IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2019] NZHRRT 24**

	Reference No. HRRT 014/2019
UNDER	**SECTION 50 OF THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**RADIUS RESIDENTIAL CARE LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Mr RPG Haines ONZM QC, Chairperson
Dr SJ Hickey MNZM, Member
Mr Mike Keefe JP QSM, Member

REPRESENTATION:
Ms J Herschell, Acting Director of Proceedings
Ms J Stafford for defendant

DATE OF DECISION: 10 May 2019

DECISION OF TRIBUNAL[1]

[1] These proceedings under s 50 of the Health and Disability Commissioner Act 1994 were filed on 8 May 2019.

[2] Prior to the filing of the proceedings the parties resolved all matters in issue and the Tribunal is asked to make a consent declaration. The parties have filed:

[2.1] A Consent Memorandum dated 8 May 2019.

[2.2] An Agreed Summary of Facts, a copy of which is annexed and marked "A".

[3] The Consent Memorandum is in the following terms:

[1] [This decision is to be cited as: *Director of Proceedings v Radius Residential Care Ltd* [2019] NZHRRT 24.]

MAY IT PLEASE THE TRIBUNAL

1. The plaintiff and defendant have agreed upon a summary of facts, a signed copy of which is filed with this memorandum.
2. The plaintiff requests that the Tribunal exercises its jurisdiction and issues a declaration pursuant to section 54(1)(a) of the Health and Disability Commissioner Act 1994 ("the Act") that the defendant has breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 ("the Code") in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.
3. In relation to the declaration being sought in paragraph 2, the parties respectfully refer to the agreed summary of facts. The parties are agreed that it is not necessary for the Tribunal to consider any other evidence for the purpose of making the declaration sought. The parties request that the agreed summary of facts be published by the Tribunal as an addendum to the decision.
4. The defendant consents to the Tribunal making the above declaration based on the facts set out in the agreed summary of facts.
5. In the statement of claim the plaintiff also sought the following relief:
   (a) damages pursuant to s 57(1); and
   (b) costs.
6. These other aspects of the relief claimed by the plaintiff have been resolved between the parties by negotiated agreement. There is no issue as to costs.
7. The defendant does not seek any order prohibiting publication of the defendant's name.
8. The aggrieved person does not seek any order prohibiting publication of his name.

[4] Having perused the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that an action of the defendant was in breach of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 and that a declaration should be made in the terms sought by the parties in paragraph 2 of the Consent Memorandum.

DECISION

[5] By consent the decision of the Tribunal is that a declaration is made pursuant to s 54(1)(a) of the Health and Disability Commissioner Act 1994 that the defendant breached the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 in respect of Right 4(1) by failing to provide services to the aggrieved person with reasonable care and skill.

.....	.....	.....
Mr RPG Haines ONZM QC **Chairperson**	**Dr SJ Hickey MNZM** **Member**	**Mr Mike Keefe JP QSM** **Member**

"A"

This is the Agreed Summary of Facts marked with the letter "A" referred to in the annexed decision of the Tribunal delivered on 10 May 2019.

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL

HRRT /19

UNDER Section 50 of the Health and Disability Commissioner Act 1994

BETWEEN **THE DIRECTOR OF PROCEEDINGS,** designated under the Health and Disability Commissioner Act 1994

Plaintiff

AND **RADIUS RESIDENTIAL CARE LIMITED,** a limited liability company having its registered office at Ground Floor, 12 Viaduct Harbour Avenue, Auckland.

Defendant

AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142
Phone: 04 494 7900 Fax: 04 494 7901

Jane Herschell – Acting Director of Proceedings

AGREED SUMMARY OF FACTS

INTRODUCTION:

1. The plaintiff is the Director of Proceedings, a statutory position created by section 15 of the Health and Disability Commissioner Act 1994 ("the Act").

2. The "aggrieved person" is the consumer, Mr Neville Clotworthy (deceased).

3. At all material times the defendant, Radius Residential Care Limited, was a limited liability company having its registered offices at Ground Floor, 12 Viaduct Harbour Avenue, Auckland. The defendant owns and operates 24 residential aged care facilities in New Zealand, including the facility ("the facility") where the aggrieved person received respite care.

4. At all material times the defendant was a healthcare provider and/or disability services provider within the meaning of s 3 of the Act, and was providing health services to the aggrieved person within the meaning of s 2 of the Act.

5. On 20 January 2016, the aggrieved person's daughter complained to the Health and Disability Commissioner about services provided by the defendant to her father.

6. On 18 September 2018, the Deputy Health and Disability Commissioner (appointed under s 9 of the Act) finalised her opinion that the defendant had breached the aggrieved person's rights under the Health and Disability Commissioner (Code of Health and Disability Service Consumers' Rights) Regulations 1996 ("the Code") and in accordance with s 45(2)(f) of the Act, referred the defendant to the plaintiff.

BACKGROUND

The parties

The aggrieved person

7. The aggrieved person was an 80 year old man with multiple health problems, including type II diabetes, and Alzheimer's dementia with delirium. The aggrieved person was cared for at home by his wife, and home care support workers.

8. The aggrieved person had executed an enduring power of attorney ("EPOA")[1] for personal care and welfare, appointing his wife as his attorney. In May 2015, the aggrieved person's general practitioner ("GP") confirmed that in light of the aggrieved person's medical condition (namely, Alzheimer's dementia with delirium), it was appropriate for the EPOA to be invoked. However, the EPOA was not activated,[2] and the aggrieved person's wife did not have the requisite authority to make decisions on behalf of the aggrieved person.

9. The aggrieved person was under his local District Health Board's ("DHB") respite care programme and he had previously received respite care under that programme in a local rest home. In November 2015, he was assessed as requiring respite care in a psychogeriatric facility.

10. On 21 December 2015, the aggrieved person was admitted to the defendant's facility for a two-week period of respite care.

11. The aggrieved person was discharged from the facility on 4 January 2016.

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[1] An EPOA is a legal document giving someone else the authority to act for a person if they are no longer able to make decisions for themselves.

[2] The required medical certificate certifying that the aggrieved person was mentally incapable had not been signed.

12. The aggrieved person died on 25 January 2016. The cause of death was identified as hypernatraemia[3] and dehydration.

The defendant

13. The defendant provides rest-home level, hospital level, and/or psychogeriatric care through its 24 residential aged care facilities throughout New Zealand, including the facility where the aggrieved person received respite care.

14. During the period of time the aggrieved person was a resident at the facility, it had 20 residents in the psychogeriatric unit of the facility, including the aggrieved person.

15. During the period the aggrieved person was a resident at the facility, it was managed by a Facility Manager ("FM"), and a Clinical Nurse Manager ("CNM"), both of whom were registered nurses. On every shift, a registered nurse ("RN") was on duty, along with five healthcare assistants (HCAs). On occasion, the facility used RNs and HCAs from a bureau. The staff roster for the period in question records that there was adequate nursing and caregiving staff in the psychogeriatric unit. However, both the FM and the CNM were away for eight days during the aggrieved person's stay, although the CNM was on call.

Pre-admission

16. On 13 November 2015, a gerontology nurse from the aggrieved person's local DHB faxed an Admission Enquiry form to the facility, on the aggrieved person's behalf. Included with the Admission Enquiry was a clinical nursing review, dated 12 October 2015, and letter from a

[3] A high concentration of sodium in the blood.

psychiatrist involved in the aggrieved person's care to the aggrieved person's GP, dated 13 November 2015.

17. The nursing review, completed on 12 October 2015, set out the aggrieved person's medical history, his current medications, social history, functional abilities, and provided a summary of his condition which stated that in the presence of Alzheimer-type dementia, and other co-morbidities, the aggrieved person's condition had continued to deteriorate, and there had been an increase of aggressive behaviour in more recent months. The gerontology nurse stated that the aggrieved person received daily personal care at home and was on a respite programme, and that it was important that a facility could manage the aggrieved person's behaviours, as his wife was not likely to cope without regular breaks.

18. In his letter of 13 November 2015, the psychiatrist set out the aggrieved person's current diagnosis as dementia of the Alzheimer's type, with late onset with delirium, and delirium NOS.[4] Having recently reviewed the aggrieved person, the psychiatrist advised that, in light of the issues the aggrieved person was having at his current respite facility, he needed more secure psychogeriatric respite care.

19. Following receipt of the Admission Enquiry form and relevant documents, the FM gave the aggrieved person's admission date and medical history to the CNM and asked her to make contact with the aggrieved person's family. The CNM spoke briefly to the aggrieved person's wife and advised her that there was a room available at the facility for the aggrieved person.

[4] Not otherwise specified.

20. The FM sent a brief email to the aggrieved person's daughter, setting out that the aggrieved person would need to bring clothing, toiletries and medication with him to the facility. The FM did not provide the aggrieved person's family with the pre-admission form which the facility had available, and did not ask for any further information about the aggrieved person.

21. Staff at the facility, except for the FM and CNM, were not advised of the particular challenges the aggrieved person might present during his respite period.

Aggrieved person's legal status and non-resuscitation order

22. It was recorded in the aggrieved person's resident register documentation, that there was an EPOA for personal care and welfare, and that the aggrieved person's wife was the appointed attorney.

23. There is no evidence that facility staff had sighted, or sought to sight, the signed EPOA or the required medical certificate, or had enquired about the EPOA's activation. There was no copy of the EPOA in the aggrieved person's clinical records. Accordingly, staff at the facility were not aware that the EPOA had not been activated, and that the aggrieved person's wife did not have authority to act on his behalf.

24. Throughout the time the aggrieved person was a resident at the facility, staff acted on the basis that the aggrieved person's EPOA was active, and his wife had the power to made decisions on his behalf, when she did not.

25. On 21 December 2015, staff at the facility inappropriately organised for the aggrieved person's wife to sign a non-resuscitation order on behalf of the aggrieved person. The form was also signed by an RN. The aggrieved

person was not consulted as to his wishes about resuscitation, and did not have the opportunity to discuss this order with a medical doctor.

Documentation

26. On 21 December 2015, a general consent form and a photograph consent form were signed by the aggrieved person's wife, on behalf of the aggrieved person. The aggrieved person's wife did not have authority to sign the consent forms. The contents of the consent forms were not discussed with the aggrieved person.

27. On 22 December 2015, a nutrition assessment was completed for the aggrieved person. The aggrieved person was noted to require a diabetic diet.

28. Also on 22 December 2015, personal hygiene, elimination,[5] and pressure risk assessments were completed. The aggrieved person was assessed as being "at risk" of pressure injuries and his score indicated that pressure relieving measures were to be taken.

29. On 24 December 2015, physiotherapy and mobility assessments were completed for the aggrieved person.

30. A fall risk assessment was completed on an unknown date. The aggrieved person was assessed as being at medium risk of falls.

31. On 25 December 2015, a social history assessment, skin assessment and a body map of the aggrieved person were completed.

32. The behavioural and activities assessment forms were not completed for the aggrieved person.

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[5] Toileting.

33. On 22 December 2015, the CNM ordered a behaviour chart be maintained daily, following an incident of reported confusion, agitation, and the aggrieved person being unmanageable. The record was commenced, but only three entries were made. There is no evidence that an analysis of the entries was undertaken with the aim to try and identify triggering factors and successful strategies, or to include these in a behavioural management plan to guide staff in the future.

Use of restraint

34. The New Zealand Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (NZS 8134.2:2008) state that restraint should be used only in the context of good clinical practice and after all less restrictive interventions have been attempted and found to be inadequate.

35. The Standards state:

> "Restraint is a serious intervention that requires clinical rationale. It should not be undertaken lightly and should be considered as one of a range of possible interventions in the care setting, and always in the context of the requirements of this Standard, and currently accepted good practice …
>
> …
>
> Any unauthorised restriction on a consumer's freedom of movement could be seen as unlawful. Organisations should develop clear policies and procedures to guide service providers in the implementation of the Standard ..."

36. The defendant's restraint policy in place at the time was consistent with these Standards. The policy emphasised that restraint was a last resort and may be commenced only after the RN has clinically assessed the client and found that restraint is indicated; all restraint alternatives have been tried and found to be unsuccessful and documented; consultation has occurred with at least one other member of the multidisciplinary team who is also on the Restraint Training Registrar; the Medical Officer is

consulted and has reviewed the indication for restraint and agreed its use is indicated. The family and the client must be consulted at each step in the process and agree to the use of restraint.

37. On 23 December 2015, an RN recorded in the aggrieved person's progress notes that the aggrieved person's wife had agreed to the use of a lap belt, as required, for the aggrieved person's safety, and that the aggrieved person's wife might visit the facility to sign a consent form on 26 December 2015.

38. On 26 December 2015, a Restraint Discussion and Consent form was partially filled out. A handwritten entry on the form recorded that restraint had been discussed with "family & RN on duty", that everyone was in agreement that a restraint trial period should commence and agreed to a lap belt being used when "client in agitated/aggressive/elevated mood", for a maximum time period of 30 minutes. The aggrieved person's wife's name was written on the form, and backdated to 25 December 2015, in anticipation of the aggrieved person's wife signing the form when she next visited the facility.

39. The aggrieved person's wife never signed the restraint consent form. The form was only signed by the Restraint Coordinator (an RN) on 26 December 2015.

40. There is no indication that an assessment was undertaken as part of the restraint approval process, to identify any potential causes for the onset of the aggrieved person's confused state and escalating behaviours.

41. There is no indication the aggrieved person was ever consulted about restraint, or his consent gained. The restraint consent form was not signed by a Medical Officer (or another member of the multidisciplinary team), as

required by the facility's restraint policy, and there is no evidence that a Medical Officer was consulted at any stage.

42. It was recorded that the aggrieved person was restrained by a lap belt for several hours on ten occasions over a period of nine days, by different staff at the facility, namely:

a) 24 December 2015, from 9 pm - 11 pm, and on and off between 11 pm – 11.30;[6]

b) 25 December 2015, from 11 am – 12 pm, 1 pm - 2 pm, and 3 pm – 4 pm, and on and off between 12 pm – 1 pm, and 2 pm – 3 pm.

c) 26 December 2015 from 11 am, for an unknown period of time;[7]

d) 27 December 2015, from 1 pm to 3 pm;

e) 29 December 2015, from 5.40 am to 7 am;

f) 29 December 2015, from 3 pm - 5 pm, 6 pm – 7 pm, and 9 pm - 10 pm, and then on and off between and 10 pm and 11 pm;

g) 30 December 2015, for an unknown period of time;

h) 31 December 2015, for an unknown period of time;

i) 1 January 2016, for an unknown period of time, but recorded to be "all afternoon"; and

j) 2 January 2016, at 9.45 am for an unknown period of time.[8]

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[6] The sleep assessment chart records that the aggrieved person was put to bed at 11.30 pm.

[7] This restraint was noted in the aggrieved person's progress notes, not on a restraint monitoring form. The aggrieved person's daughter reported the aggrieved person was still restrained when she visited between 2.00 pm and 3.00 pm that afternoon.

43. The precise time the lap belt was removed was not recorded in each instance of restraint.

44. There is no record of what cares and supports were provided to the aggrieved person during the time he was restrained, or whether the aggrieved person was monitored during this time.

45. Not all of the restraints were recorded on a "restraint monitoring form". Some restraints were only recorded on the aggrieved person's progress notes.

46. There is no record that alternatives to restraint were considered, or attempted.

47. The defendant accepts that its restraint policy was not followed by its staff.

Administration of medication

48. The information faxed to the facility on 13 November 2015 included information about the aggrieved person's medications.

49. The letter dated 13 November 2015 from the psychiatrist involved in the aggrieved person's care, to the aggrieved person's personal GP listed the aggrieved person's medications as:

    a) Risperidone[9] - 0.5mg at noon, 1.0mg at night, and 1.5mg PRN;[10] and

    b) Quetiapine[11] - 25mg PRN for agitation.

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[8] The restraints that occurred between 30 December 2015 and 2 January 2016 were noted in the aggrieved person's progress notes, not on a restraint monitoring form.

[9] An antipsychotic medication. One use of this medication is for the treatment of behavioural problems (agitation, aggression, or psychotic symptoms) on patients with moderate to severe Alzheimer's dementia.

[10] Pro re nata – as needed.

50. In contrast, the medication order sheet sent by the aggrieved person's facility GP on 23 December 2015, lists the aggrieved person's medication as:

    a) Risperidone - 0.5mg twice daily, and 0.5mg PRN for agitation; and

    b) Quetiapine - 25mg three times daily.

51. A local pharmacy distributed the aggrieved person's medication packaged in blister packs, which provided for:

    a) Risperidone - 0.5mg at breakfast and lunch; and

    b) Quetiapine - 25mg at dinner, and two further PRN doses per day.

52. The inconsistencies in the aggrieved person's medication prescriptions and doses were not reconciled on admission to the facility and neither the aggrieved person's GP nor the pharmacy was contacted to query the dosages. Further, the aggrieved person's wife was not contacted to query whether the prescribed and dispensed medications were consistent with the medication regime the aggrieved person had been following at home.

53. The PRN medication administration signing sheet recorded that the aggrieved person was administered risperidone 0.5mg on three occasions on: 22 December; 23 December; and 24 December 2015; and was offered but refused risperidone 0.5mg on 25 December 2015 and 2 January 2016.

54. The regular administration record and medication administration signing sheets recorded that the aggrieved person was administered quetiapine 25mg three times daily (at breakfast, lunch, and dinner) during his admission.

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[11] An antipsychotic medication. One use of this medication is for the treatment of psychosis in elderly patients with Alzheimer's disease.

55. On five occasions between 31 December 2015 and 3 January 2016, a dose of quetiapine was withheld because the aggrieved person appeared sleepy and unsteady.

56. Not all medication records were made on the medication charts. On occasion, administration or withholding of medication was recorded on the aggrieved person's progress notes instead of the medication charts.

57. A comment written by an RN on the aggrieved person's discharge form, dated 4 January 2016, reads:

> "…Client was still unsteady on feet and sleepy. Informed [the aggrieved person's] wife that she should:
>
> - Query review of medication;
> - Quetiapine charted TDS,[12] but only dinner quetiapine in medicine pack;
> - Sleep apnoea noted.

58. Concern about the aggrieved person's condition, or the fact that this might be linked to overmedication was not raised with the aggrieved person's family or his GP during the time he resided at the facility.

59. The unused risperidone medication was not returned to the aggrieved person or his family when the aggrieved person was discharged. The facility was unable to determine the whereabouts of this medication.

60. The aggrieved person's medication also included metformin and gliclazide, for his type II diabetes.

[12] Ter die sumendum – three times daily.

Nutrition and hydration

61. The nutritional assessment completed on 22 December 2015 recorded the aggrieved person's dietary status as diabetic. However, the dietary requirement form and the respite / short-term care plan both stated that the aggrieved person ate a "normal diet". The form also noted a recent history of weight loss.

62. The food and fluid intake forms recorded that the aggrieved person ate ice cream, cake, and other foods that did not form part of a diabetic diet.

63. Food and fluid intake charts were commended on 22 December 2015, to chart the aggrieved person's eating and drinking patterns. These charts showed that the aggrieved person was eating well, initially.

64. No food and fluid intake was recorded for the aggrieved person between 25 and 29 December 2015.

65. The food and fluid intake recording recommenced on 30 December 2015, and showed from there that the aggrieved person either refused meals, or ate and drank very little.

66. There is no evidence from the clinical records that reasons for the aggrieved person's refusal of food or fluids were evaluated. Staff did not notify the aggrieved person's family or his GP that his food and fluid intake had decreased.

67. There is no evidence that the aggrieved person's blood sugar level was monitored at any time during his stay at the facility, despite his fluctuating levels of confusion, and observations that he was not eating and drinking consistently well.

68. The defendant's Nutrition and Hydration Policy (Point 8.5 – "handling food refusal") states that an individual who continually refuses to eat or drink is at high risk of dehydration and malnutrition. The appropriate artificial support (eg nasogastric or PEG feeding) including the ethical issues involved should be discussed and documented by the multidisciplinary team, client and their family/whānau, as part of the client's care needs.

69. The aggrieved person experienced further weight loss during his stay at the facility. On 22 December 2015, the aggrieved person's weight was recorded at 59 kilograms. This weight was also recorded on the weight record sheet on 23 December 2015.

70. On 1 January 2016, the aggrieved person's weight was recorded as 57.4 kilograms.

71. The aggrieved person's weight was not recorded between 1 January 2016 and his discharge on 4 January 2016.

Personal cares and hygiene

72. "Daily Personal Cares" charts recorded the cares provided to the aggrieved person during his stay at the facility. One chart was kept for December 2015. There were two charts kept for January 2016, which were a combined but in some instances inconsistent record of the cares provided to the aggrieved person during that time.

Showering

73. It was recorded on the aggrieved person's December 2015 "Daily Personal Cares" chart that he was only showered on 24, 25 and 29 December 2015.

74. One "Daily Personal Cares" chart kept for January 2016 recorded that the aggrieved person was showered on 1, 2, and 3 January 2016. The second chart recorded the aggrieved person was showered only on 4 January 2016.

Oral health

75. It was recorded on the aggrieved person's December 2015 "Daily Personal Cares" chart that the aggrieved person's teeth were cleaned once daily on 22, 23, 24, 25, and 28 December 2015.

76. One "Daily Personal Cares" chart kept for January 2016 recorded that the aggrieved person's teeth were cleaned once daily on 1, 2, and 3 January 2016. The second chart recorded the aggrieved person's teeth were cleaned only once in January, on 1 January 2016.

77. On 5 January 2016, the day after the aggrieved person was discharged from the facility, he was diagnosed with oral thrush.

Bowel management

78. The facility's approved Bowel Record Chart was not used for the aggrieved person during his stay. Rather, bowel movements were recorded on the "Daily Personal Cares" charts. The charts are incomplete and no entries were made for 27 December 2015, or 1, 2, and 3 January 2016.

79. It was recorded that the aggrieved person's bowels had opened on 31 December 2015.

80. On 1 January 2016, it was recorded that the aggrieved person was constipated, and was "helped to moved bowels manually" [sic]. A HCA massaged the aggrieved person's anal area to enable a bowel movement,

which occurred. An RN was present during the procedure. The aggrieved person did not consent to this procedure.

Changes in overall health

81. During his stay at the facility, staff observed escalating behaviours, and a decline in the aggrieved person's cognitive status, mobility, and eating and drinking ability, and failed to respond appropriately to these changes in his overall health status.

DEFENDANT'S RESPONSE TO COMPLAINT

82. The defendant has accepted the shortcomings in the care and documentation during the aggrieved person's stay in its facility. The defendant has acknowledged the failures by senior staff to fulfil key functions of their respective roles and failures by staff to follow the defendant's policies and procedures, in particular the Radius Assessment, Care Planning and Review and Pre-Entry and Admission Policies. The defendant accepts that it had overall responsibility for the actions of its staff and had an organisational duty to ensure the provision of timely, appropriate, and safe services to the aggrieved person, and to facilitate continuity of his care.

83. The defendant has acknowledged the gaps in the aggrieved person's progress notes; a failure to follow up observations of the aggrieved person being sleepy and unsteady on his feet, with a medication review or urine analysis; a failure to complete a medication reconciliation on admission; a failure to follow its restraint policy and document restraint monitoring; and a failure to clearly document the aggrieved person's showering routine.

84. As a result of the complaint, the defendant has implemented compulsory training sessions and mentoring for staff at the facility, including sessions on assessment and care planning processes, clinical documentation, restraint management, incident reporting, medication management, and management of diabetes and other medical conditions.

85. The defendant has acknowledged its staff failed to follow its policies regarding discrepancies in the medications prescribed to the aggrieved person and the restraint processes undertaken.

86. Following the complaint, the defendant has taken steps to improve the level of service provided, and worked closely with the local DHB to ensure service provision requirements are met. A senior RN was appointed to work in the facility to provide increased clinical supervision and leadership, and to ensure immediate changes were made in both the care given and the documentation completed.

87. The defendant has since appointed a new management team at the facility to ensure systems implemented are sustained. Further, external support was provided for all staff with a site specific training programme focusing on communication, competency, accountability, and meeting individualised consumer focused needs.

88. The defendant has implemented the eCase document management system across the facility to improve the recording and collation of patient information. This system includes an "alert" function to indicate whether an EPOA has been activated.

89. Ongoing external and internal auditing illustrates an improved and high standard of service delivery across all key areas of care.

90. The defendant has provided a formal apology to the aggrieved person's family acknowledging the shortfalls in the care provided to the aggrieved person. The defendant accepts it has a duty to ensure its residents are provided with care of a reasonable care and skill, and that it does this by ensuring that appropriately qualified and trained staff at sufficient levels are employed and supported in their roles.

BREACH OF RIGHT 4(1) OF THE CODE

91. Right 4(1) of the Code states: "Every consumer has the right to have services provided to them with reasonable care and skill".

92. The defendant accepts that it breached Right 4(1) of the Code by not providing services to the aggrieved person with reasonable care and skill. In particular, the defendant accepts that:

a) no clear initial assessment was undertaken, identifying the clinical and behavioural issues that could arise during the aggrieved person's stay at the facility;

b) no evaluation of the overall clinical picture of the aggrieved person's declining health during his stay at the facility was completed;

c) restraint policy and procedures were not followed;

d) the aggrieved person's medication regime was not reviewed in light of his deteriorating condition;

e) conflicts in the aggrieved person's prescriptions were not addressed;

f) the aggrieved person's diabetes was not monitored appropriately;

g) an evaluation of the reasons the aggrieved person was not eating or taking fluids was not undertaken;

h) the personal cares given to the aggrieved person were suboptimal;

i) the aggrieved person's legal status was not clarified; and

j) the aggrieved person's wife was asked to sign a resuscitation order on the aggrieved person's behalf, when she had no legal authority to do so.

_____

Jane Herschell
Acting Director of Proceedings

I _____ agree that the facts set out in this Summary of Facts are true and correct.

_____

For or on behalf of
Radius Residential Care Limited

_____

Date: