HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

A Decision by the Aged Care Commissioner

(Case 20HDC00838)

Introduction

1. This report is the opinion of Carolyn Cooper, Aged Care Commissioner, and is made in accordance with the power delegated to her by the Health and Disability Commissioner. The report concerns a complaint from Ms A received in 2020 about the care provided to her late mother, Mrs A, at Golden Pond Lifecare Private Hospital Limited (Golden Pond), a provider of hospital and care-home services. Mrs A passed away in 2022. I extend my sincere condolences to Ms A for the loss of her mother.

2. Ms A raised concerns about the quality of the care her mother received at Golden Pond. Ms A said that often staff were disrespectful and would delay or refuse to take Mrs A to the toilet; they did not accommodate her hearing and speech problems and ignored her requests for help; they were slow to discover that Mrs A had had a fall and did not respond to it appropriately; and they did not identify that her behaviour indicated that she might have a urinary tract infection.

3. The following issue was identified for investigation:

   - *Whether Golden Pond Private Hospital Limited provided [Mrs A] with an appropriate standard of care during 2020.*

4. This report is the Aged Care Commissioner's opinion on the adequacy of the care provided to Mrs A at Golden Pond. The report sets out the key issues in the complaint and Golden Pond's response to them. This is followed by the Aged Care Commissioner's opinion on each matter, in which the issues are discussed in more detail, including key evidence and clinical notes.

5. Independent clinical advice about Mrs A's care was obtained from registered nurse (RN) Julia Russell (Appendix A).

Background

6. In 2020 Mrs A was in her seventies and lived at Golden Pond, where she received hospital-level care.[1] She had been living there since her admission in May 2019. Mrs A had a history of depression and limited vision and had been diagnosed with progressive supranuclear

[1] Mrs A left Golden Pond to live elsewhere on 1 November 2020.

Names (except Golden Pond Private Hospital Limited and the advisor on this case) have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

palsy (PSP), a complex, chronic neurological condition that affects speech, swallowing, eye movements, and mobility, and worsens over time.[2] Ms A said that the condition altered the pitch and volume of her mother's voice and diminished her ability to speak. In addition, Mrs A was 'very deaf' and needed to have face-to-face conversations in order to hear.

7. Ms A installed a motion-activated camera in Mrs A's unit for security reasons, as she had been unable to obtain insurance cover for Mrs A's personal belongings. Golden Pond was aware of this. When Mrs A began to have falls, Ms A wanted to use the camera to help to establish the cause of her mother's falls.

Initial complaints to Golden Pond

8. In early 2020 Ms A became concerned about the care her mother was receiving at Golden Pond, based on Mrs A's description of specific events and incidents captured by the motion-activated camera. On 20 January 2020 Ms A made a formal written complaint to Golden Pond stating her concern about 'ongoing incidents', including, most recently, that enrolled nurse (EN)[3] B had spoken to Mrs A rudely about her clothing and use of food thickener, had questioned her need to go to the toilet, and had been impatient when assisting Mrs A to the toilet. On 31 January Golden Pond met with Ms A to discuss her concerns, including EN B's manner and communication, as well as concerns about Mrs A's use of the call bell and the recording of Mrs A's behaviours and falls. The minutes of this meeting document that Golden Pond held a staff meeting on 22 January, during which 'attitude, respect [and] privacy' were discussed.

9. Ms A emailed Golden Pond on several occasions in March and April with further concerns about Mrs A not being able to access her call bell, staff yelling at Mrs A or speaking to her rudely and not taking her condition into account, Mrs A being told not to use her call bell, a possible unreported fall, and Mrs A not being taken to the toilet or having to wait a long time before being taken to the toilet. In an email on 30 March Golden Pond told Ms A that staff had been given an article about PSP. On 17 April an Elder Abuse Response Service support group[4] (EARS) emailed several videos from Mrs A's room to Golden Pond on Ms A's behalf. EARS suggested that a particular healthcare assistant (HCA), Ms C, cease caring for Mrs A until a meeting could be arranged, on the basis that Mrs A was becoming stressed at the way she was being treated by Ms C.

[2] Other possible symptoms include stiffness, awkward movements, falls, sensitivity to bright light, trouble sleeping, loss of interest in pleasurable activities, impulsive behaviour, laughing or crying for no reason, difficulty with reasoning, problem-solving and decision-making, depression and anxiety, rigid facial muscles, and dizziness.

[3] Enrolled nurses practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education to health consumers in community, residential, or hospital settings.

[4] The Elder Abuse Response Service supports people aged 65 years and over, and their whānau, who have experienced, or are at risk of experiencing, abuse and/or neglect.

10. Golden Pond responded to EARS on 20 April and wrote directly to Ms A about her concerns on 29 April. Golden Pond made the following (summarised) comments in these responses:

- The HCAs felt that the camera in Mrs A's room had become a 'spy cam' rather than its intended function of showing why Mrs A was falling, and it had created mistrust between the HCAs and Ms A. Golden Pond was working hard to support its HCAs 'without it affecting [Mrs A], until … a solution [could be found]'.
- Ms C appeared to be short with Mrs A in the videos, but they did not show the entire situation. Ms C was not removed as Mrs A's HCA, but she was spoken to, shown the videos, and asked to write a report. Ms C was encouraged to take a second person with her when caring for Mrs A and told that 'if she [felt] herself getting concerned to walk away [and inform a nurse] as soon as it [was] safe [for Mrs A] to do so'.
- Mrs A's condition had advanced 'markedly', especially her mobility and eyesight, and she was showing known complications of PSP: lack of insight and judgement, anxiety, mood changes, and impulsiveness. The staff were aware of her PSP symptoms and tried 'really hard to [be] understanding of [Mrs A] and her behaviours', but she would make decisions that were not always in her best interests and staff were finding her difficult to reason with. Staff had been caring for Mrs A in pairs as they were feeling 'very vulnerable'.
- Mrs A tested positive for a urinary tract infection (UTI) on 19 April. The UTI may have contributed to her feeling unsettled in the days prior to her fall on 10 April.
- The need to ring the bell during a staff break is usually minimised by taking residents to the toilet prior to breaks or meals. Mrs A's call bell had been left out of her reach on occasions, but it was made accessible, and an apology was given when the issue was identified. Mrs A's 'frequent bell calling for little things' was a concern, as it drew care away from others who needed it. A query about whether Mrs A's call bell was sounding 'on its own' had been considered, but it was concluded that the call bell system did not appear to be faulty as no other resident's bell was '[going] off on its own' and Mrs A's call bell had been changed but this did not resolve the issue.

11. On 21 May Ms A attended a meeting with Golden Pond to discuss her ongoing concerns. Notes of the meeting state that several outcomes were agreed, including more communication between the parties; an electrical check of Mrs A's call bell; care staff to be spoken to about inconsistences in care; and the camera to be covered while care was given.

Complaint

12. Ms A subsequently raised her key concerns about Mrs A's care at Golden Pond with HDC. As set out below, HDC sought responses and information from Golden Pond about those aspects of Mrs A's care.

Staff conduct and communication

Complaint

13. Ms A complained that staff were often rude, disrespectful, and/or unreasonable when speaking to Mrs A, particularly in respect of her requests to use the toilet. Ms A said that staff were aware of Mrs A's poor hearing and difficulty speaking, but did not take account of those issues when communicating with her and sometimes ignored her requests.

14. Ms A noted that owing to her disease, Mrs A was softly spoken and not always easy to understand, and she needed to be shown patience when communicating. Due to her poor hearing, Mrs A also needed to have face-to-face conversations. Ms A said that on many occasions, Golden Pond staff did not make these adjustments when communicating with her mother, and she had raised this issue with Golden Pond management constantly. Ms A noted that as Golden Pond had told her that Mrs A's HCAs fully understood PSP, the HCAs should have recognised that apathy, disinhibition, anxiety, dysphoria,[5] slurring speech, and difficulty moving the eyes are some of the key symptoms of PSP. Ms A considered that Golden Pond staff should have understood that at times Mrs A may have been unable to make appropriate or rational decisions and that she needed to have things explained clearly and sometimes needed to be reminded in a compassionate manner.

15. Ms A stated that Mrs A was also spoken to for pressing her call bell 'excessively', despite the bell having been problematic since her first day at Golden Pond, including, she said, going off without being pressed.

Response to HDC

16. Golden Pond said that the presence of the video camera was 'stressful' and 'intrusive' for its HCAs and affected 'the way they deal[t] with [Mrs A]'. Golden Pond noted that the videos showed only a 20-second period, and the lead-up to the events was not filmed. Golden Pond said that the videos were the result of 'extreme demands' by Mrs A, as she wanted her care provided in a particular way, which the staff were 'unable to rationalise' with her. Golden Pond considers that the stress of Mrs A's behaviour on her HCAs is evident in the videos and said that Mrs A had 'systematically disliked … her afternoon HCAs and made it difficult for them', leaving one HCA in tears several times. Golden Pond said that Ms C is a very experienced HCA, and she cares for her own family member who is disabled and advocates for disabled people in the community.

17. Golden Pond told HDC that it was too slow to recognise the difficulties and stress the HCAs felt when caring for Mrs A, especially in the context of the COVID-19 lockdown, and it had put strategies and support in place in that respect. Golden Pond had spoken to the care staff about concerns and strategies for Mrs A's care. The care workers Mrs A 'disliked' were supported to follow new care strategies, including diverting confrontational conversations, disengaging from conversations not related to cares if necessary, and to walk away and seek assistance from a registered nurse if they felt stressed (after ensuring that Mrs A was safe). Golden Pond stated that carers had 'learnt to manage' Mrs A, which Golden Pond said was

[5] A state of unease, unhappiness, or general dissatisfaction.

reflected in the progress notes. Golden Pond stated that Ms C continued in her role, was able to manage Mrs A, and felt quite comfortable with her relationship with Mrs A.

18. Golden Pond's notes of the 21 May meeting with Ms A state that its care staff understand PSP as they had nursed two other residents who also had PSP. Golden Pond told HDC that Mrs A's HCAs had asked her to ring her call bell only for care needs, as it was felt that she was ringing it 'excessively', which placed HCAs under additional pressure.

19. Golden Pond stated that it introduced a regular toileting regimen for Mrs A, as often she requested toileting at times that were difficult for staff (eg, mealtimes and staff break times) or very frequently. Golden Pond believes that Mrs A's toilet plan, rationale, and the changes to it were explained to Ms A. It recognised, however, that when plans were not working, additional communication with Ms A may have helped the situation.

Fall on 10 April 2020

Complaint

20. Mrs A had a fall in her room early on 10 April. Ms A complained that Mrs A lay on the floor for 40 minutes before she was discovered and then did not receive immediate help. Ms A said that the camera in her mother's room showed that her fall occurred at 2.10am and she was discovered by an HCA at 2.50am, on the floor beside the bed. Ms A said that Mrs A is seen to tell the HCA that she had been trapped, and the HCA responded: '[Y]ou should just have a pad on … saving you getting up and down.' Ms A said that the HCA did not turn on the light, ask her mother if she was injured, or review her immediately and offer help.

Response to HDC

21. Golden Pond told HDC that Mrs A lived in a private studio apartment and the door was always closed at night because she had a cat. She had attempted to use the commode during the night without calling for assistance, and the closed door and Mrs A's quiet voice had made it difficult for staff to hear her when she fell.

22. Golden Pond's notes state that the fall occurred at around 3am, and staff were alerted to it by a resident in a nearby room using her call bell. The notes record that Mrs A was found at the end of her bed, having attempted to get on the commode. She is recorded as having hit her head and right knee in the fall and been unable to reach her bell to call for assistance. The notes state that staff took observations and undertook a Glasgow Coma Scale (GCS)[6] assessment at 3.15am and gave Mrs A some paracetamol. A falls tracking form was completed, and the fall was added to Mrs A's overall falls tracking history report. Golden Pond said that it has a falls policy that requires each resident to be assessed for falls risk twice a year.

23. Golden Pond stated that Mrs A not calling for assistance to go to the toilet was a factor in her fall, in addition to her deteriorating mobility and spontaneous decision-making due to PSP. The UTI she was later diagnosed with may also have been a factor. Golden Pond said that night staff ordinarily did hourly rounds, and Golden Pond accepted that Mrs A was

[6] A tool used to measure a person's level of consciousness.

probably on the floor for 40 minutes before she was discovered. Her call bell was out of reach as it was pinned to a sheet on the bed. Golden Pond said that a wrist pendant version of the call bell would have been considered if there had been concerns that Mrs A would have further falls.

Identification of UTI

Complaint

24. Ms A complained that some of Mrs A's behaviours and her frequent requests to go to the toilet suggested a possible UTI, but this was not investigated by staff. Ms A said that Golden Pond interpreted Mrs A's behaviour as problematic, when it should have been seen as a possible indication of a health issue. Ms A considered that Mrs A was prevented from going to the toilet when she felt it was necessary, and that this, combined with a delay in testing Mrs A for a UTI, likely exacerbated her condition and behaviour.

Response to HDC

25. Golden Pond's records state that Mrs A's urine was cloudy and smelly on 10 April, at the time of her fall. She is documented as having requested to be taken to the toilet 'frequently' in the following days, and her urine output was referred to in the notes on 12, 14, and 15 April as 'minimal' and/or 'strong'.

26. On 16 April a urine sample was taken from Mrs A for testing, as her urine remained cloudy and she was experiencing 'frequency, irritability and lower back pain'. On 19 April the test results established that Mrs A had a UTI, which Golden Pond said was her first since her admission. Mrs A started a course of antibiotics and was encouraged to drink extra fluids, and overnight continence products were introduced at her doctor's suggestion and had worked well. Golden Pond said that once diagnosed, the UTI was also thought to be a possible factor in Mrs A's fall on 10 April.

27. Golden Pond told HDC that it refuted the suggestion that Mrs A developed a UTI because HCAs had not taken her to the toilet enough. Golden Pond said that Mrs A had been taken to the toilet regularly, as per the toileting regimen, and she was not incontinent during the day. Golden Pond stated that despite this, Mrs A 'would still ring for the care staff to toilet her [and] at times it was not reasonable and staff could not do it straight away'.

28. Golden Pond said that a staff member had refused to take Mrs A to the toilet on one occasion as she had been to the toilet several times in the previous hour without success and the HCA was 'under pressure' to see other residents. Golden Pond said that the HCA told Mrs A that she had a pad on, which 'is not the norm' without further explanation, and this resulted in Mrs A saying that she would wet herself.

29. Golden Pond told HDC that Mrs A's fluid intake had been poor since admission, but it did not have any fluid records for her. It said that Mrs A liked to maintain her independence and was in control of her own fluid intake. Staff encouraged Mrs A to drink, including using a sipper cup and straws, and monitored her fluid intake, but she did not always 'follow best advice'. However, Golden Pond said there had been no clinical indication to start a fluid balance chart.

Further information

30. Golden Pond's records include a care plan that was put in place for Mrs A on 13 July 2020. It was approved and signed by a Clinical Nurse and annotated with 'Daughter [Ms A] informed'. The plan covered the management of constipation, activities of daily living (ADLs), communication, PSP, behavioural symptoms, falls, spirituality and culture, participation in activities, urinary incontinence, and psychosocial factors.

31. Relevant to this complaint, the care plan included the following information and guidance for staff caring for Mrs A:

- '[Mrs A] communicates well, needs time to express herself. Speech is slow but still reasonably clear … Encourage her to keep conversing, give her time to respond.'
- '[Mrs A] is dependent on the carer for toileting … [Mrs A] is toileted regularly throughout the day, two to three hourly, to retain a level of continence. Sometimes [Mrs A] rings in between normal toileting times, does not always [pass urine] or have a bowel motion.'
- '[Mrs A] has bilateral hearing aids … need to speak clearly and slowly.'
- '[Mrs A] is prone to falls.'
- '[Mrs A's] diagnosis of [PSP] causes her frustration and anger at times … Do not argue with [Mrs A], ensure she is safe, state you are not going to get involved, walk away if necessary. Agree to disagree with [Mrs A] rather than get into an argument.'

32. In response to the provisional decision, Ms A noted that she had not been informed of any care plans 'until the complaints began to unfold'.

Response to provisional decision

33. Golden Pond was given the opportunity to respond to the provisional decision. Parts of its response have been incorporated into this report where appropriate. Golden Pond accepted the findings of the provisional decision and acknowledged that there needed to be accountability for the failings in its care of Mrs A. At the same time, Golden Pond emphasised that over five years had passed since the care in question was provided and advised that since this time, several changes have been made and the staff responsible for Mrs A's care in 2020 are no longer employed at Golden Pond.

34. As part of Golden Pond's response, it provided HDC with a written apology for forwarding to Ms A, in which it stated that Ms A's complaint about the care her mother received was justified. In the letter, Golden Pond stated:

> '[Ms A], I would like to sincerely and genuinely offer you an apology for everything that happened during the time your mother was here at Golden Pond. The way she was treated by some staff members, the lack of communication, and I would even say lack of accountability when these matters were b[r]ought to the attention of … and Clinical Team. You did not give up pursuing justice on her behalf and I am sure her rest will be more peaceful because of the actions taken by yourself.

> It has also been a learning experience for [Golden Pond] to ensure that no other family and or resident is treated in this manner. Families entrust their loved ones to us and pay for that service and it is our responsibility as a hospital level facility … to ensure all residents under our care receive an exemplarary standard of care on a consistent basis.'

35. Ms A was given the opportunity to respond to the provisional decision. She noted that she was unable to read the entire report as she found it distressing. Parts of Ms A's response have been incorporated into this report where appropriate.

Opinion: Golden Pond Private Hospital Limited — breach

36. Having undertaken a thorough assessment of the information gathered, including the video footage, and guided by the independent clinical advice I received from RN Julia Russell, I am critical of several aspects of Mrs A's care at Golden Pond. I have set out my decision on these matters below.

Staff conduct and communication — breach

37. Ms A raised concerns about the nature and tone of several interactions Golden Pond nurses and HCAs had with Mrs A. I have carefully reviewed the 23 videos Ms A provided in support of her complaint. A summary of the videos, which are numbered, is set out in Appendix B.

38. At the outset, I recognise that the videos each capture only a short period of time. I acknowledge Golden Pond's assertion that the videos potentially lack context without a record of events before and/or after the period recorded, and I have taken this into account.

Respect for dignity

39. Under Right 3 of the Code of Health and Disability Services Consumers' Rights (the Code),[7] Golden Pond had a duty to ensure that services at its facility were provided in a manner that respected the dignity and independence of its residents.

40. With this in mind, I find the interactions in three of the videos particularly concerning.

41. First, video 428 on 3 January 2020 shows RN D arguing loudly with Mrs A while she is sitting on the toilet. Mrs A sounds distressed. An HCA, who is in Mrs A's bedroom, states that she is wasting staff time. The topic of the argument does not appear to be related to Mrs A's cares. While it is not clear what happened prior to the clip shown in the video, there is no conceivable circumstance in which it would be acceptable for a carer to stand over a vulnerable consumer and argue with them while they are on the toilet. I note that the July 2020 care plan states that staff should not argue with Mrs A and should 'ensure [Mrs A] is safe [and] walk away if necessary'. It is not known whether this guidance formed part of an earlier care plan in place at the time of events, but I consider that this would have been appropriate management at the time. In my view, this incident demonstrates an appalling disregard for Mrs A's dignity.

[7] Right 3 states: 'Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.'

42. Secondly, video 521 on 12 April 2020 shows Mrs A sitting on a commode with HCA Ms C standing next to her searching for toilet paper. Mrs A states that she 'can't go to the toilet' while Ms C is there, yet Ms C does not respect Mrs A's wishes by giving her privacy while she uses the commode, instead standing in close proximity and saying abruptly that other residents can go to the toilet in front of her and Mrs A should hurry and do so. Mrs A's response to Ms C — 'I'm not everybody else' — accurately highlighted that Ms C did not respect Mrs A's individual dignity on that occasion.

43. Thirdly, in video 0.1 on 13 April 2020, Mrs A is told that she must wait to be taken to the toilet, that she had the chance to use the toilet earlier and was unable to go, and that she was wearing an incontinence pad in any case. HCA Ms C and RN D speak stridently and loudly at points while standing in front of Mrs A, who is seated. My advisor, RN Russell, advised that the manner and approach of the staff towards Mrs A was unacceptable. In the circumstances, RN Russell considered that the incident represented a severe departure from the accepted standard of care. I agree. In my opinion, this video shows Mrs A distressed and arguably pleading to go to the toilet. Her distress was not acknowledged by either staff member, and the inference that her incontinence pad would suffice instead of using the toilet did not respect Mrs A's dignity.

44. The care plan in Mrs A's clinical record post-dated most of the events.[8] However, it states that Mrs A depended on carers to take her to the toilet and that she 'wears a small contour pad during the day' to address 'very mild' incontinence. There is a significant difference between Mrs A wearing a pad during the day for reassurance and her carers suggesting that she could urinate in her pad because it was an inconvenient time to assist her to the toilet.

45. In my opinion, these repeated instances of demeaning conduct by several staff members, particularly in circumstances involving Mrs A's toileting when she was entirely reliant on staff for her cares, amount to a failure to provide services in a manner that respected Mrs A's dignity.

Respectful treatment

46. Under Right 1(1) of the Code,[9] Golden Pond had a duty to ensure that staff treated its residents with respect. This included ensuring that staff communicated with Mrs A in a respectful manner appropriate to her needs.

47. Mrs A's July 2020 care plan stated: 'Hearing: [Mrs A] has bilateral hearing aids … Need to speak clearly and slowly,' and '[Mrs A] communicates well, needs time to express herself.' Ms A also stated that Mrs A needed to have face-to-face conversations, due to her poor hearing.

48. In an email dated 14 July 2020, Ms A wrote to Golden Pond:

> 'I also meant to raise with you that several of your staff talk to mum as they are leaving the room facing away from mum, or walk away while she is talking to them (so they

[8] Care plan dated 13 July 2020.
[9] Right 1(1) states: 'Every consumer has the right to be treated with respect.'

> don't hear), or they cut her off before she has finished talking. Given how bad her hearing is, and how slow her speech is, it would be appreciated if they showed more patience. This actually happened right in front of me on Friday the 3rd July [and] Saturday 4th ([EN B] and [an HCA]).'

49. Prior to this, videos 489,[10] 499,[11] and 506[12] captured two HCAs and a nurse (HCA Ms E, HCA Ms C, and EN B, respectively) walking out of the room while Mrs A is trying to speak to them. Two of these videos[13] also show the HCAs speaking to Mrs A as they are walking out of the room. In video 499, Mrs A asks Ms C how she was supposed to have heard something Ms C said as she was walking out the door, and Ms C replies abruptly, 'Well, listen!' as she leaves the room.

50. Three other videos show staff speaking to Mrs A in a sharp and negative tone,[14] and one shows an HCA telling Mrs A in a dismissive manner that she need not be crying or upset when she was distressed.[15] My independent nursing advisor, RN Russell, noted that given that several staff were treating Mrs A in this way, it is likely that this had become the culture or was part of a plan to modify Mrs A's behaviour (to reduce frequent bell calling). Unfortunately, I agree.

51. Five of the video recordings show Mrs A being asked to wait to be taken to the toilet.[16] RN Russell considered the implementation of a toileting regimen as a behaviour modification plan to reduce frequent bell calling as good practice. However, she advised that a behaviour modification programme should not be demeaning or disrespectful. RN Russell advised that it is essential to ensure that the plan is communicated to the resident and their family adequately, and that for Mrs A, this would need to be explained at every interaction. In each of the five videos, the HCAs and nurses do give the reason for asking Mrs A to wait to be toileted (eg, because it was mealtime or breaktime). However, I am concerned that the manner and tone in which this was communicated in the videos was unnecessarily harsh, often coming across as berating rather than explaining.

52. Mrs A's use of the call bell was evidently a point of conflict. Golden Pond stated that Mrs A's carers felt that at times she was using the call bell 'excessively', and this is reflected in the progress notes.[17] The progress notes also document occasions on which the bell had rung but Mrs A had said that she had not pressed it, an issue that Ms A raised in her complaint. I note that the minutes of the 21 May meeting document that Golden Pond had scheduled an electrician to look at the call bell, but it is not known whether this occurred or what the

[10] 27 March 2020.
[11] 7 April 2020.
[12] 8 April 2020.
[13] Video 489 and 499.
[14] Videos 1.1, 520, and 519.
[15] Video 570.
[16] Videos 438, 2.1, 0.1, 549, and 183831.
[17] Throughout Mrs A's progress notes there is mention that Mrs A was using the call bell frequently (at times documented to be every 15 minutes or as soon as a carer left the room) and for 'small things' such as to draw the curtains or pass her the television remote.

outcome was. Accordingly, I am unable to make a finding about whether there was a fault with the call bell. Nevertheless, I accept that the bell was a cause of frustration for staff. I also acknowledge the added pressures that care staff faced during the COVID-19 lockdown period in March–April 2020, and that owing to her condition Mrs A's mood and behaviours were challenging at times. However, in my view, this does not excuse or mitigate the unacceptable manner in which Mrs A was treated on several occasions. I expect care-home staff, irrespective of the circumstance, to be respectful of the vulnerable consumers they are entrusted to support.

53. For the reasons outlined above, I consider that Golden Pond care staff treated Mrs A in an unkind and disrespectful way. In particular, I am critical that staff spoke to Mrs A in a harsh and abrupt tone on several occasions, dismissed or ignored her apparent distress, and repeatedly failed to respect Mrs A's communication requirements by walking away from Mrs A as she was speaking and speaking to her as they walked out of the room.

54. Golden Pond was asked to supply HDC with copies of its policies for communication with residents (particularly relating to residents with communication difficulties) and for staff training records on communication with residents and managing challenging resident behaviours. Golden Pond declined to provide this information.[18] As such, I am unable to assess whether Golden Pond had adequate policies in place to guide appropriate communication with residents or whether it provided adequate staff training to care for residents with communication difficulties and challenging behaviours. I note that Golden Pond appears to have given staff an article on PSP in March 2020. While this may have been of some help, I consider that this alone would not have equipped staff sufficiently to care for Mrs A effectively.

Conclusion

55. The evidence shows a concerning pattern of demeaning and disrespectful treatment of Mrs A involving six staff members, including two nurses. While there is individual accountability for these actions, in my view the continued widespread and repeated actions by staff at Golden Pond reflect a culture of disrespect and disregard for the dignity of those under Golden Pond's care, for which, ultimately, I hold Golden Pond responsible.

56. I note that Golden Pond had been aware of Ms A's concerns about staff attitudes toward Mrs A since at least January 2020. I acknowledge that Golden Pond held a staff meeting in late January to discuss 'attitude, respect, [and] privacy', and Ms A's concerns about communication were discussed with EN B in January and with HCA Ms C in April. However, I consider that the continued inappropriate conduct of staff, over a period of months, indicates a failure by Golden Pond to manage, improve, and monitor the situation adequately. I note that Golden Pond acknowledged in its response that it was 'too slow to pick [up on the stress staff were under] and put in strategies to deal with [Mrs A's] behaviours'. I agree with this assessment.

[18] Discussed further at paragraphs 79–82 of this report.

57. For the reasons outlined above, I find that Golden Pond failed to provide services in a manner that treated Mrs A with respect and that respected her dignity. Accordingly, I find that Golden Pond breached Right 1(1) and Right 3 of the Code.

Care planning — adverse comment

58. Golden Pond had an obligation to meet the Age-Related Residential Care Services Agreement[19] (ARRC Services Agreement) in place at the time of events. Under the ARRC Services Agreement, Golden Pond had a responsibility to ensure that Mrs A had an adequate care plan,[20] and that she and her family had an opportunity to have input into the care planning process.[21]

59. Ms A told HDC that she was made aware of the requirement for a care plan to be developed alongside the resident and family only after Mrs A had been at Golden Pond for around 12 months. Ms A stated that when she raised this with Golden Pond, she was given a copy of the care plan, which had been signed off in her name. Ms A told HDC that she had never seen the care plan previously, and Golden Pond could not answer how the care plan had been signed off by her.

60. Golden Pond supplied HDC with a copy of Mrs A's care plan dated July 2020 (about 12 months after Mrs A's admission). On the last page of the care plan, there is an undated handwritten note stating: 'Daughter [Ms A] informed.' The Care Plan Assessment Comments accompanying the July 2020 care plan state that the assessment is a 'routine 6 monthly assessment' and that information was obtained from Mrs A's carers, doctor's notes, medication chart, progress notes, and bowel chart. There is no mention that information or input was obtained from Ms A. Golden Pond provided HDC with records of its communications with Ms A between 23 January and 14 July 2020. The only mention of the creation of Mrs A's July 2020 care plan is an email dated 14 July 2020, in which a registered nurse wrote to Ms A stating: 'I have completed [Mrs A's] assessments and care plans [six-month review].'

61. As noted previously, Golden Pond declined to provide HDC with a copy of any care plans for Mrs A that were created prior to July 2020. However, I note that the minutes for the January 2020 meeting between Ms A and Golden Pond state that a care plan and assessment were also attached, so it appears that at least one previous care plan had been created. There is no indication in the minutes that Ms A had been involved with the care planning at that time.

62. In response to the provisional decision, Golden Pond agreed that there is no evidence that Ms A was consulted about Mrs A's care planning, as would have been appropriate.

[19] The ARRC Services Agreement sets out service specifications for facilities, including service philosophy, objectives, policies and procedures, and documentation. Services must meet the requirements set out in the ARRC Services Agreement.
[20] Care plans summarise a person's health needs, goals, and current treatments, which in turn guide caregivers to support older people.
[21] D16.3 of the ARRC Services Agreement.

63. Based on the evidence available, I consider it more likely than not that Ms A was not given the opportunity to have input into Mrs A's July 2020 care plan. I do not consider that 'informing' a resident's family member of the care plan meets the requirement of the ARRC Service Agreement to give the resident's family the opportunity to have input into the care planning process. Given Ms A's close involvement in her mother's care, I would expect Golden Pond to have sought her input into Mrs A's care planning, and I am critical that this was not done.

Fall on 10 April 2020 — no breach

64. Ms A described how her mother's fall happened, and the actions of staff when Mrs A was discovered, based on the videos captured by the motion-activated camera. Ms A stated that help was not given to Mrs A immediately, and that she was not reviewed or asked whether she was injured. I agree that the priority in such a situation should be the resident's safety, and immediate review and assistance up from the floor would be appropriate. The videos of this incident show only two 10-second clips of the response.[22] Based on this evidence alone, I am not able to establish the exact nature of the response Mrs A received. Neither video shows when Mrs A was reviewed, although video 2 shows that a nurse attended before Mrs A was hoisted up from the floor.

65. Golden Pond had policies in place for Falls and Falls Management. RN Russell advised that the two policies include information about universal fall precautions, risk factors, and care planning for falls, and that they have been developed with external input and include assessment tools from the Health Quality and Safety Commission. However, these documents are dated 2013 and 2014. Golden Pond told HDC that despite this, its policies are reviewed biannually, and the policy documents were up to date at the time of events. RN Russell advised that it is good practice to ensure that there are clear review dates on policies.

66. Golden Pond's Universal Fall Precautions document included: 'Ensure the call bell is within reach.' Mrs A did not have access to her call bell when she fell as it had been secured to her bed sheets. Unfortunately, this meant that Mrs A could not reach the bell to summon help and was not found for 40 minutes. While in no way minimising the distress Mrs A must have experienced during this time, I am not critical of Golden Pond in this respect as the call bell had been secured appropriately for Mrs A's use in bed. It appears that the expectation was that Mrs A would call for help if she wanted to use the commode during the night, and it was not anticipated that she would attempt to get out of bed on her own.

67. Golden Pond's Falls policy required (among other things):

- Risk factors identified on admission and documented on mobility and patient handling assessment.

[22] Video 1 and 2.

- All falls are recorded on the interRAI.[23]
- Family notified of all falls.
- Glasgow Coma Scale filled in for unwitnessed falls.

68. In line with this policy, the clinical records show that a Falls Risk Assessment was completed for Mrs A upon her admission to Golden Pond in May 2019. It was noted that Mrs A had a history of falls, had an unstable gait, and required mobility aids. Further, the clinical records show that the 10 April 2020 fall was recorded in Golden Pond's falls tracking programme, and, as the fall was unwitnessed, a GCS was completed shortly after Mrs A was discovered on the floor. Ms A was notified of the fall later that day.

69. RN Russell advised that the management of Mrs A's fall on 10 April 2020 met accepted standards. I accept this advice and am not critical of the care provided in this respect. RN Russell was, however, mildly critical that Golden Pond's GCS policy did not include the required frequency/timing of the observations and how these would be ceased (for example, on sign-off by a registered nurse). She advised that it would be expected that this would be included. RN Russell said that aside from this, Golden Pond's falls policies were adequate. I accept this advice and note that Golden Pond has since made appropriate changes (discussed later in this report at paragraph 83).

Identification of UTI — other comment

70. Ms A complained that in the week leading up to the diagnosis of Mrs A's UTI on 19 April 2020, Mrs A displayed behaviours that were seen by staff as problematic but were in fact indicators of a health issue. Ms A stated that during this time, staff prevented Mrs A from toileting as she felt necessary and delayed testing for a UTI. Ms A raised concerns that this likely exacerbated Mrs A's condition and behaviour.

71. On 10 April Mrs A fell while she was attempting to reach the commode, and her urine was documented as 'cloudy and offensive'. Between 12 and 15 April, several entries in the progress notes document that Mrs A was having 'frequent toileting', at times with 'minimal output' and one note of 'strong' urine. On 16 April a urine sample was taken and sent to the laboratory as Mrs A had 'frequency, irritability and lower back pain'.

72. RN Russell acknowledged that given the ongoing concerns regarding Mrs A's mood and behaviours during this period, her fall and need for frequent toileting may have been early indicators of a UTI that was present but not identified at the time. However, RN Russell also noted that according to the progress notes it does not appear that Mrs A's mood and behaviours improved following treatment of the UTI. RN Russell considers that this was not surprising, given Mrs A's general health and chronic conditions.

[23] A clinical assessment tool that informs and guides the planning of care and services in community-based settings.

73. Once it was confirmed on 19 July that Mrs A's urine sample was positive for a UTI, Golden Pond developed a short-term care plan. The plan was for Mrs A to be started on antibiotics, given Ural sachets,[24] and to be encouraged to drink fluids.

74. RN Russell advised that the management of Mrs A's UTI met accepted standards, as aged-care facilities do not have 24/7 access to laboratory and general practitioner services. She noted that 10–13 April was Easter weekend, so it would not have been possible to send a urine sample to the laboratory until at least 14 or 15 April, as most general practitioners would want symptoms to be discussed with them prior to sending a specimen to the laboratory.

75. While RN Russell considered that the timeframe for Mrs A to be tested for a UTI was acceptable, she noted areas for possible improvement in planning of her care and support, as a short-term care plan could have been implemented over the weekend to encourage Mrs A to increase her fluid intake.

76. RN Russell concluded that while the identification of the UTI may have been delayed slightly, the overall treatment of it was consistent with good practice, especially ensuring that the laboratory test identified the bacteria present before antibiotics were administered. I accept this advice.

77. With the benefit of hindsight, I acknowledge that Mrs A's mood and request for frequent toileting between 10 and 16 April 2020 may have been symptoms of an unidentified UTI. Given this, and noting that her urine was described as 'cloudy and offensive' and 'strong' during this period, I consider that there was a missed opportunity to implement a short-term intervention to encourage increased fluid intake, and possibly send a urine sample for testing a day or two earlier. However, I note that at the time of events Mrs A's PSP condition was known to cause challenging behaviours not dissimilar to those she exhibited in the days leading up to the UTI diagnosis. As noted by RN Russell, it does not appear that Mrs A's mood and behaviours improved following treatment of the UTI. Further, although Mrs A had had UTIs prior to entering Golden Pond, she had not had any after her admission in May 2019 until this incident in April 2020. For these reasons, I consider that it was not unreasonable that initially staff did not consider a UTI as a possible cause for Mrs A's behaviours in the days leading up to 16 April.

78. While it is evident that Mrs A's frequent requests for toileting during this period were, at times, met with resistance from her carers, I am reassured that the progress notes indicate that Mrs A was toileted regularly during this period. I have already discussed Golden Pond's use of a toileting regimen as a behaviour management plan in paragraph 51 of this report.

Provision of information to HDC — adverse comment

79. To assess the concerns raised in this complaint, HDC asked Golden Pond for responses and information. Initially Golden Pond provided the requested information. However, later in the investigation process Golden Pond stopped providing information to HDC, including

[24] A urinary alkaliniser used to provide relief from UTI symptoms.

when HDC requested a copy of any care plans in place for Mrs A prior to the version dated July 2020, copies of policies and protocols relating to guidance for communication with residents, and staff records of training on communication with residents and dealing with challenging resident behaviours. In response to HDC's request for this information, Golden Pond advised that owing to the time elapsed, it did not have any further information to provide.

80. In my view, this response is unsatisfactory. I note that Golden Pond was required to retain Mrs A's clinical records, including all care plans, for a minimum of 10 years.[25] I am critical that Golden Pond did not provide HDC with the required information that was relevant to Mrs A's care. This report includes assessment of the standard of care relating to some events that pre-date the care plan dated July 2020. Accordingly, this report has been based on an incomplete suite of information, and I have been unable to assess some aspects.

81. I remind Golden Pond of its obligation under Right 10(3) of the Code[26] to facilitate the fair and efficient resolution of complaints. This includes aiding HDC in its assessment and investigation of complaints by providing relevant information to HDC upon request. HDC relies on the cooperation and transparency of both providers and complainants to fairly assess the standard of care provided. I acknowledge that Golden Pond did provide responses and information on several occasions during the assessment and investigation of this complaint, and that unfortunately this was a protracted process. However, I am disappointed that Golden Pond chose to stop providing information near the end of the investigation process, and I do not consider that the passage of time since the events was a satisfactory reason not to provide this information.

82. In response to the provisional decision, Golden Pond agreed that the information should have been sent to HDC on request.

Changes made since events

83. Golden Pond told HDC that its policies are now dated to show the date of last review. Golden Pond provided HDC with a copy of its updated GCS form, which now requires the user to document the time and date on which observations are started and discontinued, and states that observations should be performed and recorded every half hour until a score of 15 has been achieved.

84. In response to the provisional decision, Golden Pond advised that in 2021 a new facility manager was appointed, and a new quality system was implemented. This new quality system receives updates from the Ministry of Health related to any policy changes, which

[25] Sections 5 and 6 of the Health (Retention of Health Information) Regulations 1996 require providers to retain an individual's health records for a minimum of 10 years, beginning on the day after the date on which the provider last provided services to the individual.
[26] Right 10(3) states: 'Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.'

enables Golden Pond's Quality Manager to update all policies and provide corresponding education to staff.

85. Golden Pond also advised that it had made several quality improvements that aligned with the recommendations proposed in the provisional report, including that staff education and training had been undertaken in the areas of elder abuse, respectful communication and conduct, and managing stress and challenging resident behaviours. Further, Golden Pond provided (and HDC has reviewed) its updated policies on 'resident rights', 'staff code of conduct', 'management of challenging behaviour', 'resident's safety, neglect and abuse prevention and security', 'care plans', and 'interRAI'.

86. The 'management of challenging behaviour' policy emphasises the rights of the individual to freedom of choice, dignity, and privacy and sets out a detailed procedure for management of challenging behaviours. The policy states that staff are to be educated as to how to communicate with residents who are confused and are to be aware of disease processes, and it is clear that staff should not shout or get into arguments, as this will worsen the situation. The policy lists several causes of challenging behaviours, including illness and infection, as well as guidance for staff on when to leave the situation and requirements for recording and monitoring behaviours. The policy states: 'If behaviour is totally out of character a urine specimen will be collected to eliminate a UTI.'

87. The policy for 'resident's safety, neglect and abuse prevention and security' describes several types and signs of abuse and neglect. It states that Golden Pond has a 'zero tolerance' for abuse and neglect and the safety of the resident is paramount. The policy requires mandatory staff training in elder abuse and neglect prevention.

88. The policy for 'care plans' requires that 'the resident and/or their representative, if consented to by resident, play a crucial part in the care plan development'. The policy also states that short-term care plans are to be used when unpredicted or documented problems arise from time to time.

89. Golden Pond said that the effectiveness of its quality improvement measures is evidenced in the findings of Golden Pond's latest certification audit, completed in March 2025.

90. The 2025 audit was conducted against the Ngā Paerewa Health and Disability Services Standard (Ngā Paerewa HDSS)[27] and included a review of policies and procedures, review of residents' and staff records, observations and interviews with residents, whānau/family members, the owner/director, the facility and clinical managers, a general practitioner, and staff.

91. The findings of the 2025 audit, as they relate to this investigation, included the following:

- Residents were safe from abuse. Staff understood the service's policy on abuse and neglect, including what to do should there be any signs of such. There were no examples

[27] NZS8134:2021.

of discrimination, coercion or harassment identified during the audit through staff and resident or whānau interviews, or in documentation reviewed.

- Residents and whānau reported that communication was open and effective, and they felt listened to and included when making decisions about care and treatment. Changes to residents' health status were communicated to relatives/whānau in a timely manner. Examples of open communication were evident following adverse events and during management of any complaints.
- Complaints were resolved promptly and effectively in collaboration with all parties involved. A fair, transparent, and equitable system is in place to receive and resolve complaints, which leads to improvements. The process meets the requirements of the Code. Residents and whānau understood their right to make a complaint and knew how to do so. Documentation sighted showed that complainants had been informed of findings following investigation. Where possible, improvements had been made as a result of the investigation.
- The quality and risk management systems are focused on improving service delivery and care using a risk-based approach. Residents and whānau provide regular feedback and staff are involved in quality activities. A family/whānau survey was completed from 12 January to 1 March 2024, with mostly positive outcomes. A resident survey was completed over the same timeframe. A staff wellness survey completed by staff in October 2024 indicated that staff were pleased with the level of stability of staffing at the facility, and most staff reported that they enjoyed working with the residents at the facility. Relevant corrective actions are developed and implemented to address any shortfalls. Progress against quality outcomes is evaluated. Policies reviewed covered all necessary aspects of the service and of contractual requirements and were current.
- Continuing staff education is planned on an annual basis, including mandatory training requirements. Related competencies are assessed and support equitable service delivery and the ability to maximise the participation of people using the service and their whānau. Staff reported feeling well supported and safe in the workplace.
- The service works in partnership with the residents and their whānau to assess, plan, and evaluate care. Care plans were individualised, based on comprehensive information and accommodated any new problems that arose. Files reviewed demonstrated that care met the needs of residents and whānau and was evaluated on a regular and timely basis. Residents and whānau confirmed active involvement in the process.

92. The 2025 audit did not identify any areas for improvement.

93. I commend Golden Pond on the significant improvements it has made since the events of this complaint.

Recommendations

94. Accounting for the changes made and the findings of the 2025 audit report, I recommend that Golden Pond provide evidence of its most recent staff training and education on elder abuse, respectful communication and conduct, and managing stress and challenging resident behaviours. Evidence confirming the content of the education/training (eg, training material) and delivery (eg, attendance records) is to be provided to HDC within six months of the date of this report.

Follow-up actions

95. A copy of this report with details identifying the parties removed, except Golden Pond Private Hospital Limited and the independent advisor on this case, will be sent to HealthCERT and Health New Zealand|Te Whatu Ora and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to Commissioner

The following independent advice was obtained from Julia Russell, RN M(Phil) on 7 August 2023:

'The purpose of this report is to reconsider the responses provided in the January 2021 report responding to the concerns raised by [Ms A] the daughter of [Mrs A] and the care she received at Golden Pond Lifecare. In undertaking this review the material reviewed included:

1. Letter of complaint dated 14 May 2020
2. Copy of videos sent in by [Ms A] in 2020 and a further set sent in 2021
3. Golden Pond Lifecare's response dated 14 July 2020
4. Further response from Golden Pond Lifecare dated 7 September 2020
5. Clinical records from Golden Pond Lifecare
6. Further information provided which include:
    - Formal Complaint to Golden Pond dated 20 January 2020
    - Golden Pond Lifecare's responses 26 June 2021
    - Golden Pond's Surveillance audit 14 March 2023
7. A range of documents from [Ms A] including [Ms A's] concerns raised at GP and Elder Abuse Meeting on 21 May 2020

The points reviewed in this report are:

a) The management of [Mrs A's] fluids and UTI

b) The management of [Mrs A's] fall of 10 April 2020

c) Adequacy of Golden Pond Lifecare's policies in place relating to resident monitoring and falls

d) Comments on the videos provided and whether there is evidence of abuse

e) Comments on the actions taken by the facility following [Mrs A's] fall.

It is important to note that I will not be commenting on points 1–13 of [Ms A's] 26 July 2021 letter. I will respond to elements of section C Evidence, the Complaint, Your Findings and the video clips listed in section E as they affect the above points a) to e).

Background

In 2020 [Mrs A] was a woman in her seventies living at Golden Pond Lifecare. [Mrs A] had a history of depression, limited vision and progressive supranuclear palsy. The specific concerns raised by her daughter relate to the management of her mother's urinary tract infection (UTI), a fall on the 10 April 2020 and timeliness of the facility responding to call bell requests. As a result of this review added to these concerns is

the way [Mrs A] was being spoken to and treated by the staff and is this acceptable in aged care.

[Mrs A] had a motion sensitive camera in her unit; this was installed to monitor an unrelated issue however with the increase of falls [Ms A] had spoken with … [senior manager Ms F] about the usefulness of this to assist in determining the cause of falls [Mrs A] was experiencing. [Ms A] has provided the dates and times of the first clips and further video footage in her July 2021 letter to support concerns regarding the manner that [Mrs A] was spoken to and treated.

The areas for review are:

1. The management of the April 10 2020 fall

The fall is recorded on the 4/10/20 the Falls Tracking has this recorded at 0300 hours. [Mrs A] was found at the end of her bed attempting to get to her commode. The bell had not been used by [Mrs A] as she had moved away from where the bell was secured to her sheet. It is evident from the video footage that the incident occurred earlier than recorded on the form. As it was an unwitnessed fall as per policy the Glasgow Coma Scale was completed. The recordings on the Glasgow Coma Scale were recorded at 0315 hours. Family are advised the next day as the fall occurred in the early hours of the morning. This fall occurred on Good Friday of Easter 2020. This was a long weekend as well as being the first of the Covid-19 lockdowns. Given there was no injury or decrease in function following the fall, calling the family the next day is acceptable management.

The original 2020 advice was the Falls Policy states the GCS is to be completed post fall but does not state the length of time these observations should be taken over. It would be expected that the policy would include the frequency/timing of the observations and how they would be ceased eg be signed off by the RN. Further to this the documents were dated 2013 and 2014. The January 2021 report noted that ensuring that there are clear review dates on policies is good practice. Information provided by [Ms F] was that the policies were reviewed annually and were therefore up to date.

In response to that [Ms F] noted in her June 2021 letter — 1) Glasgow Coma Scale form was updated with time that the observations were stopped and 2) that the facility policies were updated biannually and were therefore current.

The management of [Mrs A's] fall on the 10 April meets the expected standards of aged care.

2. The management of [Mrs A's] fluids and UTI

In the response to the HDC Complaints Administrator letter of the 1 October 2020, [Ms F] identifies there are no management or specific actions related to fluid management. She notes that [Mrs A] had a low intake at admission and that has continued. [Mrs A] has a diagnosis of progressive supra nuclear palsy, as this disease progresses there can be problems with swallowing. In August 2020 [Mrs A] had a Speech Language Therapist assessment which identified [Mrs A] did have some issues which

may have made her reluctant to drink given that swallowing caused her to cough. Given the August 2020 Speech Language Therapist review and recommendations it would be expected that there would be a care plan action around fluid management as well. Further to this nutrition and hydration is a care plan area that should be covered for all older people and given a history of low input the expectation that fluid would be promoted for [Mrs A]. The care plan was not provided so it is not clear what the overall plans were for [Mrs A]. On the 10 April after she had fallen it was noted her urine was "cloudy". The urine would not have been sent to a laboratory until the Tuesday 14 April due to Monday 13 April being a public holiday. The antibiotics were charted once it was identified that there was a UTI and which antibiotic was to be used. Whilst the identification of the UTI may have been delayed due to Easter, the overall treatment of it was consistent with good practice, especially ensuring that the laboratory test identified the bacteria that was present before the antibiotics were administered.

Given the ongoing concerns regarding [Mrs A's] mood and general behaviour and attitude may have meant that the fall and the need for frequent toileting were amongst the first signs of a UTI that were present and not responded to by the staff as [Ms A] states. However according to the progress notes it does not appear that [Mrs A's] general mood and behaviour changed following the treatment of the UTI — which given her general health and chronic conditions is not surprising.

It is apparent that the staff being led by [Ms F] attempted a behaviour modification plan to reduce bell ringing by implementing a toileting regime for [Mrs A]. This is good practice.

However, ensuring the resident and their significant other(s) understand the process and are fully on board are essential, otherwise it can be perceived as care rationing. It appears that this information has not been shared with [Mrs A] and [Ms A]. For [Mrs A] this would need to be explained at every interaction — which from the video footage it clearly was not. [Ms F] notes in her June 2021 letter that "further communication when plans are not working maybe this could have been more effective". In [Ms A's] 2021 letter she notes she is looking for acknowledgement that the care provided to [Mrs A] does not meet the standard she expected and anticipated.

3. Adequacy of Golden Pond Lifecare's policies in place relating to resident care

[Ms F] in her July 2021 letter noted that the policies are reviewed biannually, the comments regarding updates have been removed. The updated policies included in this review were the Hydration Policy with a 24-hour fluid chart, Falls Management Policy (FMP) and the Falls Policy, Glasgow Coma Scale.

The Hydration policy includes the 24-hour fluid chart. The indications for use of a fluid chart are if the chart would be appropriate and directs to the usage of the Frailty Care Guides. The Frailty Care guides[1] include nutrition and hydration and provide first,

[1] https://www.hqsc.govt.nz/assets/ARC/PR/Frailty_care_guides/Nutrition_and_hydration_update.pdf

second and third line treatments including ways of preventing dehydration. The 24-hour fluid chart meets the requirements of monitoring fluid in and out.

The Falls policies included information about universal fall precautions, risk factors, categories of fallers ([Mrs A] had been identified as a high risk), the importance of care planning for falls and an inpatient falls pathway, encouraging residents to have hip protectors. There was evidence in these documents of external input with the assessment tools from the Health Quality and Safety Commission. It included the need to review risk factors six monthly, and these include providing clearer instructions for the completion of neurological observations following a fall.

The policies provided by Golden Pond are adequate and meet the expectations.

4. Comments on the videos provided and whether there is evidence of abuse

[Ms A] provided information in her July 2021 letter that the camera in [Mrs A's] unit was initially for another purpose but as [Mrs A] had been falling it was to be used for identifying reasons or opportunities to prevent falls. Originally there were five videos provided with [Ms A] providing further videos as well as the dates and times of the original five which was very helpful. The new video clips are also small clips of episodes of care.

- Video 519 — it is unclear what [Mrs A] says but [HCA Ms C] responds to her by saying "why do you think I am here" so it is presumed that [Mrs A] has said she wanted to go to the toilet. The tone of voice used by [Ms C] does not sound ideal however as it is so small a clip it is difficult to make any further comment.
- Video 520 — this is the same [HCA Ms C] as video 519 and is 30 seconds. And the conversation is about ringing the bell too often which [Ms C] acknowledges she no longer does. The purpose of a conversation like this is of no benefit to either [Ms C] or [Mrs A] and [Ms C] would benefit in some communication training.
- Video [0.1] — From the further information from [Ms A's] July 2021 letter this is on the 12/4. [Mrs A] has a yet to be diagnosed UTI but it had been noted that she had been apprehensive following the fall and that her urine was "cloudy" and was maybe experiencing increased frequency. Irrespective of this the tone and approaches are not acceptable. The manner that [Mrs A] is spoken to and treated [by HCA Ms C and RN D] on this clip and others is at the least a moderate departure from the expected standard of care. If one of these staff is a Registered Nurse then this would be considered a severe departure from the expected standard.
- Video [1.1] is 30 seconds long and seems to be going along well until [Mrs A] asks for something and is told "one thing at a time". The tone of voice from [HCA Ms C] is not the same that she has used in the other clips and is sharper than appears necessary. This is not seen as a moderate departure from the standards of care but as per Video 520 would benefit from training and education.
- Video [2.1] is 14 seconds long and is where [EN B] reminds [Mrs A], she went to the toilet an hour ago. Her tone and manner was pleasant however [EN B] asks [Mrs A]

> to wait approximately 10 minutes for the [HCA Ms G]. We now know the date of this is the 10 April (information provided by [Ms A]) after the fall in the early hours of that morning — the progress notes record that [Mrs A] is to be mobilised with the standing hoist, therefore two staff would be required. Given this the staff asking for other staff to attend is acceptable practice.

The videos provided by [Ms A] in July 2021 reflect similar situations and attitudes to [Mrs A] as seen in the original series of videos. They include staff walking away from her while still speaking and leaving her without a call bell. Given there are a number of staff who have behaved in this way it is likely this has become the culture of the area or at the very least the way that [Mrs A] was being treated by staff as part of a plan to modify her behaviour. It is unknown if this toileting regime had been discussed by the staff who regularly cared for [Mrs A] and if they were provided education and support in doing this. However a behaviour management programme should not be demeaning and disrespectful to the resident. These are not acceptable and seen as moderate departures from the expected standard of care, except for those that the Registered Nurse is involved with.

[Ms A's] question about the January 2021 advice — **"Why is there allowed to be a difference in care provided between a caregiver and a registered nurse? (in terms of the language used re your expert assessment)"** — Registered Nurses are a regulated workforce and are required to do 60 hours of training across three years. Registered Nurses have a scope of practice and codes for conduct and professional boundaries, all of which expects a standard of communication that they can be held accountable to. In contrast to this the Health Care Assistants are an unregulated workforce with no regulated training requirements and there is no information provided by [Ms F] as to their level of education. Despite this all staff involved in health care are governed by Right 5 of the Code of Health and Disability Services Consumers Rights https://www.hdc.org.nz/your-rights/the-code-and-your-rights

> Right 5
> *Right to effective communication*
>
> (1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.
>
> (2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

It is expected that poor communication would be treated more seriously if the person was a Registered Nurse, in this case I have noted it as a serious departure, if the person that was speaking was a Registered Nurse and a moderate departure from the expected standard means the Health Care Assistants would be expected to undergo training.

It is important to note that there are training requirements in the National Aged Residential Care Service Agreement which all facilities are required to meet and cover a full set of education requirements.

[Ms A's] concerns included ongoing issues about the call bell which she said there had been an issue with for some time — there has been no final information as to whether the issue with the call bell system has been resolved, which would be helpful. [Ms A] also comments that the staff were busy due to other residents with high needs — palliative care requirements. This is not an acceptable reason for residents to have to wait. There is an expectation that when care needs increase staff hours will respond to this. The 2021 certification audit and 2023 surveillance audit have both been reviewed and both state that hours are increased as necessary.

Subsection 2.3: Service management The people: Skilled, caring health care and support workers listen to me, provide personalised care, and treat me as a whole person. Te Tiriti: The delivery of high-quality health care that is culturally responsive to the needs and aspirations of Māori is achieved	PA Low	There is a documented process determining staffing levels and skill mix to provide clinically and culturally safe care, 24 hours a day, seven days a week (24/7). Rosters are adjusted in response to resident numbers and level of care and when residents' needs change. Care staff confirmed that there were adequate staff to complete the work allocated to them. Family interviewed supported this.

The 2021 certification report states that "The roster is a permanent roster with staff set in shifts and set resident allocation. The nurse manager explained that this allowed for better outcomes for residents and better performance of staff who know the preferences and routines of their residents". Given these series of incidents occurred just a few weeks into the first lockdown there may have been new staff in the area that were not as experienced with her care needs.

In conclusion [Mrs A] has a complex chronic condition which meant she was often difficult to understand and was also very deaf which would further complicate this. There is no information available that staff have had training when working with Residents who experience these issues. [Ms F] notes in her July 2021 letter that the Golden Pond staff have looked after two other residents with this condition. As we know all people are individuals and how they respond to chronic health conditions will be different. [Ms F's] response to concerns of looking after [Mrs A] by her daughter may have been better met by planning further training. This would have been difficult in a Covid-19 environment but could have been done by using a worksheet with information for staff. Also, this would have assisted [Ms A] in knowing she was doing something to benefit [Mrs A's] care and support especially at a time when she could not be present.

[Ms F] comments on the importance of clear communication and it is evident in this complaint as the actions taken to improve [Mrs A's] care provision such as establishing a toileting regime are seen negatively. These communication challenges are seen in the ongoing difficulties between the family and the staff with the presence of the camera seen by the staff as a negative issue where in fact its presence can be an assurance that the good care they are providing can be observed. All aged care staff should be aware that they are observed by visitors, other residents, colleagues and that a short piece of conversation can be negatively construed.'

The following further independent advice was obtained from RN Russell on 3 March 2025:

> 'Addendum re: [Mrs A]/Golden Pond Lifecare — C20HDC00838
>
> 3 March 2025
>
> Further to your request to review the dates of when the urine was noted as smelly and when a sample was sent.
>
> The previous report regarding the management of the urinary tract infection of [Mrs A] stated
>
> "The management of [Mrs A's] fall and her UTI meets the accepted standards — however there are areas for possible improvement in planning of her care and support."
>
> The progress note regarding [Mrs A's] urine being smelly was on the 10 April 2020 at 0315 hours. The 10 April 2020 was Good Friday so it would be impossible to send a specimen until at least the 14 April which would have been the first day the Laboratory would be open for business. Most general practitioners in 2020 do not wish laboratory samples to be sent without interaction with them about the symptoms, so this may have taken further time (perhaps a day) — and will not start antibiotic treatment until the laboratory result indicates it should be started. The specimen also takes at least a day or more for a result to be available. Having read the progress notes there are no further comments about her urine being smelly after the 10 April 2020 with one comment that her urine output was minimal, despite her intake being adequate.
>
> Perhaps Golden Pond staff could have got the sample there on the 15 April, a day earlier which may have meant treatment may have been available on the 18 April 2020 (treatment started on the 19 April 2020).
>
> The comments that this was an acceptable standard of care remains as there is an understanding that aged care facilities do not have 24 hours seven days a week access to laboratory and general practitioner services. The comment "there are areas of improvement in the planning of her care and support" also remains as there could have been a planned intervention to encourage [Mrs A] to increase her intake with a short-term care plan commenced over the weekend.
>
> I hope this is of assistance.
>
> Julia Russell, RN, MN (Phil)'

Appendix B: Summary of videos provided by [Ms A]

Date	Video	HDC description/evaluation
03/01/20 4pm	0428	[RN D] (registered nurse) is speaking loudly to [Mrs A], who is on the toilet in the bathroom: 'I'm not saying that. I'm not saying anything like that.' [Mrs A]: 'You called me a liar.' [HCA Ms E]: 'Stop, you're wasting our time.' [Mrs A]: 'I'm not a liar.' [RN D]: 'Ok, that's fine, fine.' [Mrs A] appears distressed.
18/01/20 7.16pm	0439	[Ms C] (an HCA) is making the bed, [Mrs A] makes an inaudible remark. [Ms C]: 'Well, you just turn it around and it goes cold again. I'm only doing what we're told to do. Who put your sheet on back to front? No, they didn't. Righto, I've got to go. I'm behind now with that person vomiting and crapping.' [Ms C] stands beside [Mrs A] as she begins to stand within her walking frame. [Ms C]: 'That's just it, when somebody is like that you've got no extra help.'
19/01/20 10.30am	0438	[EN B] (a nurse): 'You went not so long ago.' [Mrs A]: 'I haven't put my hearing aids in.' [EN B]: 'How convenient' (sarcastic). [Mrs A]: 'I should have done. Someone put them on this table.' [EN B]: 'Can it not wait till after morning tea?' [Mrs A]: 'Can you see them?' [EN B] (interrupts [Mrs A]): '[Mrs A], [Mrs A], we're right in the middle of morning tea. Can it wait?' [Mrs A]: 'No.' [EN B]: 'Alright, get on your bike, c'mon', gestures towards the bathroom.
03/03/20 5.46pm	0463	[Mrs A]: 'Will you open my door please?' Nurse A: 'I asked you if you wanted something before I left the room.' [Mrs A]: 'I don't always use the window.' Nurse A: 'I can't keep running up and down and back and forth every five minutes OK … cos we have other residents to do.'
27/03/20 4.59pm	0488	HCA Ms E is with [Mrs A], who is distressed having been left without her call bell.
27/03/20 5.05pm	0489	[Mrs A] is on the toilet in her bathroom. HCA Ms E is in her room, then left saying: 'I will be back.' [Mrs A] started to say something and sounds distraught, but Ms E had left.

Date	Video	HDC description/evaluation
07/04/20 6.11pm	0499	[Ms C] walks out the door, stating: 'Yes, I did, as I was walking out the door. I'm not going over it again.' [Mrs A]: 'You were walking out the door and how was I supposed to hear you?' [Ms C]: 'Well listen!'
08/04/20 6.32pm	0506	[Mrs A] is in bed as [EN B] is leaving the room. [Mrs A]: 'Can I have the other remote please?' [EN B]: 'Goodnight' and exits room. [Mrs A]: 'Well I'll ring the bell then.'
10/04/20 2.10am	0	[Mrs A] loses grip of walking frame and falls to the floor. Lights are off.
10/04/20 2.50am	1	[Mrs A] is sitting up on the floor, leaning back on her bed. Lights are off. [Ms G] (an HCA) is handling the walking frame that is sitting in front of [Mrs A] and appears to be trying to move it. [Mrs A]: two short inaudible remarks (sounds distressed). [Ms G]: 'You know, you should just have a pad on, save you getting up and down.'
10/04/20 2.50am	2	[Mrs A] is sitting up on the floor, leaning on the back of her bed. Lights are on. [Ms G] and Nurse B are present. Nurse B moves the commode aside. Nurse B: 'We're going to use the hoist to get you up, alright.'
10/04/20 10.18am	2.1	[EN B]: 'You had the toilet an hour ago.' [Mrs A]: 'I've just heard that my brother-in-law has died.' [EN B]: 'So you have to go to the toilet. Do you have to go now? You can't wait for [Ms G] to come back?' [Mrs A]: 'What time is she coming back?' [EN B]: 'About another 10 minutes.'
10/04/20 3.27pm	1.1	[Ms C]: 'Are you wanting to go to the toilet?' [Mrs A]: 'Yes.' [Ms C]: 'I'll get the commode.' The commode is arranged near [Mrs A]. [Mrs A]: 'Can I have the door closed please?' [Ms C]: 'Yeah, one thing at a time, (audible sigh)'. (Sharp)
12/04/20 3.31pm	0521	[Mrs A] is sitting on the commode with her trousers down. [Ms C] is in front of her looking for toilet paper. [Mrs A]: 'I can't go to the toilet while you're faffing about.' [Ms C]: 'Well I'm sorry. Everyone else can. You do it. And please hurry.' [Ms C] walks into the bathroom.' [Mrs A]: 'I'm not everybody else.'

Date	Video	HDC description/evaluation
12/04/20 3.45pm	0520	[Mrs A]: 'The two ladies told me not to bother ringing the bell.' [Ms C]: 'That's what your bell is for. The bell is to ring for assistance. It is not to be rung just to get you a tissue or pick up something off the ground.' [Mrs A]: 'I don't.' [Ms C]: 'No you used to, you don't now, but you used to.' [Mrs A]: 'I don't, I never have.' [Ms C]: 'Yes you have (sharply) … we document everything. Everything you say and do. Just like [Ms A].'
12/04/20 5.56pm	0519	[Mrs A] is sitting in her chair. [Ms C]: 'So you'll have to come on the commode.' [Mrs A]: 'How am I going to get there?' [Ms C]: 'Why do you think I'm here?'
13/04/20 4.38pm	0.1	[Mrs A]: 'What were you going to see [another patient] about?' [Ms C]: 'Nothing. It doesn't concern you ... it was about medication for someone.' RN D: 'The bell, the bell rang. That's why I came.' [Ms C]: 'That's right. Cos you've pressed that, now it goes off this.' [Mrs A]: 'Can I do something about this wee?' RN D: 'What do you want to do about it?' (Shouty) [Ms C]: 'You've got a pad on.' [Mrs A]: 'I'll wet my chair.' RN D: 'After dinner, then you can go to the toilet, right.' [Ms C]: 'But not now, they're dishing up dinner.' [Mrs A]: 'Why can't I go now?' [Ms C]: 'No' (strident, loud). RN D: 'We're giving dinner to some people.' [Ms C]: 'You had the chance, and you didn't do anything.' [Mrs A] sounds very upset, pleading to go to the toilet.
27/04/20 3.03pm	0549	Nurse A: 'What's her name has gone. Pardon? So you'll have to wait until half past three.'
01/05/20 3.34pm	0570	[Ms G]: 'Well you don't have to cry or be like that.' [Mrs A's] voice is inaudible. She appears upset. [Ms G]: 'Well you don't need to be.' (video cuts).
22/05/20 12.32am	0614	[Mrs A] in bed without the call bell, calling out for help.
22/05/20 12.35am	0615	[Mrs A] in bed without the call bell, calling out for help.

Date	Video	HDC description/evaluation
13/07/20 6.38pm	183831	[Ms G]: 'I've been in here with you for half an hour.' [Mrs A]: 'Well you never asked me if I wanted to go.' [Ms G]: 'You have been on the commode before I got you dressed for bed, thank you. And now it's my time for my break so you'll have to just wait.' [Mrs A]: inaudible. [Ms G]: 'I'll get the RN to come and see you (audible sigh).'
04/08/20 8.31am	083108	[Mrs A]: 'I've dropped a pink pill.' [EN B]: 'You've dropped something.' [Mrs A]: 'Yeah.' [EN B]: 'Is that all you rang for?' [EN B] begins to look on the floor around [Mrs A]. [EN B]: 'No, you haven't dropped anything.' [Mrs A]: 'Yeah, a pink pill.' [EN B]: 'A pink pill.' [EN B] begins to shake out [Mrs A's] blanket.