A Rest Home and Hospital

The Rest Home Company

A Report by the Health and Disability Commissioner

(Case 05HDC04892)

Parties involved

Ms A	Principal nurse manager/facility manager
Mr B	Consumer (deceased)
Ms C	Complainant/Consumer's daughter
A rest home and hospital	Provider/Rest home and hospital
A rest home company	Owner of the rest home and hospital
Mr D	Registered nurse
Mrs E	Registered nurse/unit co-ordinator
Ms F	Charge nurse
Ms G	Clinical manager/deputy manager
Ms H	Compliance manager, the rest home company

Complaint

The Commissioner received a complaint from Ms C about the services provided to her father by a rest home and hospital. The following issues were identified for investigation:

- *Whether the rest home and hospital responded appropriately to Ms C's concerns about her father's care in the year leading up to his death.*

- *Whether the rest home and hospital provided Mr B with services of an appropriate and adequate standard in the year leading up to his death.*

An investigation was commenced on 29 August 2005.

Information reviewed

- Information from Ms C
- Mr B's medical records from the rest home and hospital
- Policies and procedures for the rest home and hospital
- Information from the rest home company
- Information from Ms A
- Information from Mrs E
- Information from Ms G

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Overview

Over a nine-month period, the daughter of a resident in a rest home and hospital repeatedly raised with staff and management her concerns about the medicine administration practice of one of the nurses. The daughter's complaints were not documented or otherwise addressed in accordance with the hospital's complaints procedure. As a consequence, safety concerns in relation to the nurse were not addressed, and residents at the facility remained at potential risk from the nurse's practice.

This report does not address the competence of the registered nurse, Mr D, because that issue has been considered by the Nursing Council. This report examines the rest home hospital's response to, and management of, the complaints relating to Mr D's medication administration practice.

The obligation of public hospitals to respond to complaints and monitor the competence of their employees is clearly recognised under the Code of Health and Disability Services Consumers' Rights ("the Code") and at common law. This report examines the analogous responsibility of rest home hospital facilities in responding to complaints and monitoring the competence of employees, to protect the safety of residents. The report also examines complaints raised by the daughter regarding aspects of the urinary catheter care and bowel care provided to her father, and the adequacy of care in those areas.

Information gathered during investigation

Background

From 1996, Mr B suffered from declining health as a result of Parkinson's disease. In around May 2003 he developed mobility problems. On 30 June 2003, he was admitted to a rest home and hospital ("the rest home") for full-time nursing care. Ms C, his daughter, provided personal care twice daily during the week and three times a day on weekends. She brought food from home and assumed a basic nursing role in addition to the care provided by the rest home staff. This required a reasonable working relationship with the hospital staff to ensure appropriate communication about Mr B's well-being. Ms C knew when aspects of her father's care were not appropriately provided and would advocate on his behalf.

Ms C had an enduring power of attorney for her father, and made a complaint under Right 10 of the Code on his behalf.

Ms A is the principal nurse manager at the rest home and is responsible for the administration of the rest home's policies and procedures, including the monitoring and safety of medication administration and nursing practice.

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The rest home policies and procedures
The rest home had a complaints procedure in place. That procedure was implemented in 1992 and reviewed in 2002 and October 2004. The stated objective of the procedure was that "[a]ll complaints will be addressed and thoroughly investigated in order to ensure resolution for all parties".

The complaints procedure stated:

> "All complaints, whether verbal or in writing, will be documented on the complaints record (attached)."

The procedure specified that all staff were responsible for referring a complaint without delay to a senior member of staff in order that action could be taken. In October 2004, the procedure was amended to clarify that "that senior staff member [was] then responsible for informing the facility manager (formerly the principal nurse manager)".

The procedure provided that the principal nurse manager/facility manager was responsible for ensuring that specified actions were taken in respect of any complaint received. Those actions generally reflected the requirements of a complaints procedure prescribed by Right 10 of the Code.[1]

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[1] The steps in the procedure were as follows:

- The complaint would be acknowledged in writing within five working days, unless it had been resolved to the satisfaction of the complainant within that period.
- The complainant would be advised of the complaints procedure and the fact that they could seek counsel with an independent advisor (examples given).
- The principal nurse manager and directors (in the policy reviewed in October 2004, the facility manager) had up to 10 working days from acknowledging the complaint to decide whether or not the claim was justified.
- If it was decided that more time was needed to investigate the complaint, the hospital would determine how much more time was needed, and if the additional time was estimated as more than 20 working days, they would inform the complainant and state the reasons why the time was required.
- If it was decided that the complaint was not justified then, as soon as was practicable, the complainant was to be informed of (i) the reasons for the decision; (ii) the actions the hospital proposed to take; (iii) any appeal procedure available; (iv) his or her right "to complain to the Privacy Commissioner". (This reference to The Privacy Commissioner is not in accordance with Right 10 of the Code.)

I note that the procedure did not set out the actions to be taken (in accordance with Right 10(8) of the Code) in the event that the provider accepted that a complaint was justified; it only dealt with actions to be taken when a determination was made that a complaint was not justified.

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The procedure also stated that the principal nurse manager would "fully document, date and sign every aspect of the complaint and what action was taken — and the appeal if there was one".

The rest home had a medication education policy in place from March 1992 (and reviewed in March 1998) that provided for written notification to be given to nurses responsible for any medication errors. The notification would specify the education actions to be undertaken to prevent further errors, and the consequences of continued medication errors.

The rest home also had in place at the relevant time an accident/incident reporting procedure that was implemented in March 1998 (and reviewed in September 2002 and June 2004). According to the procedure, specified reportable incidents, including medication incidents, were to be documented on an accident/incident form. The form was to record the cause of the incident, actions taken as a result of the incident, follow-up actions, and suggestions for quality improvement to prevent recurrence. A record of accidents/incidents was to be kept for all residents, to assist "in identifying patterns and trends in order that interventions may be put in place". Also, all incidents were to be recorded into a data collection system, and statistics from this were to be analysed monthly.

Ms A advised me that the rest home has (and had in the period with which this case is concerned) "a robust incident management process which ensures all incidents are investigated, followed up and actions evaluated. These may indicate performance shortfalls, non-adherence to policy or other areas that may require follow-up or corrective actions."

Ms A explained that the medication education and incident reporting policies would be used only where it could be established that a medication incident had occurred, rather than simply been alleged.

Ms C explained that the rest home staff gave her a Health and Disability Commissioner brochure about complaints when her father was first admitted.

History of concerns regarding Mr D

Ms A explained that she had concerns about Mr D when he used to work in the dementia unit at the rest home. In that unit, nurses work on their own, in isolation. She recalled that when Mr D was in the dementia unit, concerns would sometimes be raised about things not being done. For example, there was once a query as to whether he had dispensed eye drops. Mr D had signed the medication chart that he had given eye drops to a resident. However, the box of eye drops was new and had not been opened. When Ms A challenged Mr D about this matter, he claimed that he had used eye drops from a different box. Ms A noted that this was possible; he could have done. Therefore, she did not take the matter any further. Rather, she moved Mr D from the dementia unit to the main unit so that he would be working with another registered nurse and two nursing teams.

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Ms A recalled that, in the past, carers had made complaints about Mr D "being lazy". As an example of his laziness, she explained that he would sometimes finish his drug rounds in a quarter of the time it took everyone else, and would be sitting in a chair watching television while the other carers were still working hard. The same scenario was recounted by Ms G, clinical manager/deputy manager of the rest home.

Ms A provided documentation that indicates that Mr D had undertaken a "drug administration nursing practice review" to evaluate his competence to administer medication safely. The record provided shows that Mr D attained a 100% pass. This was part of a routine annual competence programme for registered nurses at the rest home.

First complaint about medication administration

In January of the year in question, Ms C noted that her father, aged 80 years, was drowsy in the evenings and that it was difficult to wash him and communicate with him. At that time, her father was taking three tablets at 4pm (Sinemet, for Parkinsonism, and two Panadol) and one and a half tablets at 9pm (Quetiapine, an anti-psychotic, and tolcapone, for Parkinsonism). Mr B told her that Mr D had not given him his nightly medication. From that time, Ms C became vigilant about her father's medication, and noticed that when Mr D was on duty, he gave Mr B his afternoon and evening medications together (in the afternoon).

On 27 May, at around 5.30pm, Ms C saw Mr D give multiple medications to another patient. The patient questioned him about whether he should be taking "the 9pm tablet", and Ms C heard Mr D state that "I made it easier for you". On 28 May, Ms C reported the incident to unit co-ordinator Mrs E (a registered nurse). Ms C expressed her fears that medication was being incorrectly dispensed to her father. She did not name the nurse involved at first. Mrs E asked Ms C whether the nurse was male or female, and she confirmed that the nurse was male. Mrs E then guessed that the nurse was Mr D. Mrs E explained that Ms C did not want her to raise the issue directly with Mr D for fear that he might effect reprisals against her father. She asked Mrs E to keep the complaint confidential and to monitor Mr D's medication administration practice.

Mrs E spoke to Mr D on this occasion and, without mentioning Mr B's name, reminded him of his obligation to ensure that all medications were given at their prescribed times. Mr D responded by saying that he always gave medications at the correct times.

Mrs E did not record Ms C's complaint in accordance with the organisation's complaints procedure. Mrs E was aware that the rest home had a complaints policy at this time, but stated that complaints were dealt with differently then (from how they are currently dealt with). She stated that complaints were not documented unless they constituted a "serious matter", and that an incident form would be completed in the event of a serious medication error.

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Ms A also confirmed that at that time she did not document all complaints received. She stated that Ms C made complaints about all sorts of things, many of which were not serious, but that she would have documented anything that was serious. In contrast, Ms C commented that all her complaints to management were about important matters affecting patients' rights.

Mrs E recalled that, as with all complaints she received from Ms C regarding Mr D, she told Ms A about the complaint received on 28 May. Mrs E also told Ms C that she had passed on this complaint to Ms A. Ms A believes that she was not told about this complaint, although she is not sure about this.

Second complaint about medication administration
On 2 June, Mr B was admitted to a public hospital with a chest and urinary infection. He was, at that time, taking Atrovent[2] in a nebuliser[3] (0.5 mg twice a day) to help with his breathing. Ms C noticed that Mr D omitted to give her father his nebuliser on some occasions, and that his condition deteriorated.

On 11 June, Ms C rolled the wire of the nebuliser and knotted it, to enable her to check in the morning whether the nebuliser had been administered. Ms C returned early the next morning and noted that the nebuliser wire was still knotted. She concluded that Mr D had not administered the nebuliser to her father the previous evening. Later that day her father's chest infection worsened, and he developed breathing difficulties. The same day (12 June) Ms C raised her concerns with the charge nurse, Ms F. Ms F looked at the medical records in her presence, and noted that Mr D had recorded that the nebuliser was administered. When Ms C informed Ms F about the knotting of the nebuliser wire, Ms F promised to follow up the matter.

Ms F has limited recall of this incident but it appears that she did not document the complaint or the concerns about Mr D's practice. No action appears to have been taken to address the complaint, to report an incident of possible medication omission/error, or to complete a medication education form. Ms A could not remember whether she was made aware of the complaint made by Ms C on 12 June.

On this occasion, Ms F contacted a doctor regarding Mr B's condition. The nursing notes for 12 June record that a doctor was informed of Mr B's condition (he was "chesty" and was experiencing breathing difficulties and abdominal pain), and Mr B was prescribed an antibiotic, and the dose of Atrovent to be administered by nebuliser was increased (to 0.5 mg four times a day, on an "as required basis").

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[2] An anticholinergic medication used for the maintenance of bronchospasm associated with chronic obstructive pulmonary disease, including chronic bronchitis and emphysema. Atrovent opens the air passages, allowing more oxygen to reach the lungs.

[3] A device for dispensing liquid (medication) in a fine spray.

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Regarding the complaints Ms C made in May and June, Ms A stated:

> "The hospital was always extremely limited in its ability to properly address issues relating to this particular nurse as when [Ms C] raised concerns she insisted that they be anonymous and it actually took some time before we were able to identify the nurse, as she refused to give the name 'for fear of reprisals'."

Ms C advised me that it was only her name that she asked to be kept confidential, not the nurse's. Similarly, Mrs E confirmed that she knew that the nurse involved in the 27 May incident was Mr D. Without a documented account of the complaint, it is difficult to determine precisely what information was given and what was requested to remain confidential. However, it would have been a simple matter to confirm which nurse was responsible for dispensing medication to patients, as all registered nurses were required to initial the dispensing of medication on the patient's medication administration record.

Ms C continued to monitor the application of nebuliser treatment by Mr D, and advised me that it was often not administered when Mr D was on duty. She was able to confirm this by placing tape over the electric socket on the wall and finding the tape still present on the morning following Mr D's shift. Mr B was readmitted to the public hospital in July with a chest infection, breathing difficulties, and a urine infection.

Third complaint about medication administration — review meeting on 30 September
In September, Ms C was concerned that Mr D was still not administering the nebuliser to her father. Before she left her father for the evening on 8 September, Ms C rolled the electric cord for the nebuliser and placed tape over the radio plug (which was plugged into the electric wall socket). The following day she found the nebuliser and the radio plug as she had left them.

Ms C recalled that on 16, 17 and 22 September Mr D did not administer the nebuliser to her father, and gave the ampoule to her to administer. On 24 September, Ms C asked Mr D for the nebuliser and gave it to her father herself. The rest home medication administration procedure provides that medication for use in a nebuliser is to be administered by qualified staff.

On 29 September, Ms C saw Mr D give only one tablet to her father at 5.25pm (she was aware that he should take three tablets in the afternoon). Also, she saw that Mr D did not administer her father's nebuliser or inhaler[4] to him. She did not administer either of these to her father on this occasion.

A "review meeting" was held at the rest home on 30 September to discuss Mr B's care. This was a standard part of the rest home procedure and was attended by several

[4] Mr B was prescribed Flixotide, a corticosteroid used to prevent asthma attacks.

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members of the multidisciplinary team and by Ms C (as the representative of Mr B's family).

At the meeting, Ms C raised, as a matter of "serious concern", the medication administration practice of "a registered nurse", whom she did not name. She alleged that the nurse was not administering medications in accordance with the prescription, and that medications were omitted or that afternoon and evening medications were given together. Ms C did not initially name the nurse, as she was afraid of reprisals against her father. Ms A asked whether the nurse concerned was Mr D, and Ms C confirmed that it was. Ms A stated that this meeting was the first time she became aware of Ms C's concerns about Mr D's medication administration practice.

Ms C told the meeting that on several occasions Mr D had not administered her father's nebuliser or inhaler. She told them that whenever she reminded Mr D to administer her father's nebuliser, he said that he was busy. When she insisted, he would give the nebuliser ampoule to her to administer herself. According to Ms C, Mrs E commented that that was not acceptable practice. Mrs E could not recall the details of the discussion at the meeting. However, she recalled that, if any of the nurses were late administering the nebuliser to her father, Ms C would get the ampoule and administer the nebuliser herself. (Ms C denied this and stated that she only ever administered the nebuliser to her father (on the premises) when Mr D had failed to do so. She explained that all the other nursing staff administered the nebuliser as they were supposed to.)

Ms C told the staff at the meeting that the previous evening she had witnessed the nurse administer her father's afternoon medication, but that he had not administered his inhaler or the nebuliser. Ms C explained that her father became very sick that evening. At Ms C's suggestion, Mrs E checked the medical records at the meeting and found that Mr D had recorded that he had administered both the nebuliser and the inhaler.

Ms A acknowledged that she did not document Ms C's complaint on a complaints form. Nor was a medication education or accident/incident form completed. Ms A recorded the complaint on the "review meeting checklist". This lists the persons present at the meeting and the issues discussed. Under the heading "New Complaints/Issues to be addressed", the following matters have been recorded:

> "Follow up medication and nebuliser on specific days
> Loss of laundry — underclothes, socks
> Watch positions of catheter and catheter bag when getting up
> Senior staff to do [Mr A's] cares
> [Ms C] keep a note book in top drawer and notes to staff re bowels etc."

Concerning Ms C's fear of reprisals, Ms A said that she "offered repeated assurances that this would not be tolerated" and that it "was most unlikely that this would occur given my knowledge of the staff member involved".

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Ms A stated that Ms C was unhappy about Mr D being confronted but that "we felt our obligations regarding 'duty of care' to our resident overrode her reluctance for us to confront the staff member". Later that day a meeting was held with Ms A, Ms G, Mrs E and Mr D. At that meeting the allegation was put to Mr D that he had given afternoon and evening medications together. He denied this and guessed that the complaint had been made by Ms C.

Ms A also put to Mr D the allegation that he had not always administered Mr B's nebuliser when he was required to, including the previous evening. Mr D advised Ms A that there were times when he had not administered the nebuliser to Mr B because he had refused it. Ms A recalled that Mr B was frequently seated directly outside her office and she had on occasion heard him refuse the nebuliser. Accordingly, she accepted Mr D's response.

Ms A discussed with Mr D the fact that he had recorded in the medical record that the medication had been given, when he should have recorded that it had been refused. (The medication charts record only one instance of Mr B refusing medication, namely Panadol, over a year-long period.) Mr D acknowledged that this was an error on his part (he stated that he forgot) and assured her that he would correctly record refusals in the drug administration chart.

A note of this meeting in Mr D's personnel file states:

> "Meeting … following [Mr A's] review when daughter [Ms C] had spoken of his not giving medications/nebulisers @ due time. Had been seen giving 8 pm meds at 5 pm — (no real evidence of this). [Ms C] had set several traps to ensure nebuliser had been given (wound cord specific way). [Mr D] denied this but said he refused it — had signed it as given — said he forgot. Expectations of role explained. Promised to ensure he would follow all correct procedures."

Regarding the action she took to address Ms C's complaint, Ms A stated:

> "[W]e felt the explanation given by [Mr D] was acceptable, he was audited and directly supervised completing a drug round and performed well. We saw no reason to institute further monitoring at that stage."

Ms A said that she spoke to the other resident who Ms C claimed had been given afternoon and evening medications together, but the resident could not remember the incident. She stated that she did not feel that she could take this matter any further as it was Mr D's word against Ms C's.

In the early responses to my investigation, Ms A stated: "[Mr D], as an employee, had rights established by industrial law. He was entitled to give his explanation for his actions and, as there was no other evidence apart from [Ms C's] word, there was little we could do in this instance."

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Ms A advised me that, following the meeting with Ms C on 30 September, she had "instigated an investigation and undertook disciplinary action aimed at bringing about the desired behaviour/practice changes in the staff member concerned". By this she was referring to the action taken following the review meeting on 30 September.

Ms A informed Ms C about her meeting with Mr D. Ms C was very upset about this, as she believed that Mr D would know who had made the complaint. Ms A stated that she assured Ms C that action would be taken if there was any evidence of vindictive behaviour by Mr D.

Ms C alleged that following the meeting between Ms A and Mr D, Mr D would spill water on Mr B's chest while giving medications late at night, leaving him uncomfortable and unable to sleep. Ms C did not complain again but placed a towel over her father's chest to protect him.

Further complaints about medication administration
In early October, Ms C had a long conversation with Mrs E in the passage outside her father's room. Ms C again expressed her concerns about Mr D's practice in administering medication to her father, and in relation to her observations of his management of other residents. Mrs E said that Ms A was on leave but that she would pass on the information to Ms G. There is no documentation of the complaint, nor of any action being taken regarding it. Ms G stated that this complaint was not passed on to her.

Between 4 and 11 October Mr B was admitted to a public hospital with a chest infection. He was discharged back to the care of the rest home. Following her father's return from hospital, Ms C noticed that Mr D was still not administering her father's inhaler to him. As a result, Ms C remained until after the evening drug round on all of Mr D's evening duties. Ms C recalled that she had to keep reminding Mr D to administer her father's inhaler in the evenings.

On 28 October, Ms C told Mrs E that Mr D's medication administration practice had not improved. She suggested that Mrs E put tape on the cap of her father's inhaler to check whether it had been used. She recalled that Mrs E made a note on a piece of paper to convey to Ms A. During a telephone conversation with Mrs E on 10 November, Ms C asked whether any steps had been taken regarding her concerns about Mr D. Mrs E advised her that she had not taken any action as she was extremely busy, but that she would.

Around 15 December, Ms C observed that Mr D had omitted to give Mr B an antibiotic that had been prescribed for a urinary infection. Ms C reminded Mr D that the antibiotic had been prescribed and requested that it be administered. On 20 December she telephoned Mrs E and told her about the incident. Mrs E thanked her for the information.

Mrs E recalled that several verbal complaints were made by Ms C regarding Mr D's medication administration practice (as well as other matters). However, she could not

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recall specific details of the complaints or what action, if any, she took in relation them. She stated that, in accordance with her usual practice, she would have informed Ms A about any complaints. Mrs E stated that Ms C would not allow her to confront Mr D directly about her complaints, because of her concerns about retaliatory action being taken against her father. However, in all instances she told Mr D that she expected him to comply with the policies and procedures of the hospital. She did not document Ms C's complaints, nor did she complete medication education or incident forms.

On 1 January the following year, Ms C was with her father from 3.25pm to 8.55pm. She noted that Mr D did not give her father his 4pm medication. On 8 January she also noted that Mr D failed to administer the 4pm medication to her father. Mr B continued to decline in health. According to Ms C, "there was no improvement of administering medicine by [Mr D]".

On 9 January, Ms C felt that she "could not control her emotions" and complained to a senior caregiver about Mr D. At the senior caregiver's urging, Ms C went to see Ms F and repeated her concerns about Mr D administering afternoon and evening medications together, and that he had not been administering her father's inhaler or nebuliser. She expressed her belief that her father had become sick as a result of Mr D's actions.

According to Ms F, Ms C requested that the rest home not take action on her complaint until her father had died, because she was worried that Mr D might take it out on him. Ms C explained that she would make a formal complaint following her father's death.

Ms F wrote to Ms A the same day setting out her conversation with Ms C. The letter stated:

> "While [Mr D] was away on leave, she says her father was alright and there was no problem. All this has been documented in her diary and she says when her father dies she will write in a complaint officially to you and send a copy to the Ministry of Health. She is going to do this for the sake of the residents here because she feels the residents are not looked after properly by [Mr D]. Why she is doing it <u>after</u> the death of her father is because she does not want her father to face the consequences of [Mr D's] reaction.
>
> …
>
> She requested us to do an investigation on [Mr D] before any action is taken on him.
>
> I am writing this to let you know as I do not want the hospital to be under investigation by the MOH at a later date."

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On the following day, after consulting with Ms C, Ms A moved Mr B to an alternative wing in the hospital with different staff. As to why this action had not been taken earlier, Ms A stated:

> "We had, some time previously, moved [Mr B] to a more attractive room with its own en suite, in another unit. His daughter was outraged and threatened to remove him from the hospital if he was not returned to the room he had occupied. We were under the impression that she wished him to remain in that room and it was only as a last resort that I offered to shift him again."

Ms A further stated:

> "Several times later during [Mr B's] stay senior staff considered transferring [Mr B] (certainly [Ms C] never requested a move) but our decision was always coloured by her reaction to the first shift."

Ms C explained that, after Mr B had been at the rest home for around three months, the rest home management asked if they could move him from the hospital section to the rest home section as he was a mentally alert patient. Ms C was told that the rest home had plans to convert part of the rest home to hospital care later. Ms C agreed to the move. However, she recalled that her father found it difficult to stay among the mobile residents of the rest home and became very distressed. For this reason, she asked for him to be returned to his old room. She was told that there were no vacancies in the hospital section of the rest home at that time, so Ms C put her father on the waiting list for another rest home and hospital.

Mr D stated that he had on two occasions asked Ms A if either he could be moved or Mr B could be moved, so that Mr D would no longer be involved in his care. This did not occur until Mr B was moved in January.

Mr C's health further deteriorated and he later died.

Investigation into Mr D's medication administration practice

On 14 and 15 January, Ms A performed a drug stock control check to monitor Mr D's medication administration. According to Ms A, this was in part due to another patient not being given medications appropriately by Mr D. An audit of medication numbers found that Mr D could not have dispensed as he had documented for two other patients. This, together with Ms C's complaint to Ms F, led to Mr D's dismissal from the rest home. In a letter to Mr D Ms A notified him of his dismissal and the reasons for it. These included:

> " 'Inappropriate or negligent behaviour which results in injury or distress to a resident' in that you allegedly did not give medication to residents ([Mr B] and [another resident]). Your response was that you did sign for them but may have forgotten to give them … Your explanation is unacceptable. I find this allegation proven. This constitutes serious misconduct …

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> 'Inappropriate or negligent behaviour which results in injury or distress to a resident' in that you signed for dispensed medicine (nebulisers and inhalers) that were not given. Your response was that you did not know why they had not been given but admitted that you had pre-signed for them. Your explanation is unacceptable. I find this allegation proven. This constitutes serious misconduct."

Ms A reported Mr D to the Nursing Council of New Zealand. In her letter to the Nursing Council regarding Mr D, Ms A stated:

> "We became aware of his failing to administer drugs following a complaint from a vigilant family member who watched him consistently miss residents out, including her relative. She was alerted by her father always seeming to be 'sicker' after his [Mr D's] duty. We monitored the drug numbers to find it was his custom to not administer to some residents, but to sign that they had been given. The same occurred with nebulisers and, we suspect, BSL [blood sugar level] monitoring however we failed to get the number of testing strips verified by a second staff member so have given him the benefit of the doubt."

Ms A met with Ms C on 2 February to discuss her complaint and the outcome of disciplinary action against Mr D. Ms A recalled that Ms C expressed her satisfaction with this and pointed out that she also wrote several letters to the hospital staff expressing her satisfaction with the care her father received.

Ms C recalled that Ms A acknowledged at the meeting that the rest home should have taken action earlier regarding Mr D. Ms C clarified that she wrote a letter to Mrs E expressing her appreciation for her help and assistance. She also wrote a general thank-you note from Mr B's family to "those staff" who had assisted her father. Neither of those documents was addressed to the rest home management.

Ms C is concerned that, although she alerted the rest home management on several occasions from May the previous year about her concerns regarding Mr D's practice, she was unable to get the situation remedied for her father while he was still alive. As to the subsequent action taken by the rest home to monitor and dismiss Mr D, she noted: "What a difference it could have made to my father's health, well-being and quality of life, if the hospital did that when I first communicated this matter to the management."

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Actions taken by Nursing Council

Mr D's case was heard by a Professional Conduct Committee ("PCC") of the Nursing Council in August. On the recommendation of the PCC, the Council referred Mr D to a competence panel, which reviewed his competence in November. At its December meeting, the Council determined that Mr D did not meet the required standards of competence for a registered nurse and ordered that he undertake an individualised competence programme and assessment against all competencies for his scope of practice. Mr D is currently attempting to comply with these orders.

Written complaint about urinary catheter care

From May the previous year, a service plan contained in the nursing notes for Mr B recorded steps to be taken to maintain his urinary catheter and eliminate the risk of infection. The plan specified that a night-time catheter bag (with 2000 ml capacity) would be attached at night and that his daytime catheter bag was to be changed weekly, on Mondays. His urine output was to be recorded on the fluid balance chart.

On 23 July, Ms C made a written complaint to Ms A regarding the urinary catheter care provided to Mr B. In a letter to Ms A of that date Ms C complained about two instances — on 19 and 22 July — when she had found the catheter bag full well beyond its 500 ml capacity, to 850 ml and 1000 ml respectively. Ms C expressed concern that an over-full bag could cause a back-flow into her father's urinary system and pose a threat of infection. The complaint also noted that the catheter bag that had just been changed had been in place for nearly three weeks. Ms C was concerned that the current practice had contributed to a diagnosed urinary tract infection, and remained an ongoing problem.

Mr D stated that the rounds to empty catheter bags were carried out by caregivers at the rest home, not by registered nurses. However, Mrs E advised that emptying of catheter bags was carried out by both nurses and caregivers and that nursing staff were responsible for ensuring that catheter bags were emptied appropriately.

Ms A did not document Ms C's complaint on a complaints record or otherwise use the rest home's complaints procedure.

Ms A responded to the complaint in writing on 27 July and stated that the protocol was for bags to be emptied regularly three times a day, and that the fluid recording chart appeared to show that this had occurred. She also stated that the bags were changed weekly and queried whether Ms C was sure about this aspect of the complaint. However, the fluid balance summary chart does not indicate that staff were regularly emptying the bag, nor is there a record in Mr B's medical records of weekly changing of the bag. Ms A pointed out to Ms C that the medication prescribed to Mr B (frusemide[5]) increased urinary output and that it was difficult to anticipate how

[5] A loop diuretic used to treat oedema associated with chronic heart disease, renal disease and hepatic cirrhosis.

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much urine would be generated. Ms A stated that Mrs E would instigate a two-hourly check of the bag by staff and that this would be monitored for effectiveness.

Ms A consequently instructed nurses to ensure the frequent emptying of the catheter bags. The nursing records for 27 July refer to Ms B's "formal complaint" and state that, when Mr B returned from hospital, staff were to commence two-hourly checking of the bag and emptying as required.

Ms C, unhappy with the response from Ms A, wrote to her again on 29 July and explained how she knew that a catheter bag had been in place for three weeks. Ms C felt that staff were not aware of the protocol for changing the bags.

By letter dated 30 July, Ms A apologised to Ms C for the distress caused regarding her father's catheter bag and encouraged her to insist on a change of bag rather than allow the matter to go unchallenged. (Ms C believes that, in saying this, Ms A tried to "pass the blame" to her concerning the responsibility for changing the bag.) Ms A also assured Ms C that Mrs E had spoken to the staff and would implement a surveillance programme to ensure that Mr B's urinary output was correctly monitored.

Following Ms C's complaint, Mrs E implemented a new procedure that staff would check Mr B's catheter bag every two hours and empty it as required. From 3 August, a problem management sheet was used by the rest home staff to formally record that the catheter bag was checked two hourly and emptied as required. (I note that the comments made by staff on this sheet vary in the level of specificity — on some days a single entry has been made recording that "IDC checked and draining well"; on other days the specific times when the bag has been changed have been recorded, together with the volume of urine in the bag at that time.) A separate problem management sheet was commenced on the same day to record the weekly change of Mr B's catheter bag. Problem management sheets were kept in a "dressing book" that qualified staff (nurses and clinical assistants) would refer to every day. Mrs E stated that it was up to qualified staff to oversee the problem management sheet. According to her, staff were completing the sheet and the system appeared to be working well.

Diary records that Ms C kept during September suggest that the volume of urine in her father's daytime catheter bag (which had a capacity of 500 ml) was in excess of its capacity on several occasions when she emptied the bag. The volume recorded in her notes, and the corresponding comments in the problem management sheet, are as follows:

5 September (650 ml)	"IDC checked 2 hourly and emptied pm — bag checked and emptied as required"
9 September (800 ml)	"Bag checked and emptied as required"
11 September (1050 ml)	[no entry on sheet]

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23 September (800 ml)	"IDC checked 2 hourly and emptied 0600 hrs"
24 September (900 ml)	"IDC checked as usual, emptied 0600 hrs
	pm — IDC checked and emptied PRN [as required]"

At the review meeting on 30 September Ms C raised the failure by staff to empty the bag, and other issues relating to the comfortable and secure placement of the catheter bag. None of these matters was documented on a complaint record (although the position of the catheter bag is briefly referred to in the notes of the meeting).

Mrs E could not recall the issue of the catheter bag being raised at the meeting on 30 September or whether any further action was taken as a result.

A service plan contained in the nursing notes and commenced on 30 September reiterated that the day bag was to be changed weekly and that staff were to sign off the problem management sheet to confirm that this had occurred. Mrs E commented that this may have been a response to matters raised at the 30 September meeting, but she was unsure.

Complaint about bowel care

Mr B was prone to constipation. This was identified in his nursing care plan on his admission. On that date the care plan records that, in order to promote regular bowel habits, Mr B would be given laxatives as charted, and that all bowel movements were to be recorded in a bowel book. The plan recorded that, when he had not passed a bowel motion for three days, he was to be given a Microlax enema. This instruction was reviewed by staff subsequently and was to continue to apply.

The rest home's notes for Mr B contain a "bowel record" that recorded his daily bowel motions and when a suppository/enema was given. This record appears to have been maintained from late June until the following January when Mr B died.

Mr D stated that bowel records were filled in by caregivers, rather than registered nurses, as it was the caregivers who were primarily involved with the residents at the times when they would pass bowel motions. Mrs E explained that both caregivers and nursing staff completed "bowel records", and that the person who carried out this task would depend on who was caring for the patient at the relevant time. However, she explained that it was the responsibility of nursing staff to ensure that caregivers completed all relevant documentation, including bowel records, before finishing their shift.

Ms C continued to care for her father and, because of the amount of time she spent caring for him, was often present when he passed bowel motions. She explained that, as her father's bowel motions and urinary output was measured by the hospital, she would record the fluid intake, urinary output and bowel movements that she observed while she was with him. She would leave this information on post-it notes in her

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father's room for the nurses to pick up. These notes would then be used to update Mr B's medical records.

Ms C recalled instances of her father being given a Microlax enema, despite having passed sufficient bowel movements in the preceding days. Her diary notes record that this occurred on 3 September, although Mr D had not updated Mr B's records (from her post-it notes). Similarly, on 18 September, she noted that Mr D had not updated the bowel motion chart for three days, although Mr B had passed two bowel motions in this time and Ms C had left notes recording this. Because no bowel motions were recorded on the chart, her father was prepared for a Microlax enema. Mr B managed to communicate to the nurse attending him that he had passed bowel motions and he was not given an enema.

Ms C felt that this matter has caused additional distress to her father. She raised this issue at the review meeting on 30 September and referred to the incidents on 3 and 18 September. Ms C stated that Ms A's suggestion was that Ms C leave "post-it notes" about the bowel movements on her (Ms A's) office window. Ms C stated that she did not agree that this was appropriate. Ms A denied suggesting that Ms C leave post-it notes about bowel movements on her office window and explained that she has a letterbox in the wall of her office which could be used to post confidential information to her, if necessary.

Ms C agreed to record in a notebook an account of her father's bowel movements, for the staff to transcribe into the nursing record. This notebook was to be kept in the top drawer of Mr B's chest of drawers. Ms A confirmed that this was the solution agreed to.

Ms C stated that, following the meeting on 30 September, she initially made notes of her father's bowel motions on loose pieces of paper (held together with a bulldog clip) and kept these in the chest of drawers. Around a month after the meeting, she began to record her notes in a notebook.

Ms A stated that the nurse in charge of Mr B's daily care monitored the notebook and transferred any entries regarding his bowels into the bowel record. Ms C recalled that most of the nurses did a good job of transferring her notes into the bowel record.

Ms C confirmed that there were no further instances of her father being given an enema unnecessarily after the meeting on 30 September.

The complaint regarding the nursing staff using enemas unnecessarily was not documented or dealt with in accordance with the rest home complaints policy or accident/incident reporting policy.

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Additional information

Ownership of the rest home
Until April 2004, the rest home was owned and operated by another private company. On 1 April 2004, the rest home was sold to the rest home company. In April 2005, Ms H on behalf of "[the rest home company]" wrote to the Ministry of Health to advise that all contracts in respect of the rest home should be in the name of the rest home company.

Ms H, compliance manager for the rest home company, advised that the rest home has been surveyed by Quality Health New Zealand since 1989. She stated that the rest home was first accredited against the Health and Disability Sector Standards in 2001 and that a further three years' accreditation was obtained in November 2004.

Changes implemented at the rest home
Ms A confirmed that, as a result of Ms C's complaint, the rest home company has reflected on its practice and management of complaints. A revised complaints policy was put in place following Mr B's death. Ms A advised that:

- Staff are now given compulsory education in the recognition and management of complaints. This emphasises the need to document and address verbal complaints and concerns, and includes guidance in what action to take when a complainant wishes to remain anonymous or where the complainant speaks confidentially to a staff member.

- Complaint forms are now readily available in the hospital foyer, as well as a "complaints box" to facilitate anonymous complaints.

- The complaints procedure is advertised throughout the hospital.

- Consumers are reminded of the complaints procedure and their right to complain when they attend a review meeting.

- A complaints record has been established which is linked to the rest home company's risk management system and is forwarded monthly to the care services manager to ensure that correct intervention and resolution has occurred.

In addition, Ms A stated:

> "In reflecting on my own management of 'confidential' complaints, I would not willingly divulge the source of the complaint. However, the safety and welfare of the consumer must remain paramount. In discussing the issues with [Mrs E], she felt she had dealt with the complaints without breaking [Ms C's] confidence but would now follow the revised policy or encourage [Ms C] to use the process for laying a confidential, formal complaint."

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Responses to Provisional Opinion

Responses to the provisional opinion were received from the New Zealand Nurses Organisation ("NZNO") on behalf of Mr D, and from Ms A on behalf of herself and the rest home company.

NZNO commented that Mr D does not agree with all of the material in the provisional opinion that relates to him. However, NZNO did not wish to respond in a detailed way as no findings had been made against Mr D.

Ms A commented:

> "It is concerning that no consideration appears to have been given to the fact that all the staff at [the rest home] who were in receipt of complaints from [Ms C] and her entreaties that we "not do anything" sincerely believed they were acting in accordance with her wishes. The fact that she never sought an outcome or requested information on our follow-up of issues she raised supports this. We strongly feel that the report should reflect the invidious position that this put us in.
>
> [Ms C] continually requested us not to take action and at no stage were we aware that this meant that only her name was to be withheld. She had regular and ongoing contact with all senior staff and was comfortable speaking with them at all times. When she was aware that we had spoken with [Mr D] on 30 September regarding issues she had raised she was extremely reproachful and angry this action had been taken. [Ms C's] ambiguity and our desire to comply with her wishes contributed greatly to determining what action she would permit us to take and again, this put us in an extremely difficult position.
>
> …
>
> On reflection (and with the added advantage of hindsight) I now realise I have made an error of judgment and if faced with a similar situation I would consider the safety of the resident overrides any requirements to meet the needs of the family, which is what we strived to do with [Ms C]. The senior team has altered its practice as a result of the issues raised by this investigation and ensures stringent adherence to complaint management and processes. A Complaint Management Record has been developed by the organisation to ensure thorough documentation and evidence of actions taken.
>
> While I accept that I should have been more active in ensuring that both my staff and I should have followed policy more stringently, I feel the report is unduly harsh in light of the difficulty we were in and does not take into account that our failure was due, in the most part, to [Ms C's] ambiguity."

Ms A enclosed with her response a copy of certification audit results for the rest home and the draft progress report for accreditation with Quality Health New Zealand, both of which related to audits conducted in May 2006. She submitted that these

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documents demonstrated the rest home company's commitment to the provision of a high standard of care at the rest home.

Ms A offered to write an apology to Ms C "for any failings of [the rest home] or the staff who cared for her father". She also indicated that the Care Services Team at the rest home company will develop a policy regarding the management and supervision of any registered nurses where there are issues regarding their practice.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code are applicable to this complaint:

Right 4
Right to Services of an Appropriate Standard

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

Right 10
Right to Complain

(1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

…

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

…

(6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that —
- *(a) the complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and*
- *(b) the consumer is informed of any relevant internal and external complaints procedures, including the availability of —*
  - *(i) Independent advocates provided under the Health and Disability Commissioner Act 1994; and*
  - *(ii) The Health and Disability Commissioner; and*
- *(c) the consumer's complaint and the actions of the provider regarding that complaint are documented; and*
- *(d) the consumer receives all information held by the provider that is or may be relevant to the complaint.*

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(7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, —
(a) decide whether the provider —
(i) accepts that the complaint is justified; or
(ii) does not accept that the complaint is justified; or
(b) if it decides that more time is needed to investigate the complaint, —
(i) determine how much additional time is needed; and
(ii) if that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

(8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of —
(a) the reasons for the decision; and
(b) any actions the provider proposes to take; and
(c) any appeal procedure the provider has in place.

Opinion: Breach — The rest home and hospital (the rest home company)

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

Introduction
Under Right 4(1) of the Code, Mr B had the right to have services provided with reasonable care and skill. He (and his daughter by virtue of her power of attorney) also had a right to complain about the services provided to him, and to have any complaints documented and appropriately dealt with in accordance with Right 10 of the Code.

In my view, the rest home (now the rest home company) failed to meet its obligations to respond to and address Ms C's complaints, and to adequately monitor and ensure the competence of Mr D in the face of repeatedly expressed concerns about his medication administration practice. This failure amounted to a breach of Rights 10 and 4(1) of the Code. The reasons for my opinion are set out in more detail below.

Complaints about Mr D's medication administration practice
Ms C first put the rest home on notice of her concerns about Mr D's medication administration practice on 28 May by her complaint to senior staff member Ms E. At that time, Ms C asked Mrs E not to confront Mr D directly about the issue but to monitor his practice. Mrs E did not document or deal with the complaint in accordance with the rest home's complaints procedure. She reminded Mr D to give medications at the appropriate times but did not initiate any monitoring of his practice.

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Ms C complained to another senior staff member, Ms F, on 12 June regarding another aspect of Mr D's drug administration practice. Ms F had limited recall of this incident but there is no evidence that she dealt with this complaint in accordance with the rest home complaints procedure.

Ms A was unsure, but did not believe that she was made aware of the complaint made on 28 May. However, Mrs E stated that she did inform Ms A about this complaint and I consider it very likely that she did so. Ms A could not recall whether she was made aware of the complaint made to Ms F on 12 June.

Ms A stated that the rest home was limited in its ability to properly address issues relating to Mr D because it took some time before staff were able to identify the nurse as Ms C refused to give the name "for fear of reprisals". This matter could only be relevant to complaints made before the 30 September review meeting, where Ms A confirmed that the nurse involved was Mr D.

Ms C was fearful that Mr D might retaliate against her father if he knew about her complaints. However, she advised that it was only her name that she asked to be kept confidential, not that of the nurse involved. Both accounts of the complaint made on 28 May indicate that Mrs E knew that the nurse involved was Mr D. According to Ms C, Mrs E told Ms F that "[Mr D] had not administered her father's nebuliser" on 12 June. Ms F could not recall the incident. I am satisfied from the available evidence that the rest home staff knew the name of the nurse who was the subject of Ms C's complaints.

At the review meeting on 30 September, Ms C raised both the practice of Mr D in giving afternoon and evening medications together, and his failure to administer her father's nebuliser or inhaler (including on the night before the meeting). Again the complaint was not documented on a complaints record or dealt with in accordance with the complaints procedure, even though several senior members of staff were present at the meeting.

A meeting was held later that day with Mr D, and Ms C's complaints were put to him. He denied the allegation that he had administered afternoon and evening medications together, and said that Mr B had refused his nebuliser, but that he had forgotten to note this on the medication chart. Ms A, who led the discussion at this meeting, remembered that she had, on occasion, heard Mr B refuse his nebuliser. Accordingly, she accepted Mr D's explanation. Ms A also spoke to the other patient mentioned in Ms C's complaint, who could not recall Mr D giving him his afternoon and evening medications together.

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Regarding the action she took following the review meeting, Ms A stated:

> "[W]e felt the explanation given by [Mr D] was acceptable, he was audited and directly supervised completing a drug round and performed well. We saw no reason to institute further monitoring at that stage."

Ms A explained that, following the meeting with Ms C on 30 September, she had "instigated an investigation and undertook disciplinary action aimed at bringing about the desired behaviour/practice changes in the staff member concerned". However, there was no monitoring or supervision of Mr D's practice following the meeting on 30 September. The review of Mr D's drug administration was carried out prior to the complaint and cannot be considered a response to it.

It is particularly concerning that Ms A did not see any further need to monitor or supervise Mr D's medication administration practice when she already had reason to have concerns about his practice. She explained that questions had been raised about whether he had administered eye drops to residents while in the dementia unit, and that they were significant enough for her to move him to the main unit, where he would be working with other nurses. Also, she recalled that other caregivers had complained about him being "lazy" and sometimes finishing his drug round in a quarter of the time it took everyone else. This was a clear signal that he was taking shortcuts in his medication administration practice, or at the very least an indication that his practice needed to be closely monitored.

Between 30 September and 20 December, Ms C raised her concerns about Mr D and his medicine administration on three more occasions. It is clear that these complaints were not appropriately documented or responded to in accordance with the rest home's complaints policy and its obligations under Right 10 of the Code.

Mrs E could not recall the details of the complaints she received from Ms C between September and December, or what action she took regarding those complaints. It is understandable that the rest home staff might find it difficult to remember the details of events that occurred some considerable time earlier. That is why it is so important to document verbal complaints when they are made and all actions taken in response to them. It was the responsibility of the rest home staff to record that information.

The rest home's accident/incident reporting policy purportedly involved keeping a record of incidents for all residents to assist in "identifying patterns and trends in order that interventions may be put in place". Yet this policy was not used in respect of any of Ms C's complaints. If complaints regarding Mr D's medication administration practice had been documented and retained, his actions (and omissions) may have been identified and addressed much earlier. The fact that Ms C's concerns were documented by Ms F on 9 January (albeit not on a complaints record) led to investigatory action finally being taken in respect of Ms C's complaints. It seems that this may have been prompted by Ms C's indication that she would make a formal complaint and copy this to the Ministry of Health.

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Ms A acknowledged that the rest home staff failed to respond to Ms C's complaints in accordance with its complaints policy and its obligations under Right 10 of the Code.

Ms A stated that Ms C's insistence that the complaints remain anonymous made it difficult for the rest home to take action, and that Ms C "would not allow them to go further" for fear of reprisals against her father. This explanation was supported by Mrs E. Ms A reiterated this in her response to the provisional opinion, and stated that the rest home's failure to act on Ms C's complaints was due "in the most part, to [her] ambiguity".

Ms A submitted that the fact that Ms C never sought an outcome or requested follow-up of issues she raised shows that she did not want the rest home to take any action on her complaints. Ms F stated in her letter of 9 January that Ms C had requested that the rest home not take action on the complaint she made that day until her father had died, as she was worried that Mr D might take it out on him.

However, it appears that, while Ms C did not want the rest home to confront Mr D directly (because she was concerned about identifying her father and exposing him to the risk of retaliatory action by Mr D), she did request action to be taken regarding her complaints. In May, she asked Mrs E not to confront Mr D directly, but to monitor his practice. In October, she asked Mrs E whether any steps had been taken regarding her concerns about Mr D, and also suggested means by which Mrs E could monitor his drug administration practice (for example, by placing tape on the cap of her father's inhaler to check whether it had been used).

I accept that the rest home may have been unsure as to whether and how Ms C wanted them to address her complaints. This was a difficult situation that needed to be carefully managed. However, it appears that Ms C's concerns could have been addressed while the rest home took appropriate action on the complaints regarding Mr D.

The rest home needed to allay Ms C's fears that Mr D would retaliate against her father, perhaps by moving Mr B to another area of the hospital at an earlier stage, or by reassigning Mr D's duties (following a drug stock control check or other means of monitoring him). Mr D claimed that he had suggested both of these options to Ms A, so that he would not be involved in Mr B's care. Ms C asked for her father to be returned to his old room after he was moved on an earlier occasion. However, this should not have prevented Mr B's location in the home from being reconsidered, in consultation with Ms C.

In any event, once the complaints were made, the rest home had an obligation to take action to protect Mr B and other residents from risk.

I note that Ms A advised that following the meeting on 30 September she confronted Mr D despite Ms C's concerns about reprisals because "we felt our obligations regarding 'duty of care' to our resident overrode her reluctance for us to confront the staff member".

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It seems that it would have been possible to honour this obligation by monitoring Mr D's practice as early as May the previous year (following the first complaint) without identifying Ms C as having made a complaint. At the very latest, monitoring of Mr D's practice should have occurred following the review meeting on 30 September.

Ms A also explained that it was difficult for the rest home to act because Mr D was entitled to give his explanation, and they were faced with Ms C's word against Mr D's. In particular, Ms A stated: "[Mr D], as an employee, had rights established by industrial law. He was entitled to give his explanation for his actions and as there was no other evidence apart from [Ms C's] word, there was little we could do in this instance."

When concerns are raised about an employee's practice, the employer must ensure that safety is the paramount consideration, and that someone takes responsibility for addressing the concerns. As noted in the employment context by Judge Finnigan in *Samu v Air New Zealand Ltd*,[6] "where safety is genuinely involved in the operations of an employer it is not just another ingredient in the mix, another factor to be taken into account. Safety issues have a status of their own."[7] What is true for the safety of air travel (with which parallels are often drawn by quality experts in the medical profession) is equally true of patient safety in hospitals, including rest home and hospital facilities.

It is inaccurate for Ms A to state that nothing could be done because Mr D was protected by industrial law. Although employees are entitled to be treated fairly, the safety of residents at a rest home and hospital must come first. As noted in the report of the Tauranga Hospitals Inquiry,[8] challenges to the legality of action taken by a hospital in accordance with employment contracts should not dissuade employers from acting decisively in the face of serious concerns about an employee's practice. Ms C's concerns about Mr D's medicine administration practice were clearly serious, and decisive action should have been taken by the rest home to properly investigate those concerns, to protect resident safety.

For the rest home to take action on Ms C's concerns only after Mr B's death was clearly inadequate and unacceptably late. There was no new information available to the rest home at that time to justify formal enquiries into Mr D's practice that was not available in September the previous year. In fact, it seems that monitoring of Mr D's medication administration practice should have commenced as early as May, particularly given that Ms A already had concerns about him at that stage. By the time

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[6] [1994] 1 ERNZ 93, 95.

[7] This decision was affirmed by the Court of Appeal in *Samu v Air New Zealand Ltd* [1995] 1 ERNZ 636.

[8] Case 04HDC07920, 18 February 2005 (see www.hdc.org.nz).

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an investigation of Mr D's practice commenced the following January, Ms C had made seven complaints about Mr D's medication administration practice over a period of nine months.

The rest home did have a procedure in place which stated that "all complaints will be addressed and thoroughly investigated in order to ensure resolution for all parties". The procedures in place at the rest home at the time were clearly not properly understood and utilised by staff.

Both Ms A and Mrs E stated that, at the time of Ms C's complaints, they would have documented "serious" complaints. Mrs E also stated that "serious medication errors" would have been documented on an incident report. Yet each of the complaints regarding Mr D's medication administration practice raised serious clinical issues. Medications are prescribed to be given at particular times for very important reasons. And there were clinical reasons why Mr B had been prescribed Atrovent and a Flixotide inhaler. Failing to administer those medications was a serious matter that could potentially have harmed Mr B's health.

From May to December, Ms C raised concerns about the medication administration practice of Mr D. However, none of the staff to whom Ms C complained seemed to appreciate the potential seriousness of her allegations. Senior rest home staff, including Ms A, did not appear to appreciate the clinical risk posed by a nurse who could be wrongly dispensing drugs, or the undoubted impact on the care, comfort and well-being of the residents.

Ms C expressed her belief to rest home staff that Mr D's actions had impacted upon her father's condition. She told them that he became sicker following Mr D's omissions, particularly the failure to administer his nebuliser or inhaler.

Employers of health-care providers owe a duty of care to patients to monitor and maintain the competence of their employees, and to respond decisively to any complaints or concerns about an employee's practice. This obligation is embodied in Rights 4(1) and 10 of the Code, and has been discussed in several major Health and Disability Commissioner reports,[9] and in case law.[10] A number of international inquiries have also commented on employer obligations to create and foster a culture of safety.[11] These reports highlight the need for organisations to create and foster a

[9] For example, the Tauranga Hospitals Inquiry, ibid; *Canterbury Health Ltd* (April 1998); and Case 03HDC05563 (see www.hdc.org.nz).

[10] See *Roylance v General Medical Council* [1999] 3 WLR 541.

[11] For example, *The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984–1995* (see www.bristolinquiry.org.uk) and the Australian Capital Territory's Community and Health Services Complaints Commissioner's *Final Report of the Investigation into Adverse Patient Outcomes of Neurological Services Provided by the Canberra Hospital* (2003).

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culture of safety, in particular by ensuring that employees are competent and safe to practise, and to have systems in place to respond to concerns about clinical competence in a timely fashion.

The rest home's duty of care to protect its residents through such processes is no different from the organisational duty of care and skill owed by public and private hospitals. As an employer of health-care practitioners, the rest home has a legal responsibility to respond decisively to complaints and concerns about the practice of its employees, to protect resident safety. It failed to respond appropriately in this case.

Summary

In summary, the rest home's failure to document Ms C's complaints and to address them in accordance with the complaints procedure in place was clearly inadequate and was a breach of Right 10 of the Code.

The rest home's failure to respond adequately to Ms C's complaints and the potentially serious issues surrounding Mr D's practice was also a significant breach of its duty of care to its residents. In the face of clear concerns from Ms C, an articulate and dedicated advocate for her father, the rest home should have done more to ensure that its residents were receiving safe and appropriate care. The rest home's failure to take action in May, and following the further medication complaints in June, September, October, and December exposed Mr B, as well as other residents, to significant risk. Ms C expressed concerns about reprisals from action being taken against Mr D, and this presented a difficult situation for the rest home to manage. However, this does not excuse the rest home's failure to respond appropriately to her complaints.

By failing to take appropriate action on Ms C's complaints, the rest home (the rest home company) did not provide services to Mr B with reasonable care and skill and breached Right 4(1) of the Code.

Other comment

Role of nursing staff

I am concerned that two senior nurses, Ms F and Mrs E, failed to follow the correct procedure for complaints or incident reporting over a period of eight months. In addition, Ms A, the principal nurse manager, acknowledges that she did not follow the complaints or incident reporting procedures. None of these senior nurses appeared to understand the requirements of the complaints or incident reporting procedures. Of most concern is the fact that these processes were not utilised by Ms A, who was responsible for the administration of the rest home policies and procedures.

Even more troubling is the fact that Ms A, Mrs E and Ms F did not appear to appreciate the clinical risk presented to residents from a nurse who may have been wrongly dispensing medication. As the principal nurse manager, Ms A had a duty to ensure the safety of medication administration in the rest home facility, and the safety

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of the practice of the nursing staff. It was her role to identify and address the risk presented by Mr D.

Having been alerted to possible medication omissions or errors on 28 May and again on 30 September, Ms A should have been more vigilant and proactive in safeguarding the welfare of the residents. As stated in the discussion above, I consider that she should have commenced a proper investigation of Ms C's complaint following the May complaint, including monitoring Mr D's medication administration practice. At the latest, this should have occurred following the review meeting on 30 September.

Complaint about urinary catheter care

Ms A's initial response to Ms C's complaint about catheter care was not appropriate. Instead of initiating the formal complaints procedure, she checked the fluid recording chart and responded that the bags were changed regularly three times a day. However, even if nursing staff and caregivers had changed the bags three times a day (the fluid balance summary sheet does not demonstrate that this occurred), this did not answer Ms C's complaint. The fact that Mr B was taking frusemide meant that his urinary output was unpredictable. Accordingly, emptying the bag three times a day may not have been sufficient.

Ms A should have dealt with Ms C's complaint in accordance with the rest home complaints procedure (including documenting and properly investigating the complaint). However, I consider that Ms A and Mrs E took appropriate actions to address the issues regarding emptying and changing of the catheter bag. The system employed to ensure the weekly change of the catheter bag (by recording the change when it occurred) effectively addressed that issue. While it appears not to have been completely effective,[12] the procedure of two-hourly checking of the bag was a significant undertaking for a busy rest home and hospital.

It appears from the complaints made by Ms C (and the response to those complaints) that the urinary catheter care Mr B received at the rest home relating to changing and emptying of the bag may have been less than optimal at times. However, I am satisfied that the rest home appropriately addressed the issues raised by Ms C in respect of her father's catheter care. Consequently, I intend to take no further action on this aspect of Ms C's complaint.

[12] The problem management sheet relating to the emptying of the catheter bag does not demonstrate that it was being checked every two hours and emptied as required. In order to do so, staff needed to consistently record the actual times when the bag was checked (and whether or not it was emptied at that time). This practice was followed when the problem sheet was first commenced but did not continue. Ms C's reports of the bag being over-full on several occasions in September suggest that this system was not completely effective in addressing Ms C's concern.

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Complaint about bowel care

An issue in relation to Mr B's bowel care arose because Ms C's notes in relation to her father's care (in particular, his bowel motions) were not transferred into his bowel record. This happened on two occasions, and it appears that Mr D was the nurse who failed to transfer the information from Ms C's post-it notes to her father's medical records. However, the consequences of that failure for Mr B (namely being given or prepared for a Microlax enema unnecessarily) were unpleasant and distressing.

Ms C's complaint regarding this matter was not addressed in accordance with the rest home complaints procedure, as it should have been.

However, a solution to the problem was found, which involved Ms C supplying a notebook to record her father's bowel motions and keeping this in her father's chest of drawers. She considered that most of the staff did a good job of transferring her entries into the bowel record and there were no further incidents of her father being given an enema unnecessarily.

The matters Ms C raised regarding her father's bowel care were satisfactorily resolved (albeit not in accordance with the complaints procedure). There is no evidence that the bowel care the rest home provided to Mr B was inadequate in any other respects. Accordingly, I intend to take no further action on this aspect of Ms C's complaint.

This is an issue that arose because of the amount of time that Ms C spent with her father, essentially providing nursing cares. In these situations, consideration should be given to allowing responsible family members who are closely involved in a patient's care to access, and record entries in, relevant parts of the medical records (such as fluid balance or bowel charts). Where family members are to be extensively involved in rest home or hospital care, this issue needs to be anticipated and addressed before it impacts upon patient care.

Recommendations

I recommend that the rest home (the rest home company):

- apologise in writing to Ms C for breaching the Code. The apology is to be sent to this Office and will be forwarded to Ms C;

- undertake an audit of compliance with its current complaints and incident reporting procedures to ensure that all staff fully understand and are adhering to the procedures;

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- review its complaints and incident reporting procedures in light of the audit to ensure that the procedures comply with Right 10 of the Code and are adequate to ensure the safety and quality of services for the residents of the rest home and hospital;

- develop a policy for monitoring the practice of registered nurses and ensuring supervision in the event that an aspect of their practice is found to be substandard.

I recommend that the Ministry of Health audit the rest home and confirm, by 30 November 2006, that it has complied with my recommendations and that its current procedures and practices are safe and appropriate.

Follow-up actions

- A copy of the final report will be sent to the Ministry of Health, DHB New Zealand, Waitemata District Health Board and Quality Health New Zealand.

- A copy of the final report, with details identifying the parties removed, will be sent to Healthcare Providers NZ and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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