 25 September 2000, marked with a 'D'. (4 pages)
> - Telephone interview with [Mrs L], caregiver, recorded 11 February 2000, marked with an 'E'. (2 pages)
> - Telephone interview with [Mr O], husband of resident, recorded 17 July 2000, marked with an 'F'. (1 page)
> - Letter of response to the Commissioner, from [Ms M], community mental health nurse, dated 4 August 2000, marked with a 'G'. (10 pages)
> - Clinical records (Mental Health Services for Older People) relating to [Mr B], marked with an 'H'. (42 pages)
> - [The hospital's] clinical records relating to [Mr B], dated 19 October 2000, marked with an 'H'. (84 pages)
> - Letter of response to the Commissioner from [Dr I], consultant psychiatrist, dated 12 November 2001, marked with an 'I'. (2 pages)
> - Additional [the rest home] clinical records relating to [Mr B], dated 20 December 2001, marked with a 'K'. (36 pages)
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> Registered Nurses work under the Nurses Act 1997 as set by the Nursing Council of New Zealand.
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> The Nursing Council of New Zealand is a statutory authority and hence governs the practice of nurses and midwives. The Council's primary concern is public safety. The Nurses Act 1977 sets out conditions for registration of nurses. The Act restricts the

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right to practise as a nurse those names entered in the Nursing Council Register and who hold a current practising certificate.

The Code of Conduct provides a guide for:

1. Public access to minimum standards expected of nurses and midwives.
2. Nurses and midwives to monitor their own performance and that of their colleagues.
3. Nursing Council to apply its judgement in determining professional misconduct.

There are four principles as criteria for the Code. They are:

1. Complies with legislated requirements
2. Acts ethically and maintains Standards of Practice
3. Respects the rights of patients/clients
4. Justifies public trust and confidence.

[Mr B] was referred to the Neuroservices Unit following deteriorating memory over the last 5–6 years. Following specialist advice community placement was sought. A letter by [a neurologist] dated 2/10/96 notes that 'because of the main safety issues of him with his dementia, poor short-term memory and complete lack of insight it was decided that he would be better placed in a home'.

Admission to [the rest home] October 1996

The records from [the rest home] do not include their initial assessment of [Mr B].

Daily Care Review notes are included from 1996. These notes indicate that [Mr B] had many periods of being unsettled and aggressive. It is identified throughout the progress notes that [Mr B] had problems settling at night and would spend many nights wandering around. It is documented throughout the notes that [Mr B] could become aggressive when staff attempted to encourage him back to his bed. He also had nocturnal continence problems; whether this was in fact incontinence or he became confused finding his way to the toilet is not clear.

Early on, following admission it is identified that [Mr B] entered other residents' rooms.

There were two visits by social workers a short time after admission.

Staff had arranged for [Mr B] to attend community care and craft. He was also able to go outside the facility independently.

In July 1997 [Mr B] was admitted to [the hospital] with left lower lobe pneumonia and discharged back to [the rest home].

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Entries on and around 21/8/97 identify [Mr B] as being very aggressive. Staff have written in the notes 'Please do something about him before somebody gets hurt from him.'

The following day 28/8/97, [Mrs D] has written:

'Seen by Dr Today. Continue to observe and report on verbal or aggressive behaviour.'

Throughout the daily report entries are written by [Mrs D] for staff to observe carefully and document findings.

e.g 18/12/97
16/10/97
15/1/98

Medical staff were aware of [Mr B's] behaviour.

An entry on 22/1/98: 'Seen by Dr. The above was discussed with [Mr B].'

A referral was made to the [Assessment and Rehabilitation] team on 12/2/98. [Mr B] was seen by the [Assessment and Rehabilitation] team [Dr I] on 25/2/98. A behaviour chart was commenced (Chart attached to file marked 'C').

Behaviour does not appear to have improved, incidents are noted in the daily reports form on: 26/4/98
15/5/98
28/6/98

Again there is an incident and staff asking for 'something to be done'. [Mrs D] discussed issues with [Mr B] on 29/7/98.

Daily report form in supporting information 'K' finishes documentation on 26/11/98.

Daily report recommences on 18/7/99.

No Daily Report form between 26/11/98 to 18/7/99.

From 18/7/99 it is evident that [Mr B's] problems remain. Incidents of close association with female residents are noted.

e.g 23/7/99
20/12/99
3/2/00

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Throughout this period it is well documented that [Mr B] was aggressive. It is also documented that he was in deteriorating physical health, mobility was affected with falls documented in the daily report form.

Referral was made to the Physiotherapist.

A referral was again sent from [Dr H] *21/1/00* to the [Assessment and Rehabilitation] team requesting assessment. This followed complaints and requests from [Ms R], of Age Concern.

Summary of Supporting Information
[Mr B] was a frail 77 year old man with a diagnosis of:

Dementia – Lewy Body
Short and long-term memory loss
Aggression
Parkinsonism

He required rest home care in 1996. Throughout his time at [the rest home] staff identified periods of inappropriate sexual behaviour and aggression. He also had periods where he was settled and enjoyed watching TV and visiting his friends. He obviously attempted to be independent and would get upset when staff went to redirect him.

Documentation
Documentation is vitally important in all aspects of Nursing, especially in frail elderly with behavioural problems.

Accurate documentation allows other health professionals to review residents' behaviour and incidents in a logical manner. Comprehensive documentation allows professionals to follow any patterns that may emerge. It also allows specialist health professionals to plan appropriate interventions.

The documentation that was completed at [the rest home] was logical in order. It appears that the Daily Reporting form was documented on an event basis. Documentation was not undertaken on each shift. It appears to be done when an incident or event happened. No other supporting information was presented such as daily activity living cares.

Also not presented in supporting information is accident/incident reports. Throughout the clinical records, incidents are mentioned. Many of these relate to [Mr B] having contact with other residents and staff. Accurate incident forms should have been complemented, or if completed presented with supporting documentation.

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More thorough documentation would have given the visiting professional more evidence of inappropriate behaviour. This may have meant a move to a more suitable facility.

The documentation presented does demonstrate that [Mrs D] asked nursing staff to write accurately, the behaviour that [Mr B] demonstrated. It also shows that medical advice was sought from the General Practitioner, [Dr H].

Included was a nursing care plan in which four problems had been identified. These are:

1. Confusion related to dementia
2. Inability to maintain cleanliness due to dementia
3. Poor mobility due to dementia
4. Inappropriate sexual advances.

The care plan was written on 10/8/99. The nursing objective and nursing interventions are appropriate. There is limited evaluation. The care plan is a working tool that nursing staff and care staff work with. [Mr B's] plan is lacking in specifics and the evaluation should have been more thorough.

Although there are areas in documentation which could have ensured a more comprehensive daily assessment, intervention and evaluation the documentation is typical of documentation one would find in a Stage II rest home.

Appropriate Referrals

Very early in [Mr B's] care staff identified that there were behavioural problems from aggression to inappropriate sexual behaviour. Despite two referrals to the [Assessment and Rehabilitation] team, it does not appear that action was initiated to protect both [Mr B] and other residents suffering from dementia.

In both outside interventions the idea of placement in a more suitable facility was not discussed but rather altering medication and behaviour modification. It is implied that senior staff told the [Assessment and Rehabilitation] team that things had settled down. This is not indicated in the daily report. [Mrs D] was asked twice to review this man. Staff were concerned for other residents.

A more proactive approach from [the rest home] would have ensured a much better outcome for [Mr B]. It must also be noted that the removal within 48 hours was distressing to both [Mr B] and his family and ended with distressing results.

It is my opinion that [the rest home] should have sought specialist advice when interventions that had been recommended did not work.

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Client Centred Care

Each resident/patient in long-term care should have an individual plan to meet their specific needs, both physical and psychological needs. A nursing care plan was written. There was no evidence of any activity plan. There was no record of social history nor was there any record of what things [Mr B] liked to do.

It was obvious throughout the notes that [Mr B] liked to be independent and at times this put him at risk, eg being in the kitchen and making cups of tea. There is no evidence that there was any structured plan. This may have given [Mr B] more purpose in daily activities. It does appear from evidence produced that [Mr B] did attend community care for a short time. It appears [Mr B's] daily life revolved around the rest home.

From the documentation presented there was limited evidence of any individual care plan which took into account [Mr B's] psychological well being.

Staff Training

The dependency of rest home residents has risen in the last 10 years. Stage II rest homes historically provided care for the frail but generally they were well elderly who needed a structured environment, but a reasonably high level of independence.

This has changed in the last 10 years. Many residents are frail and rather than being slightly forgetful, now many are suffering from dementia, behavioural problems as well as medical problems.

There has been limited mandatory training for staff and many rest homes accept residents who require greater skills to be cared for adequately, where care is more nursing rather than assistance with their daily activities. Aggressive behaviour can be managed very differently in facilities where staff have attended training on behaviour management.

Despite the staff's best intentions, the level of understanding and intervention management appears to be limited in [Mr B's] case. This is evident in such things as documentation and a specific psychological plan.

In evidence (K) there are two copies of minutes of meetings where inservice was noted. On 24/4/98 'Difficult behaviours discussion' and on 11/3/97 'Challenging behaviour.' Both of these say '(With [Mr B] in mind)'. It was therefore identified that there was a problem with [Mr B].

It is my professional opinion that staff training was very limited. Appropriate education of staff may have meant that [Mr B's] behaviour could have been managed more appropriately and that staff would have had the knowledge to refer and that referrals would have had the accurate and more appropriate assessment to accompany it.

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Summary

The care and services provided to [Mr B] were adequate to meet his physical needs such as daily living activities. It is my opinion that more care and attention could have been given to [Mr B] in relation to his aggression and inappropriate sexual behaviour. Throughout his stay [Mr B] displayed behaviour that was distressing, both to himself and others and senior staff appeared to act reactively to his behaviour. Although assessments were sought from specialists, when no improvement in behaviour was noticed, further referrals were not made. This led to an emergency placement which was distressing to [Mr B] and his family."

Psychiatric advice

Dr Crawford Duncan, consultant psychiatrist specialising in psychiatry of old age, provided the following independent expert advice:

"1. Purpose

1.1 To provide independent advice about whether [Mr B] and female residents at [the rest home] received an appropriate standard of care.

2. Background

2.1 [Mr B] was placed at [the rest home] in October 1996 by the [Assessment and Rehabilitation] team. [Mr B] was suffering from Lewy body dementia and a history of inappropriate sexual behaviour.

2.2 While he was at [the rest home], [Mr B] was sexually and physically abusing female residents, and responding in an aggressive manner to staff who attempted to dissuade him from this behaviour.

2.3 In December 1999 [Mr B's] behaviour was notified to Age Concern, who reported the concerns to the [Assessment and Rehabilitation] team. [Dr H], the general practitioner visiting the home, also referred [Mr B] to the [Assessment and Rehabilitation] team for a re-assessment at this time.

2.4 On 25 February 2000 [Mr B] was transferred to another rest home.

3. Complaint

3.1 The complaint was that:

3.1.1 Staff have seen [Mr B], who suffers from dementia, touch female residents at [the rest home] on the breasts and masturbate in front of [Mrs C].

3.1.2 There are unconfirmed reports that [Mr B] is sexually assaulting female residents in their beds.

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3.1.3 [Mr B] is allowed to go for walks unaccompanied outside the rest home.

3.1.4 On Friday 17 December [Ms A] brought these matters to the attention of the Nurse Manager [Mrs D] at a staff meeting, and was told that [Mr B] couldn't be transferred until there was someone to replace him.

4. Supporting Information

4.1 Letter to the Commissioner, from [Ms A] received 23 December 1999, marked with an 'A'. (3 pages)

4.2 Letter of response to the Commissioner, from [Mrs D], manager, [the rest home], dated 9 February 2000, marked with a 'B'. (3 pages)

4.3 Clinical records relating to [Mr B] at [the rest home], marked with a 'C'. (40 pages)

4.4 Letter of response to the Commissioner, from [Dr H], dated 25 September 2000, marked with a 'D'. (4 pages)

4.5 Telephone interview with [Mrs L], caregiver, recorded 11 February 2000, marked with an 'E'. (2 pages)

4.6 Telephone interview with [Mr O], husband of resident, recorded 17 July 2000, marked with a 'F'. (1 page)

4.7 Letter of response to the Commissioner, from [Ms M], community mental health nurse, dated 4 August 2000, marked with a 'G'. (10 pages)

4.8 [The hospital's] clinical records relating to [Mr B], dated 19 October 2000, marked with an 'H'. (84 pages)

4.9 Letter of response to the Commissioner, from [Dr I], consultant psychiatrist, dated 12 November 2001, marked with an 'I'. (2 pages)

5. Expert Advice Required

5.1 To advise the Commissioner whether, in your professional opinion, [Mr B] and residents of [the rest home] were provided with services with reasonable care and skill. In addition:

5.1.1 What is Lewy body dementia?

5.1.2 What is the accepted management of Lewy body dementia?

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5.1.3 What are the difficulties in managing patients with Lewy body dementia?

5.1.4 What is its correlation to sexual disinhibition?

5.1.5 What are the options for managing such people when they display sexual disinhibition and sexually assault others?

5.1.6 Should there have been protocols/guidelines in place to deal with this kind of behaviour?

5.1.7 Are there any professional, ethical and other relevant standards that apply and in my opinion were they complied with?

5.1.8 Any other comment you consider relevant that may be of assistance?

6. The Independent Advisor's Report

6.1 Review of Supporting Information

6.1.1 'A': Letter to the Commission from [Ms A]

6.1.1.1 This is the original letter of complaint. I am asked to comment on only one area of the complaint, namely, that a resident with dementia is sexually abusing other residents. Of note is that [Ms A] has not seen the sexual abuse but has been told about the behaviour by other members of the rest home staff. [Ms A] was concerned about three specific areas. First, [Mr B] should be moved to a safe male rest home. Second, [Mrs D], the nurse manager, put financial concerns ahead of the safety of the residents. Third, the community at large was at risk because of [Mr B's] ability to walk beyond the confines of the rest home.

6.1.1.2 I do not get any sense of a time frame from this letter. [Ms A] has worked at the rest home for almost a year. On the one hand, during that time, [Ms A] has not observed the inappropriate sexual behaviour, and it is not clear whether the reported behaviour occurred during her tenure, or during [Mr B's] tenure, at the rest home.

6.1.2 'B': Letter of response to the Commissioner from [Mrs D].

6.1.2.1 This is the nurse manager's response to the complaints. The first page is a strongly critical comment about [Ms

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A]. The second page gives an outline about [Mr B] and then responds to the complaints identified in the original letter. Of note is that [Mr B] is identified as having a history of inappropriate sexual behaviour and that he has a diagnosis of Lewy body dementia. The response addresses four specific areas. First, [Mr B] is sensitive to certain medications. Second, the discrepancy between the reported behaviour of [Mr B]. Third, [Mr B] has shown considerable physical deterioration. Finally, the inappropriate sexual behaviour exhibited by [Mr B] has ceased.

6.1.2.2 [Mrs D] disputes the reported observations of inappropriate sexual behaviour. She correctly points out that [the rest home] does not offer a safe care environment as that associated with specialised dementia care units. She also undermines the veracity of [Ms A] and concludes the knowledge and experience of [Ms A] makes her unsuitable to work with residents suffering from dementia.

6.1.3 'C': Clinical records relating to [Mr B] from [the rest home]

6.1.3.1 These consist of daily reports from 17 July 1999 through to the 9 February 2000 and the visiting general practitioner's notes for this same period of time. In addition there are nursing care plans, behaviour observation charts, medication charts as well as correspondence from various specialist services and information on Lewy body dementia. They make very interesting reading but only the daily records contain information pertinent to the complaint. There appears to be no doubt that [Mr B] had dementia, most certainly of the Lewy body type, and that he exhibited difficult behaviour that would be challenging in most residential care settings. I have attempted to categorise the behaviour observations and record their frequency.

6.1.3.2 The time covered is 208 days, 64 of them have an observation recorded. Of these, 15 were positive, 31 were neutral and 18 were negative. Of the 18 negative observations 5 were nocturnal restlessness, 4 were abusive, 3 were intrusive into other residents' space, 3 were inappropriate sexual behaviour, 2 were aggressive, and 1 was wandering outside the rest home. If this is a

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representative sample it represents, on average, 1 difficult behaviour incident every fortnight and 1 inappropriate sexual behaviour incident every 2½ months.

6.1.4 'D': Letter of response to the Commissioner from [Dr H].

6.1.4.1 [Dr H] is the general practitioner to [the rest home]. [Dr H] summarises [Mr B's] medical diagnosis and documents the incidents of inappropriate sexual behaviour he was aware of. The source of his observations is not provided. From the first incident on 28 November 1996 until the last incident on the 13 March 1999, a period of 835 days, 11 incidents are recorded. This represents 1 inappropriate sexual behaviour incident every 2½ months. [Dr H] also summarises the input from the psychogeriatric services and, in my view, correctly concludes on the lack of specific effective interventions available to treat inappropriate sexual behaviour in people with dementia.

6.1.5 'E': Telephone interview with [Mrs L].

6.1.5.1 [Mrs L] is a caregiver at [the rest home] and this interview confirms inappropriate sexual behaviour had been observed and that other incidents had been reported to her by other caregivers. [Mrs L] indicates there are other behaviourally disturbed residents at [the rest home]. [Mrs L] believes that behaviourally disturbed residents and [Mr B] specifically, remain at [the rest home] to maximise bed occupancy. [Mrs L] comments that [Mr B] is responsible for his actions and that the staff do not provide appropriate care for the residents.

6.1.6 'F': Telephone interview with [Mr O].

6.1.6.1 [Mr O] is the husband of a resident at [the rest home]. None of the information provided me identifies [Mr O's] wife as being subject to [Mr B's] unwanted attention but this is the basis of this telephone interview. [Mr O] said he had threatened [Mr B] to leave his wife alone and had complained to [Mrs D]. [Mr O] felt nothing had come of his complaint.

6.1.7 'G': Letter of response to the Commissioner from [Ms M]

6.1.7.1 [Ms M] is a community mental health nurse employed by the [Assessment and Rehabilitation] team, Mental Health

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Services based at [another public hospital]. This letter documents the contact the psychogeriatric service had with [Mr B] and [the rest home]. Of note is that their involvement starts about 18 months after [Mr B] was placed at [the rest home]. His behaviour fluctuated resulting in the psychogeriatric service not being 'connected' to [Mr B] and the difficulties he was causing at [the rest home]. The letter concludes with an account of [Mr B's] replacement, which is described as being a knee-jerk reaction rather than a considered process. It is not clear how or why the Ministry of Health came to be involved but their involvement appears to have precipitated [Mr B's] removal from [the rest home]. This chapter raises a number of issues that are not directly related to the complaint but are indicative of the ethos that surrounds the management of people with dementia exhibiting inappropriate sexual behaviour. From [Ms M's] perspective, the outcome for [Mr B] was not in his best interests.

6.1.7.2 The attached correspondence includes a record of the complainant's contact with [Ms R] who I understand from elsewhere in the documentation is associated with Age Concern. This document is dated 23 December 1999 and asks that [Mr B] have an urgent psychogeriatric assessment. The reply to this request is of concern as it states the psychogeriatric assessment could/would not take place. The remainder of the attachments provides an account of [Mr B's] transfer from [the rest home]. There are two concerns raised. First, it appears from the words used that the caregivers at [the rest home], and [Ms A] in particular, do not understand, or are unsympathetic to, the clinical significance of frontal lobe degeneration. Second, how can a Ministry of Health employee on the telephone from [one city] give orders and stipulate conditions with regard to the appropriate replacement of an individual, in this case [Mr B], in [another city]?

6.1.8 'H': Clinical records relating to [Mr B] from [the hospital].

6.1.8.1 These clinical records predominantly relate to after [Mr B's] transfer from [the rest home] and do not relate to his period of residence there. There are insights to the confusion surrounding [Mr B], eg., the copy of the e-mail

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from [Ms M] to [another mental health care provider] on 10 March 2000.

6.1.9 'I': Letter of response to the Commissioner from [Dr I].

6.1.9.1 [Dr I] is a psychiatrist employed for a time by the [Assessment and Rehabilitation] team, [the hospital]. This letter outlines information conveyed to the [Assessment and Rehabilitation] team about [Mr B] and summarises the medication introduced to influence [Mr B's] behaviour. The issue raised by this letter is to do with lines of responsibility for the oversight of clinical management of people with psychological and behavioural symptoms associated with dementia.

6.2 Conclusions from supporting information.

6.2.1 Knowledge.

6.2.1.1 An impression gained is an ignorance of the impact of dementia upon an individual. As far as is known [Mr B] led an exemplary life and the loss of cognitive function has resulted in behaviour that is uncharacteristic of his pre-morbid personality. That he is responsible for his behaviour indicates a prejudice that is not consistent with sound nursing care. Dementia is a tragic illness and it is impossible to know what it is like to experience. I include in this report material that I have provided in medical reports to the Family Court with regard to the Protection of Personal and Property Rights Act (1988). The purpose is to try and convey the tragedy of dementia.

6.2.1.2 Dementia

6.2.1.2.1 Dementia as a clinical syndrome represents a progressive deterioration in all areas of brain function, which maintain the individual's links with their present and past personal, social and physical environment. The reactions and adaptations to such erosion of the boundaries of the self provide additional psychopathological features that may at times, especially early on, overshadow the original cognitive impairment. As the remaining cognitive self-maintenance skills decline so these reactions and adaptations themselves

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deteriorate and fail leading to increasingly regressive elements in behaviour. This brings into sharper focus the extent of mental incompetence until the brain ceases to manifest any sustained control over the immediate personal environment and the person can no longer look after themself.

6.2.1.2.2 From this point on sequences of behaviour become increasingly severed from any sustained purposive, intact behaviour, eventually resulting in ever-limited reactivity to the immediate physical environment.

6.2.1.2.3 At one level then this deteriorative process begins with a reduction in cognitive or conceptual mastery: new information cannot be assimilated and interests and concerns become narrower, more limited and more concrete. Indifference, dislike or fear of the new and personally distant world may produce withdrawal, lack of curiosity and increasing rigidity. Such a retrenchment may be slowly and apparently successfully negotiated without evident distress and with the appearance of retained personal integrity albeit of a more egotistical and restricted nature. Alternatively, the inability to assimilate new or personally distant information may arise more rapidly, resulting in increased threat, especially if the individual's personal and social environment is relatively extensive where their limited competence can be more severely taxed. As failure in recall and incompetent retrieval strategies become evident, the field of mastery is further reduced, and the immediate familiar environment can no longer provide a secure field in which the person can maintain their integrity. At this point, there may be further withdrawal and indifference – to household chores, to family news etc. – or the employment of evidently incompetent defence mechanisms of denial and projection. As the person shows increasing inability to rationalise effectively, to give plausible accounts of their

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own actions, to relate their behaviour to the immediate environment, self-neglect becomes evident. A process of alienation from others then seems to emerge. Close family feel they can no longer understand or get through to the dementing person at this stage. From this point many of the individual problems of hostility, apathy, wandering, even incontinence now are overshadowed by the more central loss – the loss of the person. The demented individual now seems to have become disorientated, not simply to their own surroundings but to their previous self. Occasional echoes of the self and old habits emerge but without evident continuity. Behaviour becomes increasingly reactive, purposeless and disjointed. As even this reactivity declines a vegetative state predominates, with minimal voluntary activity. Such an endpoint seems rarely observed in the community and may be normally reached only when institutional medical care is continuously maintained.

6.2.1.2.4 The understanding of the syndrome of dementia requires consideration of what constitutes the self, what makes a person, what holds together the acts of an individual to give them personal integrity, consistency and ultimately value. Psychoanalysts speak of the importance of personal relatedness and the growth of self as the growth of personal reality within one's self; the concept of personhood. This sense of personal reality seems to be the essence of what decays as dementia progresses. This personal reality seems to depend upon the intactness of memory, the ability to continue to interpret the present within the structure of personal experience in the past, and the ability to extend this continuity to one's future intentions. The confusion that surrounds the dementing person is a confusion over reference points, both current and historical, which dislocates actions, misperceives experience and loses the thread that gives them meaning and intentionality to behaviour, which taken globally reflects a

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fundamental loss of relatedness, to both the physical and social environment.

6.2.1.2.5 This loss is not simply one of memory in the sense of an inability to learn or to store information. Patients, who as a result of brain trauma lose the ability to update their knowledge, fail to learn and store anything new. They are not demented nor do they appear demented. One may argue that their self does not or cannot develop, yet it is retained.

6.2.1.2.6 Equally patients who, as a result of head injury, became increasingly self centred, immature and shallow, are not perceived to be or to have demented. Their behaviour may be impulsive, abstract codes of conduct may be easily over ruled by the inability to delay gratification, yet however much personality change is recorded, the remaining person retains a self and a grasp on reality and continues to develop.

6.2.1.2.7 Finally mentally handicapped people whose language is limited to a few stereotyped utterances, who struggle to put on a coat, and who precariously learn to carry a plate from the table held high and awkwardly as if it would slip at any moment, nevertheless do not seem demented. They recognise their place in the family, the familiar route home, they seek a limited but meaningful relationship with people around them.

6.2.1.2.8 Yet in some way the static deficits observable in the amnesic person, the disinhibited brain damaged person and the intellectually handicapped person all share similarities with the pattern of dynamic impairment observable in the dementing person. It is the onslaught from all sides that seems to take away any opportunity to maintain some form of orientation and personal integrity.

6.2.1.3 A number of psychiatric phenomena are associated with dementia as typified by Alzheimer's disease. For instance, out of a sample of 178 patients with Alzheimer's disease,

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aggression was present in 20%, wandering in 19%, binge-eating in 10%, hyperorality in 6%, urinary incontinence in 48% and sexual disinhibition in 7% (Burns, A., et. al., 1990. The *British Journal of Psychiatry* 157:86-94). It is said, unfortunately I do not have a reference, that a half of nursing home residents have dementia and two thirds of nursing hospital residents have dementia. [Mr B] is not a common scenario in the residential care setting but on the other hand it is not an atypical problem that has to be dealt with. For any caregiver working in the residential care sector it is not a matter of if a patient with inappropriate sexual behaviour will have to be managed but rather a matter of when.

6.2.1.4 The successful management of inappropriate sexual behaviour in the residential care setting is dependent on assessment, communication, teamwork and philosophy.

6.2.1.4.1 Assessment focuses on what is the problem, who has the problem, and appreciating the context of dementia and the loss of self.

6.2.1.4.2 Communication focuses on the development of an understanding that is the result of a collaboration of all the caregivers in the rest home.

6.2.1.4.3 Teamwork focuses on a consistent persistent approach towards the inappropriate sexual behaviour by all caregivers in the rest home.

6.2.1.4.4 Philosophy focuses on the culture of the rest home and the attitude of the individual caregivers towards the residents.

6.2.1.5 In my opinion, the information provided indicates a deficiency in knowledge in both parties of this complaint. [Ms A] does not exhibit sympathy or empathy towards [Mr B]. [Mrs D] may understand the impact of dementia upon [Mr B] but does not exhibit the leadership necessary to weld an effective team to cope with his inappropriate sexual behaviour.

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6.2.2 Responsibility.

6.2.2.1 In New Zealand an individual is responsible for their actions until proven otherwise. With regard to health care an individual is responsible for decisions and behaviour they make and it is only in a limited number of scenarios that this authority does not apply. In an emergency when a person is unable to give consent is the most obvious example. The health services are not responsible for an individual's health; they can advise but they cannot make decisions on an individual's behalf. Exceptions to this are the Mental Health Act and the Protection of Personal and Property Rights Act. The problem that confronts [Mr B], who, with his dementia, has in all probability lost the capacity to make decisions with regard to his care and well being, is who is responsible for meeting his health care needs? In this situation, who is responsible for ensuring that [Mr B's] best interests are being addressed? Who is responsible for addressing the appropriate management of inappropriate sexual behaviour in people with dementia?

6.2.2.2 In New Zealand there is not a statutory relationship between an individual and their medical adviser. In the United Kingdom, the National Health Service stipulates that a person is to be registered with a general practitioner for their primary health care and in return the general practitioner is obliged to respond to the health needs of the individual. This obligation is transferred to a hospital specialist when the person is admitted to hospital, by identifying the responsible medical officer, and transferred back to the general practitioner on discharge. In New Zealand such an obligation is absent in the primary health care setting, and though in practice exists in the hospital setting is not a statutory obligation. The exception to this exists in the Mental Health Act where a Responsible Clinician is defined and has a role identified by legislation. The residents of [the rest home], such as [Mr B], do not have a medical practitioner responsible for their health care needs other than the arrangement arrived at between [Dr H] and [Mrs D]. It is likely that [Dr H] is of the view that he has responsibility for the health care of the residents at [the rest home] but this is a moral and contractual obligation rather than a statutory obligation. More importantly, there is no obligation for the specialist

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health services, such as the psychogeriatric services, to be responsible for the management of [Mr B's] inappropriate sexual behaviour. Any obligation for such responsibility ended when the public health sector terminated the provision of residential care in the health sector changes of the 1980s. The Code of Practice promulgated by the Health and Disability Commissioner represents a responsibility to provide best practice but is not a statutory obligation for an identified medical practitioner to be responsible for an identified individual's health care. The importance of this distinction is that once upon a time the public sector psychogeriatric services were responsible for the long-term treatment and care of behavioural and psychological problems of dementia. But with (virtually) no public sector long-term beds this responsibility has been transferred to the private sector and general practitioners.

6.2.2.3 In my opinion, the information provided indicates a deficiency in responsibility in both sectors of this complaint. [The rest home] and [Dr H] do not exhibit the necessary expertise to manage the inappropriate sexual behaviour of [Mr B] and yet were responsible for the care and welfare of the residents including [Mr B]. The expertise in the form of [Dr I] and the psychogeriatric services provided appropriate advice but did not control the utilisation of resources to manage [Mr B's] behaviour. There was not an obligation by the psychogeriatric services to be responsible for the treatment provided [Mr B] and the care and welfare of the other residents at [the rest home].

6.2.3 Standards.

6.2.3.1 There is no gold standard with which to judge the management of inappropriate sexual behaviour associated with dementia. Professional bodies have standards and their members, by belonging, indicate their intention to comply with these standards. Without examining these different standards in detail I am not in a position to comment. However I have been asked to comment on Right 4(1) of the Code of Health and Disability Services Consumers' Rights. Namely, every consumer has the right to have services provided with reasonable care and skill.

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6.2.3.2 With regard to inappropriate sexual behaviour associated with dementia, what is reasonable care and skill? In my opinion, the cornerstone of reasonable care and skill begins with an assessment and ends with the implementation of a planned intervention.

6.2.3.3 From the information provided I have ascertained that [Mr B] entered [the rest home] in October 1996 and that the psychogeriatric services were not involved with his placement. I assume this suggests that at the time of admission [Mr B] was not exhibiting inappropriate sexual behaviour.

6.2.3.3.1 [Dr H] identifies the first incident on the 28 November 1996. From the information provided I have ascertained the first assessment to the psychogeriatric services was on 12 February 1998. From [Dr H's] reply this was after three incidents, there being a year between the first and second incident. From a pragmatic perspective this seems reasonable.

6.2.3.3.2 [Mr B] was assessed by a psychogeriatrician, [Dr I], and a follow-up was arranged for input from a psychologist, [Dr J]. Again this seems reasonable.

6.2.3.3.3 [Dr J] does not indicate when she visited [the rest home] but writes on the 9 April 1998 that there had been 'no further episodes of aggression' and [Mr B] was discharged. This improvement in [Mr B's] behaviour is substantiated in [Dr H's] report. Over the following ten months [Dr H] reports 6 further incidents and re-refers to [Mr B] to the psychogeriatric service on 12 March 1999. Of note is that [Dr H] asked about chemical castration. Again this seems reasonable.

6.2.3.3.4 On this occasion a telephone conversation with [Dr I] considered medication and there was some ongoing contact with the community nurse from the psychogeriatric services. There was a change in [Mr B's] medication but it was not the 'chemical castration' [Dr H] was requesting. Unfortunately [Dr I] does not

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address this matter in her report. However, the introduction of risperidone, generally considered a reasonable intervention, in view of [Mr B's] diagnosis of Lewy body dementia would be considered with an increased risk of causing adverse effects. [Dr H] reports that side effects caused the risperidone to be discontinued. Perhaps the introduction of a testosterone antagonist, as [Dr H] requested, would have been the more reasonable intervention.

6.2.3.3.5 [Dr H] does not report any further incidents so perhaps it is reasonable that the introduction of a testosterone antagonist was not pursued further.

6.2.3.3.6 The nursing records indicate that there were further incidents and they led to [Mr B's] re-referral for transfer to another rest home. In the context of the concerns expressed by [Ms A] such a request is probably in the best interests of [Mr B] and therefore represents reasonable care.

6.2.3.4 What is lacking from the information provided is an account of the assessment undertaken in the context of the rest home. The documentation of [Dr I's] assessment indicates reasonable care and skill. But the subsequent documentation does not indicate a consultation liaison relationship established between the psychogeriatric services and [the rest home]. Nor does the documentation indicate that the staff at [the rest home] considered management strategies as a cohesive nursing team.

6.2.3.5 The clinical records from [the rest home] do indicate an awareness of the problem. [Mrs D] has documented requests to observe [Mr B's] behaviour closely. And staff have documented they have intervened when they have observed [Mr B] to be behaving inappropriately. In the sense that that is all that was asked of them the staff have provided services with reasonable care and skill. However, as addressed earlier there is the wider issue of knowledge and responsibility and it is likely [Mr B] and

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the other residents of [the rest home] were disadvantaged by deficiencies in these areas.

6.2.4 Reality.

6.2.4.1 'People in glass houses shouldn't throw stones.'

6.2.4.2 [Mr B's] dementia is a personal tragedy for him. To a lesser extent, but no less significant, his behaviour which (in all probability) is beyond his control because of his dementia is a tragedy for the other residents in the communal living situation they shared. Similarly, the caregivers that felt the burden of providing care for [Mr B] and the other residents at [the rest home]. Similarly, again, for [Mr B's] family confronted with behaviour that was (presumably) uncharacteristic of their family member. In no way can the enormity of this tragedy be minimised.

6.2.4.3 But it is a tragedy that occurs to a surprisingly high number of New Zealanders. Though one has sympathy for [Ms A's] complaint, unfortunately, the reality is that inappropriate sexual behaviour as a consequence of dementia is a hugely difficult clinical management problem. For the rest home and its caregivers that are thrust into the position of having to care for these individuals it is bad luck. But the comment by [Ms A] to transfer [Mr B] to an all-male facility is not an unreasonable one. Before deinstitutionalisation, single sex wards in the old psychiatric hospitals catered successfully for inappropriate sexual behaviours. For most metropolitan centres in New Zealand a private sector single sex rest home is not economically viable.

6.2.4.4 The reality is that there, but for the grace of God, go I. There is no absolute right or wrong way to treat [Mr B]. And I fear there are too many [Mr B] in my own catchment area. However, once appraised of [Mr B's] existence I expect of myself that an assessment of his behaviour and a collaboration with the rest home to manage his behaviour in the least restrictive way, giving due regard to the safety and welfare of the other residents, can be demonstrated. The reality is that despite the best of intentions compromises are made to pragmatically cope with the unforgiving tragedy of dementia. I fear that the many interactions I have with rest homes in my own catchment area are not documented to the extent that the

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quality of the professional relationship can be determined in hindsight. The information provided with which to provide this report is limited and may not reflect the realities of the conditions and situation at [the rest home].

7 Advice.

7.1 What is Lewy body dementia?

7.1.1 For the Commissioner's information I attach a recent journal article describing the features of Lewy body dementia (McKeith I, O'Brien J. Dementia with Lewy bodies. *Australian and New Zealand Journal of Psychiatry* 1999; 33:800-808). I draw the Commissioner's attention to the conclusion. 'Dementia with Lewy bodies is a common cause of cognitive impairment in late life which appears to be clinically and neuropathologically distinct from Alzheimer's disease. All clinicians should be aware of the typical triad of clinical features (fluctuating cognitive impairment, visual hallucinations and parkinsonism) which characterise the disorder and either avoid antipsychotics or prescribe them with extreme caution in such patients. Further research is likely to result in advances in diagnostic methods and therapeutics in the near future.'

7.2 What is the accepted management of Lewy body dementia?

7.2.1 There is no specific 'accepted management' of Lewy body dementia that separates it from other dementias. As the previously reported paper suggests, there is the possibility that people with Lewy body dementia may respond better to acetylcholinesterase inhibitor medication than those with Alzheimer's dementia. Currently, this suggestion remains at the anecdotal level. There are other difficulties with using acetylcholinesterase inhibitor medication, not the least being access, as the Pharmaceutical Funding Agency does not fund this medication. The most important practice point in the management of Lewy body dementia, as noted in the letter of response to the Commissioner from [Mrs D] (paragraph 6.1.2.1), is caution in (or preferably avoidance of) the use of antipsychotic medications.

7.3 What the difficulties in managing patients with Lewy body dementia?

7.3.1 In one sense patients with Lewy body dementia do not present any specific difficulty in their management compared with patients with other causes of dementia. However, the fluctuating cognitive impairment, the visual hallucinations, and the increased sensitivity

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to antipsychotic medications do present particular challenges to management that other dementias do not.

7.4 What is its correlation to sexual disinhibition?

7.4.1 To my knowledge there is no correlation between Lewy body dementia and sexual disinhibition.

7.5 What are the options for managing such people when they display sexual disinhibition and sexually assault others?

7.5.1 There are four main options to consider. First, assessment, in particular understanding the context of the behaviour. Second, observation / monitoring, to allow the early recognition of behaviour that may signal inappropriate sexual behaviour and an intervention by a caregiver to prevent the occurrence of inappropriate sexual behaviour. Third, medication, in particular the role of testosterone antagonists in curbing the biochemical drive that may contribute towards inappropriate sexual behaviour. Finally, geography, in that placement of the patient in a single sex residential care setting usually removes the opportunity and thereby inhibits the expression of inappropriate sexual behaviour. It should be noted that with the demise of long-term residential care in psychiatric hospitals, single sex facilities have virtually disappeared. Most, if not all, metropolitan centres in New Zealand are too small to maintain financially viable single sex residential care settings.

7.6 Should there have been protocols/guidelines in place to deal with this kind of behaviour?

7.6.1 It is my view that protocols/guidelines are only of value when there are clearly defined clinical pathways with predictable outcomes that are supported by the appropriate resources of caregiver expertise and funding. The management of dementia, and in particular the behavioural and psychological symptoms of dementia, do not meet these criteria. There are several educational aides in the management of people with dementia and specialist services, as represented by psychogeriatric services, are well versed in the assessment and treatment of these people. Residential care settings that focus on the long-term care of people with dementia often develop expertise in this area of care. However, it is not acknowledged from the funding authorities the peculiar difficulties managing some of the more difficult behaviours associated with dementia and the need for case-by-case funding to

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address the drain on a residential care facilities resources such behaviour creates.

7.6.2 The residential care sector is funded by Disability Support Services (DSS) through the Ministry of Health. The DSS have four levels of residential care, two in the nursing home sector and two in the nursing hospital sector. The least restrictive level in the nursing home sector is the 'stage 2 rest home', such as [the rest home]. The least restrictive level in the nursing hospital sector is the continuing care hospital. The difference between these two levels is the nursing dependency of the patient. If a person is suited to the nursing home level of care but has dementia and some behaviour that makes placement in a stage 2 rest home untenable, the next level of care is a 'stage 3 unit'. If a person has behaviour that makes placement in a stage 3 unit untenable and/or has a nursing dependency that makes placement in a rest home untenable, the most restrictive level of care is a 'high dependency unit', also known as a psychogeriatric hospital. Appendix 1 has a diagram demonstrating the four levels of residential care funded by the DSS. Though the four levels do recognise the additional costs of providing care for the behavioural and psychological symptoms of dementia, there are some behaviours, such as aggression, inappropriate sexual behaviour and perseverative calling out, that such limitation is extremely limited. A process whereby the most demanding and challenging behaviours could be adequately resourced, in my opinion, would do more for the management of inappropriate sexual behaviour than prescriptive measures such as protocols/guidelines.

7.7 Are there any professional, ethical and other relevant standards that apply and in your opinion were they complied with?

7.7.1 I assume the standards referred to would have to be those subscribed to by the owners and staff of [the rest home] and the different disciplines employed by the Psychogeriatric Services of [the hospital]. I do not know the documents that all the individuals involved with [Mr B] might subscribe to.

7.7.2 However, there are some basic ethical standards that can be applied to all health professionals, and probably to those employed in the residential care sector that are not health professionals. I refer to the principles of autonomy, beneficence, non-maleficence, and justice. With a person whose capacity to be responsible for their behaviour is impaired, as is not uncommon in a person with dementia, and when this person is residing in a communal situation,

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these principles compete against each other when they are applied to the individual and the fellow residents. When the threshold of one principle for one resident is overcome by the threshold for a competing principle for the other residents is debatable, and in my view not possible to resolve by such a review as this.

7.7.3 In my opinion, the outcome of transferring [Mr B] after his behaviour had been documented, and to an extent reviewed, does suggest these general ethical principles were complied with in the broader sense.

7.8 Any other comment you consider relevant that may be of assistance.

7.8.1 Sympathy and empathy.

7.8.1.1 Inappropriate sexual behaviour in people with dementia attracts stigmatisation. It is essential to recognise their behaviour is beyond their control because of a disease that is destroying the person they were. To try and explain how to understand this experience I refer to principles central to inter-cultural communication. To understand the behaviour of strangers, we must use their frame of reference, not our own. Stated differently, we need to empathise rather than sympathise.

7.8.1.2 Sympathy refers to 'the imaginative placing of ourselves in another person's position'. In other words, we use our own frame of reference to interpret incoming information. If we apply the 'Golden Rule' (to be found in Luke 6:31 'Do unto others as you would have them do unto you') in interactions with strangers, we are being sympathetic because the reference is our own standard of appropriate behaviour. On the other hand, empathy is 'the imaginative intellectual and emotional participation in another person's experience'. The reference for empathy is not our own experience, but that of the stranger. An alternative rule has been proposed to the 'Golden Rule', the 'Platinum Rule': 'Do unto others as they themselves would have done unto them.'

7.8.1.3 Though, as health professionals we would not consider the people we provide care for as strangers, inappropriate sexual behaviour in people with dementia turns stalwarts of society into strangers. I believe the Golden Rule is essential to our attitude, our commitment towards these

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people, and the Platinum Rule is essential to our behaviour, our treatment of these people.

7.8.2 Disappointments.

7.8.2.1 On a personal level, I am disappointed there is a sense from [Ms As] letter of complaint a lack of sympathy and empathy towards [Mr B] and the tragedy that had overtaken him.

7.8.2.2 Also, I am disappointed there is such a personal attack on [Ms A] in [Mrs D's] response to the Commissioner and an apparent lack of sympathy and empathy towards vulnerable staff.

…

8. Final conclusion.

8.1 Aspects of [Mr B's] management could have been done better. However, on the information provided to me, and paying due regard to the context of the complaint, I believe [Mr B] and the other residents at [the rest home] received services with reasonable care and skill within the limitations of the resources allocated to provide these services.

9. My comments are as above."

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

Right to Services of an Appropriate Standard

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

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Opinion: Breach – Mrs D

Right 4(4)

There is no doubt that Mr B exhibited inappropriate behaviour, and that his behaviour presented challenges to the staff who cared for him. However, the question I must determine is whether all that reasonably could have been done for Mr B was done. Mr B's notes record intermittent but repeated instances of aggression to staff, and occasional instances of aggression to other residents. There are also recorded instances of Mr B touching female residents on their breasts, and of him wandering into residents' rooms at night. My psychiatric advisor commented that during the seven months prior to his transfer from the rest home, Mr B is recorded as having four abusive episodes, three episodes of entering other residents' space, three incidents of inappropriate sexual behaviour and two incidents of aggression. My advisor calculated that these recorded incidents represent one behavioural incident per fortnight and one inappropriate sexual behaviour incident every two and a half months. My advisor also referred to the incidents reported to me by Dr H. Mr B had a behavioural incident every two and a half months. (Dr H reported one incident in 1996, one in 1997, five in 1998, three in 1999 and one incident in 2000.)

Mrs D is a registered nurse employed as the manager of the rest home. She was responsible for the care provided to Mr B and the other residents. Her responsibility included managing Mr B's behaviour, in particular, his sexual disinhibition and aggression, as it affected the other residents.

The action taken to control Mr B's behaviour consisted of Mrs D reporting the incidents to Dr H and recording the fact of those discussions in Mr B's notes. She left repeated instructions to staff to watch, monitor and report Mr B's behaviour and staff discussed Mr B's behaviour at their daily staff meetings. A behavioural chart was commenced in March 1998 at the request of the Assessment and Rehabilitation team, which was continued for six weeks. Mrs D's instructions to staff appear to have been carried out, as there are reported instances in Mr B's notes about his behaviour.

Dr H prescribed a range of medication to try to control Mr B's behaviour. The medication had limited success and in February 1998, and again in March 1999, Dr H referred Mr B to the Assessment and Rehabilitation team for assessment. The third referral to the Assessment and Rehabilitation team was in January 2000, when Dr H requested Mr B be placed elsewhere.

My psychiatric advisor stated that there are four options for managing people who have Lewy body dementia and sexual disinhibition: assessment and understanding the context of the behaviour, observation/monitoring, medication and placement in a single sex residential care setting. In respect of Mr B, my advisor said that in his opinion, "[Mrs D] may understand the impact of dementia upon [Mr B] but does not exhibit the leadership necessary to weld an effective team to cope with his inappropriate behaviour." My advisor also commented that the staff at the rest home did not demonstrate that they had

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the skills necessary to manage Mr B's inappropriate sexual behaviour, although he did note that Mrs D and Dr H both took some action to control Mr B's behaviour and the effect of that behaviour on the other residents.

However, more could have been done. In my view, Mr B's behaviour warranted more active intervention in the form of transfer to a single sex institution sooner than January 2000, when the referral for transfer was made. A complaint was made that Mr B had exposed himself to a female resident one month after his admission in October 1996. The matter was followed up, but was disregarded as Mr B denied the incident and there had been no previous reports of such behaviour. However, the incident was not an isolated one. Mr B continued to behave inappropriately until his transfer from the rest home in February 2000, more than three years since his admission.

My nursing advisor said that "a more proactive approach by [the rest home] would have ensured a much better outcome for [Mr B]". She also commented that "the care and services provided to [Mr B] was adequate to meet his physical needs such as daily living activities" but that in her opinion, "more care and attention could have been given to [Mr B] in relation to his aggression and inappropriate sexual behaviour. Throughout his stay [Mr B] displayed behaviour that was distressing, both to himself and others and senior staff appeared to act reactively to his behaviour."

Dr I commented: "Ideally [Mr B] should have gone into a Stage III home. However there were only 204 such beds in all of [the city] at that time. These were constantly full."

My psychiatric advisor stated that Ms A's comment that Mr B should be transferred to an all male facility was not unreasonable. The Assessment and Rehabilitation team had assessed Mr B, he had been monitored and staff requested to prevent the occurrence of inappropriate sexual behaviour, and medication had been prescribed, all with limited effect. The remaining option was to transfer Mr B. The referral for this transfer did not occur until January 2000, ten months after the referral to the Assessment and Rehabilitation team when Mr B was prescribed risperidone, which had to be discontinued because of the side effects. Although Mr B became increasingly frail during 1999, there were still recorded instances of him bailing up female residents, stroking the breast of one resident and being verbally abusive to staff. In my opinion, Mr B's inappropriate behaviour was not well controlled. The remaining option of transferring Mr B to an all male facility was not considered soon enough or with sufficient urgency.

I acknowledge that caring for patients with dementia is difficult, and that inappropriate sexual behaviour is not something that is easily or quickly remedied, particularly when that behaviour occurs in an elderly man suffering from dementia. I also acknowledge that Mrs D did not ignore Mr B's behaviour. However, three years is too long before considering transferring a resident who needs to be continually watched to ensure that he does not approach and hit, or touch, other residents. Accordingly, in my opinion Mrs D breached Right 4(4) of the Code.

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No further action

Mr B was allowed to go for unaccompanied walks
One of the allegations made was that Mr B was allowed to go on unaccompanied walks and could be a threat to the community.

The rest home is a Stage II rest home. I am advised that of the two levels of care in the nursing home sector, the stage II rest home is the least restrictive level. Residents are not incapacitated and may undertake independent activities.

Mr B was not heavily dependent on staff at the rest home and, in the early years of his stay there, visited family and friends. He would often make himself cups of tea. My nursing advisor commented that it was obvious from Mr B's notes that he liked to be independent. There were also occasions when Mr B did leave the rest home unaccompanied. However, during his stay at the rest home, Mr B's condition deteriorated and he became increasingly frail.

Mrs D informed me that Mr B did not leave the rest home unaccompanied after October 1999, because of his increasing frailty. There is no record in the notes of Mr B leaving the rest home unaccompanied after October 1999. Nor have I received any information that indicates Mr B offended anyone while away from the rest home. I note the repeated instructions to staff to watch Mr B.

In the circumstances, I consider there is insufficient information to substantiate this allegation. I have therefore decided to take no further action in respect of this matter.

Meeting on Friday 17 December
Ms A alleged that at a staff meeting on Friday 17 December 1999, shortly prior to Ms A ceasing to work at the rest home, she drew Mrs D's attention to Mr B's behaviour. Ms A said that she raised her concerns that Mr B should be moved to a safe male rest home. She advised me that Mrs D responded angrily to her allegation and stated that Mr B could not be transferred until there was someone to replace him.

Mrs D denied the allegation that residents are kept at the rest home until a replacement is found. She informed me that if she was of the view it was in a resident's best interests to be moved to another establishment, this would be done as soon as possible in conjunction with advice from Dr H and the Assessment and Rehabilitation team.

Mrs D did not, however, inform me what action, if any, she took in response to Ms A's suggestion. I note that Ms A obviously voiced her concern about Mr B for the purpose of having some action taken about his behaviour. I note also that the third referral to the Assessment and Rehabilitation team by Dr H, dated 20 January 2000, referred to Mrs D's concerns that it was no longer possible to appropriately care for Mr B and that an all male residence appeared to be appropriate.

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The meeting on 17 December 1999 was a significant time ago and I have received different accounts concerning what transpired at that meeting. Unfortunately, it has not been possible to obtain further information from others who attended the meeting. While Ms A and Mrs D may not have agreed, at that time, about the appropriate steps to take with respect to Mr B, I am satisfied that Mrs D did raise her concern with Dr H. I note that the third referral to the Assessment and Rehabilitation team by Dr H occurred soon after the meeting in December 1999. Whether this was as a result of Ms A's comments is undetermined. Accordingly, I have decided to take no further action in relation to this aspect of the complaint.

Alleged shouting at patients and staff

An allegation was made that Mrs D shouts at patients and staff when she is stressed. The Code applies to consumers of health services. Staff at the rest home are not consumers for the purposes of the Code and accordingly, Mrs D's treatment of staff does not fall within my jurisdiction as Health and Disability Commissioner. However, treatment of consumers, including shouting at them, does raise issues under the Code and whether consumers were treated with respect. (Right 1(1) of the Code affirms every consumer's right to be treated with respect.)

Mrs D has informed me that it is not "in [her] nature to shout at anyone, and certainly not at any of our residents". Mrs D also referred to there being a difference between shouting and the raising and lowering of the tone of voice.

I have not received any other information during my investigation of this complaint that substantiates the allegation that Mrs D shouts at patients. In the circumstances, and in light of the response provided to me by Mrs D, I have decided to take no further action about this allegation.

Missing temazepam

An allegation was made that temazepam regularly went missing from the rest home. However, this allegation also referred to the fact that the complainant had only heard about this "unofficially".

Mrs D advised me that residents' medication is dispensed by a pharmacy in a 28-day Webster Pack system. The packs are made up by the pharmacy and delivered to the rest home. When the medication is administered to residents, staff take the pack to the resident and "pop" the appropriate blister directly from the pack. When packs are not in use, they are locked in the medicine cupboard and are checked by the manager or registered nurse daily. Mrs D strongly denied that medication goes missing.

I have reviewed the patient charts provided to me by the rest home for the two residents who were prescribed temazepam. There is no indication that the temazepam was not administered and in the circumstances described by Mrs D, it is difficult to see how temazepam could go missing, particularly as it is provided to the rest home in packs provided for specific residents. I note also that in the notes concerning Mr B, there is a clear instruction to staff that they are to watch while patients take their medication.

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In all of the circumstances, I am satisfied that there is no substance to the allegation that temazepam has gone missing from the rest home. No consumer has been identified as not receiving his or her medication. Accordingly, I have decided to take no further action in relation to this matter.

Opinion: Breach – The rest home

Vicarious liability
Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. 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's breach of the Code.

Mrs D was the manager of the rest home. She was employed by the former licensee of the rest home. (I note that the previous organisation no longer owns the rest home.) The rest home, like other stage II rest homes, provides services to elderly residents whose physical and mental condition will invariably deteriorate over time. Recognising a resident's deterioration, and responding appropriately to it, is a fundamental aspect of providing care to the elderly. Mrs D did not take reasonable steps to optimise the quality of Mr B's life, and her inaction resulted in the other residents being exposed to harm from Mr B. I accept that the owners of the rest home should have been able to rely on Mrs D to provide appropriate services to Mr B. However, I have received no evidence that the previous licensee took any steps to ensure Mrs D was acting appropriately as the manager responsible for the daily care provided to the residents of the rest home.

In the circumstances, and in the absence of evidence that, as an employer, it took reasonable steps to prevent the shortcomings on the part of its manager, the previous licensee is vicariously liable for Mrs D's breach of the Code.

Other comment

Mrs D
I note that during the course of my investigation, staff encountered numerous delays by Mrs D in providing information. In particular, at the interview in July 2000, Mrs D was tearful, unhelpful and unco-operative.

The Health and Disability Commissioner is required under section 6 of the Health and Disability Commissioner Act to conduct a fair, simple and speedy investigation. Mrs D's conduct throughout this investigation has not facilitated the resolution of this complaint.

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Documentation

A matter that has been commented upon by my independent expert nursing advisor, and that was very evident during my investigation of this matter, is the inadequate or incomplete nursing records for patients at the rest home.

I have not received a complete copy of Mr B's nursing records for the time that he was a resident at the rest home. In addition, no document concerning Mr B's initial assessment was provided. Nursing notes were sporadic with gaps in the recordings. Of particular note is the lack of incident forms recording the alleged serious incidents involving Mr B and other residents. I would have expected such serious incidents to be recorded, not only in Mr B's notes but in the notes of those residents whom Mr B was alleged to have assaulted. In relation to the instances where it is recorded that Mr B did touch other residents, the affected residents' notes do not refer to the incident. My nursing advisor stated:

> "Documentation is vitally important in all aspects of nursing, especially in frail elderly with behavioural problems.
>
> Accurate documentation allows other health professionals to review residents' behaviour and incidents in a logical manner. Comprehensive documentation allows professionals to follow any patterns that may emerge. It also allows specialist health professionals to plan appropriate interventions.
>
> …
>
> Documentation was not undertaken on each shift. It appears to be done when an incident or event happened. …
>
> Also not presented in supporting information is accident/incident reports. Throughout the clinical records, incidents are mentioned. Many of these relate to [Mr B] having contact with other residents and staff. Accurate incident forms should have been complemented, or if not completed presented with supporting documentation.
>
> More thorough documentation would have given the visiting professional more evidence of inappropriate behaviour. This may have meant a move to a more suitable facility."

The limited documentation concerning Mr B and his alleged behaviour has made my investigation of this complaint difficult. The allegations made are serious. I would have expected more detailed regular recordings to be made in the circumstances discussed in this report. I do not consider the record keeping at the rest home to have been of an appropriate standard.

Dr H

Mrs D was not the only person responsible for the care of Mr B. She acted in consultation with Dr H, who visited the rest home every week to treat the residents.

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Decisions relating to the physical care concerning the transfer of residents and their referral to other agencies were made by Mrs D in consultation with Dr H. My psychiatric advisor referred to Dr H's role in caring for Mr B. He stated: "[T]he information provided indicates a deficiency in responsibility in both sectors of this complaint. The rest home] and [Dr H] do not exhibit the necessary expertise to manage the inappropriate sexual behaviour of [Mr B] and yet were responsible for the care and welfare of the residents including [Mr B]."

My nursing advisor also commented that "[the rest home] should have sought specialist advice when interventions recommended did not work". She referred to the fact that further referrals were not made and that it was eventually necessary for an emergency placement to be made.

In my view, a prudent doctor would have followed up the care provided to Mr B and reviewed this on a regular basis to ensure that the medication prescribed to him was sufficient to address his medical needs, including the management of his sexual disinhibition. It is particularly concerning that, on the basis of the information provided to me, and the fact that medication was prescribed to control Mr B's sexual disinhibition, it appears that Dr H did not actively follow up and review Mr B.

Actions taken

In response to my provisional opinion, Mrs D provided an apology for Ms A and confirmed that in future, in relation to residents at the rest home with special needs, she will take the following actions:

- prepare a detailed Nursing Care Plan when residents are admitted
- initiate the formation of a multi-disciplinary team at the first indication that it is needed
- review the Nursing Care Plan monthly
- conduct three-monthly audits of each Nursing Care Plan
- record carefully on the resident's personal file details of the resident's behaviour, and the response to and management of that behaviour by herself and by staff.

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Other actions

- A copy of this report will be sent to the Nursing Council of New Zealand and the Ministry of Health Licensing Office.
- A copy of this report, with identifying features removed, will be sent to Residential Care New Zealand, the Nursing Council of New Zealand, the Royal New Zealand College of General Practitioners, and the Royal Australian and New Zealand College of Psychiatrists, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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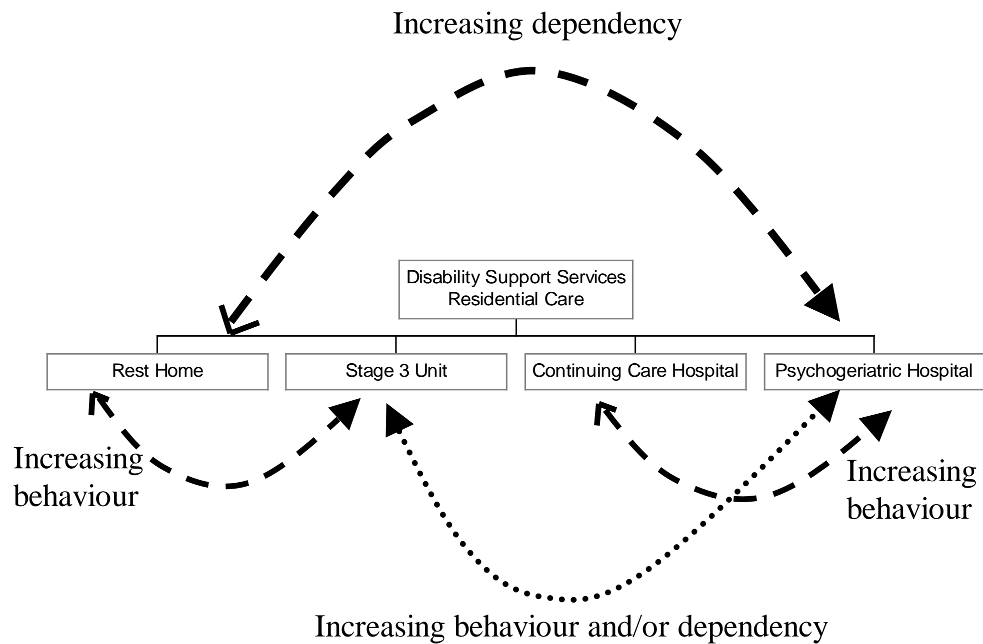
Appendix 1

Four levels of residential care funded by Disability Support Services, and a simplification of the relation between



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