(1) ORDER PROHIBITING PUBLICATION OF NAME OR IDENTIFYING PARTICULARS OF THE AGGRIEVED PERSON

(2) ORDER PREVENTING SEARCH OF THE TRIBUNAL FILE WITHOUT LEAVE OF THE CHAIRPERSON OR OF THE TRIBUNAL

IN THE HUMAN RIGHTS REVIEW TRIBUNAL **[2022] NZHRRT 29**

I TE TARAIPIUNARA MANA TANGATA

	Reference No. HRRT 028/2022
UNDER	**THE HEALTH AND DISABILITY COMMISSIONER ACT 1994**
BETWEEN	**DIRECTOR OF PROCEEDINGS**
	PLAINTIFF
AND	**RADIUS RESIDENTIAL CARE LIMITED**
	DEFENDANT

AT WELLINGTON

BEFORE:
Ms GJ Goodwin, Deputy Chairperson
Dr SJ Hickey MNZM, Member
Ms S Stewart, Member

REPRESENTATION:
Ms K Eckersley Director of Proceedings
Ms K Rowe and Mr D McGill for defendant

DATE OF HEARING: **Heard on the papers**

DATE OF DECISION: **16 August 2022**

(REDACTED) DECISION OF TRIBUNAL[1]

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[1] [This decision is to be cited as *Director of Proceedings v Radius Residential Care Ltd* [2022] NZHRRT 29. Note publication restrictions.]

[1] These proceedings under the Health and Disability Commissioner Act 1994 were filed on 15 July 2022.

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

[2.1] A statement of claim dated 15 July 2022.

[2.2] A consent memorandum dated 27 June 2022.

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

[3] In the consent memorandum dated 27 June 2022 the parties request that the Tribunal exercises its jurisdiction and issues:

> 2(a) 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; and
>
> 2(b) A final order pursuant to s 107(3)(b) of the Human Rights Act 1993 prohibiting publication of the name of the aggrieved person in this matter (Ms A, deceased) and all identifying details.

[4] Having considered the Agreed Summary of Facts the Tribunal is satisfied on the balance of probabilities that actions of the defendant breached 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(a) of the Consent Memorandum.

[5] The Tribunal is also satisfied that it is desirable to make a final order prohibiting publication of the name and identifying details of the aggrieved person, for the following reasons.

[6] The Tribunal may order final suppression orders under s 107(3) of the Human Rights Act 1993 if it is "satisfied it is desirable to do so". In this context, "desirable" is considered from the point of view of the proper administration of justice; a phrase that must be construed broadly to accommodate the particular circumstances of individual cases as well as broader public interests. Any name suppression order should do no more than is necessary to achieve the proper administration of justice. For an order there must be some material before the Tribunal to show specific adverse consequences that are sufficient to justify an exception to the fundamental rule of open justice; see *Waxman v Pal (Application for Non-Publication Orders)* [2017] NZHRRT 4 and *Director of Proceedings v Smith (Application for Final Non-Publication Orders* [2019] NZHRRT 32.

[7] Ms A was the consumer in this matter. The Agreed Summary of Fact contains sensitive details about her private health information and about her death. As Ms A is deceased it is not possible to seek her opinion on suppression of her name and identifying details. Ms A's niece represented her throughout the proceedings. Publication of Ms A's name and identifying details would cause her niece significant distress and her strong preference is that her aunt's name be suppressed.

[8] There is public interest in the details of the defendant's failures being published, as set out in the Agreed Summary of Facts. There is, however, little or no interest in the publication of Ms A's name, nor in her being identified in connection with this case. In

these circumstances, the privacy interests of Ms A (deceased) outweigh any public interest in knowing her name. The publication of Ms A' name would cause her niece specific adverse consequences.

[9] The presumption of open justice is satisfied by publication of the Tribunal's decision and the detailed Agreed Summary of Facts, with Ms A's name and identifying details redacted.

[10] Accordingly, the Tribunal is satisfied the order sought by the parties in paragraph 2(b) of the Consent Memorandum should be made.

DECISION

[11] The decision of the Tribunal is that:

[11.1] 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.

[11.2] A final order is made prohibiting publication of the name and of any other details which might lead to the identification of the aggrieved person, Ms A (deceased).

[11.3] There is to be no search of the Tribunal file without leave of the Tribunal or of the Chairperson.

.....	.....	.....
Ms GJ Goodwin	**Dr SJ Hickey MNZM**	**Ms S Stewart**
Deputy Chairperson	**Member**	**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 16 August 2022

BEFORE THE HUMAN RIGHTS REVIEW TRIBUNAL
I TE TARAIPIUNARA MANA TANGATA

HRRT No.

UNDER	Section 50 of the Health and Disability Commissioner Act 1994
BETWEEN	**DIRECTOR OF PROCEEDINGS**, designated under the Health and Disability Commissioner Act 1994
	Plaintiff
AND	**RADIUS RESIDENTIAL CARE LIMITED,** a duly registered company having its registered office at Level 4, 56 Parnell Road, Parnell, Auckland, 1052, New Zealand
	Defendant

REDACTED AGREED SUMMARY OF FACTS

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Level 11, 86 Victoria Street, Wellington 6011
PO Box 11934, Wellington 6142

Kerrin Eckersley – Director of Proceedings

REDACTED AGREED SUMMARY OF FACTS

INTRODUCTION:

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

2. The "aggrieved person" is Ms A (deceased).

3. At all material times the defendant was a duly registered company which owned and operated Radius Elloughton Gardens ("REG") in Timaru, where the aggrieved person was a resident.

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 and/or disability services to the aggrieved person.

5. On 20 March 2019 the aggrieved person's niece ("the complainant") complained to the Health and Disability Commissioner about the services provided to the aggrieved person by the defendant.

6. In February 2021, 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 Aggrieved Person

7. The aggrieved person, aged 79 at the time of these events, had been a resident in the Elizabeth Wing[1] at REG since early 2017, after her previous care facility closed down.

8. The aggrieved person had several comorbidities including an intellectual disability, bipolar disorder, anaemia, congestive heart failure, osteoarthritis, osteoporosis, and a previous fracture to her left fibula.

9. The aggrieved person required hospital-level care, including assistance with most aspects of her daily living. She had limited communication ability and required a four point walking frame when mobilising. She also required assistance to mobilise from her bed or chair, but she was noted on her care plan to be a low falls risk.

10. At some time between 9 and 10 November 2018, the aggrieved person sustained serious injuries whilst residing at REG. She subsequently died in late November 2018.[2]

The Defendant

11. The defendant company owns and operates REG, a facility which provides rest home and hospital-levels of care (both of which encompass respite and palliative care) to up to 86 residents.

12. Over the relevant period of time during which the events in question occurred, approximately 16 care staff (a mixture of health care assistants

[1] The Elizabeth Wing is a hospital-level wing, consisting of approximately 23 residents.
[2] Her cause of death was not the injuries she sustained.

and registered nurses) were rostered on duty at REG. There were no visitors or outside contractors in the facility during this period of time.

RELEVANT EVENTS, 9 – 10 NOVEMBER 2018

Friday 9 November 2018

13. At 1.43pm on Friday 9 November 2018, the aggrieved person was described in her progress notes as "eating and drinking as tolerated", and no concerns were documented by the care staff during the day. The last note in her progress notes on Friday 9 November 2018 was documented at 7.48pm by a health care assistant ("HCA"), which stated: "Washed, changed clothes and pad, settled to bed after cares, cleaned dentures and put it in the container, no new concerns."

14. At some point between 2:45pm and 11:15pm on Friday 9 November 2018, a HCA checked on the aggrieved person while she was asleep (however this check was not documented, and the exact time of the HCA's observation is unknown). When asked about this observation, the HCA confirmed she had no concerns when she checked on the aggrieved person at this time.

15. Another HCA, who started her shift at 11:00pm on Friday 9 November 2018, said that she provided cares for the aggrieved person at 1.30am and 4.30am on Saturday 10 November 2018, which included changing her pad. Neither of these cares were documented in the aggrieved person's records. The HCA did however document a "Type 7" bowel movement in the aggrieved person's bowel chart at 6.01am on Saturday 10 November 2018, although the HCA subsequently denied that this bowel movement occurred and could not explain why she made such an entry into the aggrieved person's bowel chart.

16. All other staff who were rostered and working on the night shift between Friday 9 November 2018 and Saturday 10 November 2018 denied that there were any incidents involving the aggrieved person during their shifts. The handover report between the night shift registered nurse and the morning shift registered nurse, RN B, did not mention any concerns about or incidents involving the aggrieved person. There were no further entries in the aggrieved person's progress notes or charts until 9.34am on Saturday 10 November 2018.

Saturday 10 November 2018

17. At 6:45am on Saturday 10 November 2018 the morning shift registered nurse, RN B, began her shift as the rostered nurse in the Elizabeth Wing. Her shift was scheduled to end at 3:15pm. RN B began working as a registered nurse at REG on 27 August 2018. She had not previously worked in a rest home setting. Less than two weeks into starting work at REG, RN B suffered an injury which meant she was absent from work from 10 September 2018 to 14 October 2018. The commencement of her orientation was therefore delayed until she returned to work on 15 October 2018. As at 10 November 2018, RN B had not completed her REG orientation and was yet to receive training on a number of key areas of her role, including responding to a resident falling, transferring a resident to hospital, incident reporting, eCase documentation, and access to after-hours GP care.

18. According to RN B, when she was preparing medication for the morning medication round she overheard a conversation between two of the night shift HCAs about a fall that had occurred overnight. RN B said that she was focused on preparing the medications, and did not pay any

further attention to what the HCAs were saying. The two HCAs involved in this conversation subsequently denied that it occurred.

19. RN B started the morning medication round, which included giving the aggrieved person her medications. RN B said she had a brief conversation with the aggrieved person during the round and that she was "fine", had "no complaints of pain", and that she "didn't notice anything unusual about her condition, or state." This medication round and the conversation with the aggrieved person were not documented by RN B in the aggrieved person's progress notes and/or medical charts.

20. At 9.34am on Saturday 10 November 2018, another HCA documented in the aggrieved person's personal cares chart that "all cares done, washed, dressed her up, dentures cleaned, on chair in her room after cars, bed made, eating and drinking less, not well, informed RN." The same HCA made an identical entry into the aggrieved person's progress notes at 2:50pm on Saturday 10 November 2018. The HCA later told the defendant that despite what she had documented at 9:34am and 2:50pm, she did not in fact perform the cares for the aggrieved person on this day. She told the defendant that she documented the cares on behalf of two other HCAs, but did not provide an explanation for why she did this.

21. At around 9:30am on 10 November 2018, RN B was informed by some caregivers that there was something "unusual" about the aggrieved person and RN B was asked to review her.

22. RN B proceeded to check the aggrieved person. Upon review, she found the aggrieved person half dressed in her bed, with a care staff member attempting to put a top on her. According to RN B, the aggrieved person was screaming and yelling because of the pain and refused to let RN B

touch her. This was apparently unusual for the aggrieved person, who was usually complaint and cooperative.

23. RN B attempted to complete a head to toe review of the aggrieved person. RN B said the aggrieved person indicated she had pain and redness on her right upper arm, and that the pain score was 9 out of 10. RN B said that she asked the aggrieved person several times whether she had fallen, but the aggrieved person did not reply. RN B said that the aggrieved person also complained of pain (5 out of 10) in both legs, and could bend both knees around 35 degrees. These assessments were not documented in the aggrieved person's progress notes at the time (although RN B did partially document this process much later in the day[3]).

24. After RN B discovered the aggrieved person's injuries, she instructed three HCAs who were assisting her to leave the aggrieved person on the bed while she contacted the GP to request a review of the aggrieved person. She told the HCAs not to move the aggrieved person or finish dressing her until she had been seen by the GP. RN B then administered 30mg of codeine to the aggrieved person.[4]

25. At some point after this, RN B phoned Timaru Medical Centre to speak with the GP. RN B said it was around 11:00am. She told the receptionist that she suspected a patient had suffered an unwitnessed fall and required review by a GP. After the phone call, RN B sent a fax to the Timaru Medical Centre, which said: "[the aggrieved person] … Severe pain on right hand (near elbow region). Couldn't move her lower limbs

[3] RN B made an entry into the aggrieved person' progress notes at 6.00pm on 10 November 2018, recording her vital signs. The entry did not include the pain assessment she carried out.

[4] The codeine administration was not documented at the time, however an entry into the aggrieved person's progress notes at 6:00pm on 10 November 2018 notes that it was administered at 10:30am.

too. She suggests to see the GP." RN B was subsequently informed that the GP would attend to the aggrieved person at around 12:00pm.

26. After RN B had finished contacting Timaru Medical Centre, she returned to the aggrieved person's room to find she had been moved to a chair and fully dressed, contrary to her instructions. RN B said that while she was disappointed her instructions had not been followed, the aggrieved person looked very peaceful so she closed the curtains and left her to sleep. She said that she asked the aggrieved person how she was feeling, and the aggrieved person nodded and smiled at her.

Review by GP

27. The aggrieved person was seen at REG by the afterhours GP between 12:45pm and 1:00pm on Saturday 10 November 2018.

28. The GP described the review of the aggrieved person as follows:

> "I was asked to visit the patient at 12pm on the 10/11/18 … I saw the patient at about 1pm. (exact time not recorded) … [T]he afterhours nurse told me that patient had fallen and injured their arm. I am not sure which rest home nurse contacted the afterhours clinic (or how) … I examined the right arm and advised that the patient go immediately to [the Emergency Department] for further assessment and x rays (she was in a lot of pain and so needed further examination in [Accident and Emergency] with acute pain relief). I advised the nurses that the patient needed to go quickly to [Accident and Emergency] for x rays and further assessment."

29. At around 2:00pm, RN B phoned the complainant to inform her about the aggrieved person's condition.

30. About 30 minutes after that, at around 2:30pm, RN B called 111 to request an ambulance to take the aggrieved person to the hospital. RN B said it was the first window of opportunity she had to make the call for

an ambulance, as she had to finish the lunchtime medication round, phone the complainant, seek guidance from a manager, and help another nurse to tend to another resident before she could phone 111.

Ambulance transfer to hospital

31. The ambulance arrived at REG to collect the aggrieved person at approximately 2.40pm on Saturday 10 November 2018.

32. The attending ambulance personnel documented that the aggrieved person was difficult to communicate with owing to her special needs, and appeared agitated when the attending personnel tried to gather more information regarding her injuries.

33. Because the aggrieved person refused to go to hospital, the complainant was called to assist staff with moving the aggrieved person onto the stretcher. With the complainant's assistance, ambulance staff were eventually able to move the aggrieved person into the ambulance.

34. The ambulance departed to Timaru Hospital's Emergency Department at 3.38pm.

Admission to hospital

35. The aggrieved person was admitted to Timaru Hospital's Emergency Department at around 4.00pm on Saturday 10 November 2018.

36. Following assessment by hospital staff, the aggrieved person was found to have suffered a right shoulder dislocation and a periprosthetic fracture of her left tibia and fibula. Her shoulder was re-located and a plaster cast was put on her left leg. The complainant was told that the aggrieved person was now in palliative care, and would not walk again.

37. At 7.38pm, the complainant received a telephone call from a person who said they were a nurse from REG. The person asked about the aggrieved person's condition. It was later confirmed that the nurse who phoned the complainant was RN B.

38. Hospital staff determined that the aggrieved person's injuries were not for surgical management and she was subsequently discharged to remain on bedrest at REG on 16 November 2018.

39. The aggrieved person passed away in late November 2018. Her cause of death was coronary heart failure.

SUBSEQUENT EVENTS

Internal investigation by the defendant

40. On 12 November 2018, the complainant met with the defendant to raise her concerns and make an internal complaint about the poor care provided to the aggrieved person. She also asked REG' Facility Manager for further information about the incident and how the aggrieved person sustained her injuries. This meeting with the complainant was the first time that the defendant's management was made aware of the incident involving the aggrieved person.

41. After meeting with the complainant, the defendant immediately commenced initial enquiries into the incident. These inquiries did not provide sufficient information about how the aggrieved person incurred her injuries, so a formal internal investigation was commenced.

42. The formal investigation was undertaken from 14 to 16 November 2018. A second series of investigation meetings was undertaken from 21 to 27 November 2018. As part of these investigation meetings, the defendant

conducted interviews with the 16 staff who were rostered on the day of the incident. In total, the defendant carried out 26 formal staff interviews in relation to this event. The defendant also had a compulsory all staff meeting on 23 November 2018 to implore any staff with any information about the incident and the aggrieved person's injuries to come forward.

43. Following the 16 staff interviews and all staff meeting, the defendant was still unable to gather sufficient information to explain the aggrieved person's injuries. There were also discrepancies and inconsistencies between the statements provided by staff during the course of the interviews. The only confirmed findings that the defendant was able to make were that:

    a. The aggrieved person was well at 8:00pm Friday 9 November 2018;

    b. The aggrieved person's shoulder injury was first detected at around 9:30am Saturday 10 November 2018;

    c. The aggrieved person's fractured lower leg was detected after admission to Timaru Public Hospital;

    d. After sustaining her injuries the aggrieved person could not have returned to her bed without considerable assistance from another person or persons;

    e. The only people in the facility were staff and residents. There were no visitors or contractors on site at the time.

External investigation

44. On 12 December 2018, the defendant engaged an external investigator to investigate the incident involving the aggrieved person. The external investigator found that:

    a. It appeared that the injuries suffered by the aggrieved person were the result of a fall, or the attempt to lift/pull her off the floor to return her to bed;

    b. On the grounds of probability, the injuries sustained occurred between 11pm on 9 November 2018 and 7am on 10 November 2018;

    c. It was more likely than not that the incident occurred when one of the HCAs took the aggrieved person to the toilet at 6.01am on 10 November 2018, as even though the HCA denies this, she cannot explain why she entered in eCase (the defendant's documentation software) that the aggrieved person had had a bowel motion, and multiple staff members recall the HCA stating that she changed the aggrieved person's sheets at this time;

    d. There was a practice of staff spending time in other wings during their shifts, and a practice of staff completing notes hours after completing tasks or recording notes of observations that they did not see. The external investigator stated that this is an ongoing risk to the defendant that needed to be considered; and

    e. The use of CCTV in the corridors would have greatly assisted the investigation, and it was recommended that CCTV be installed to increase security.

45. On 11 April 2019, the defendant advised the complainant of the external investigation findings and sent her a copy of the report. The defendant apologised to the complainant for being unable to explain the events around the incident and injuries that the aggrieved person suffered.

THE DEFENDANT'S RESPONSE TO COMPLAINT

46. As outlined above in this agreed summary of facts, the defendant undertook internal and external investigations after this incident came to light. Following a period of statutory management and the recommendations in the Deputy Commissioner's report, the defendant has implemented the following actions:

    a. implementing a benchmarking system for its registered nurses to enable them to measure their performance in terms of outcomes such as falls, rate of injuries with falls, and compliments and complaints;

    b. ensuring that all registered nurses work as a team to complete care plans in a timely manner;

    c. installing CCTV in the corridors at REG to increase security;

    d. updating its policies and practices, including its documentation policy, falls policy, and adverse event management policy;

    e. developing an online training programme to provide continuing education to all care staff across its facilities on open disclosure, adverse event management, and documentation, which will be completed by all new staff at orientation;

    f. implementing a system whereby work tasks are managed via worklogs in the eCase Software Care System;

g. increased oversight and monitoring by the facility manager and clinical manager, to ensure staff are not spending time in incorrect wings during their shifts and that documentation is up to the expected standard;

h. reviewing all staff training records to ensure records are complete and up to standard; and

i. conducting random audits of staff compliance with REG' policies on documentation, falls, and adverse event management;

j. developing an anonymised case study of the Deputy Commissioner's report, focusing on the breaches of the Code identified, and using it as a learning tool for its staff at REG.

47. The defendant has provided a written apology to the complainant, in accordance with the recommendations of the HDC.

BREACH OF THE CODE

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

49. The defendant has a responsibility to operate its facilities in a manner that provides its residents with services of an appropriate standard. The New Zealand Health and Disability Sector Standards also require that rest homes ensure the operation of their service is managed: "in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers".[5]

[5] New Zealand Health and Disability Sector (Core) Standards (NZS8134.1.12:2008, Standard 2.2).

50. The defendant acknowledges that it had the ultimate responsibility to ensure the aggrieved person received care that was of an appropriate standard and complied with the Code, and that it failed in that responsibility as follows:

    a. the aggrieved person suffered serious injuries whilst under the defendant's care;

    b. staff failed to make any entries into the aggrieved person's medical charts and/or records between 7.48pm on 9 November 2018 and 9.34am on 10 November 2018, which meant the cause of the aggrieved person's injuries was undeterminable;

    c. staff failed to report and/or document the incident which caused the aggrieved person's injuries;

    d. following discovery of the aggrieved person's injuries, there is no evidence that any staff undertook hourly observations of the aggrieved person in accordance with the defendant's "Falls Assessment and Intervention" policy;

    e. the nursing review of the aggrieved person following the discovery of her injuries was not documented in her medical charts and/or records at the time her injuries were discovered;

    f. when the nursing review of the aggrieved person was eventually documented in her medical charts and/or records, the entry did not sufficiently detail the findings of the review;

    g. despite the aggrieved person's serious injuries and poor presentation, there was a significant delay between staff discovering her injuries and contact being made with the GP;

h. despite GP advice that the aggrieved person required urgent emergency department assessment and x-rays, there was a significant delay in requesting an ambulance;

i. the aggrieved person's next of kin was not informed about her injuries until around 4.5 hours after they were first discovered; and

j. the only registered nurse rostered on in the aggrieved person's wing on 10 November 2018, RN B, had not completed her REG training and orientation.

51. Accordingly, the defendant accepts it breached Right 4(1) of the Code.

52. The defendant accepts full responsibility for the suboptimal care provided to the aggrieved person while she was in its care, and acknowledges that it should have attended to the aggrieved person with greater care.

_____

Kerrin Eckersley
Director of Proceedings

_____

Date

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

_____

Brien Cree
For and on behalf of Radius Residential Care Limited

_____

Date