From: [redacted]
Sent: Thursday, 15 August 2013 14:47
To: Complaints (WDHB)
Subject: Fwd: workplace-shambles

Good afternoon,

I'd like to forward a communication to you, that I have had with the Dep of Labour/Union a cpl of weeks ago, they now suggest, contacting you about these issues.

As I will have a meeting with my manager, [redacted], manager of the Waratah Resthome, tuesday next week, where she wants to raise a number of concerns about her standards of care, and me not reaching some of them (i.e. not engaging in communication with difficult residents..), laundry-procedure etc), I however, urgently want ot bring up a number of issues, that I feel very strongly about. I have emailed them to [redacted], but don't get any reply.
I used to work in H&S for many years at my previous work [redacted], and in hospitals [redacted] so I believe, I do know a thing or two about this.
Apart from the "samples" below, the most recent incident, I was very concerned about:
I helped one resident out of an armchair to get her to the toilet before tea, saw (and smelled) that not only her, but also the chair next to her, were both soaked in urine! So I removed the cushions, took them to the laundry, so I could deal with them later. I thought, of course, the covers would need to be removed and washed, and the rubber-foam cleaned thoroughly too. How wrong was I, my collegue told me to leave the covers on, just sponge everything down, and then put them in the HWC to dry!! Doesn't take rocket-science, does it, to know, that's not "good".
I have documented (in my email) all these issues, [redacted] does not reply to my concerns, so I feel rather concerned, she would really "just" deny them, I know, they are true. Other staff tell me, she does that all the time >coming down like a ton of bricks about standards, but never any recognition about what we do good.
Please see below my earlier communication I had sent to the Union,
thanking you, with kind regards
[redacted]
Hi

my name is [redacted]

2 months ago, I started to work as a caregiver at The Waratah Resthome in Henderson.

As much as the work itself really suits me, and I have a great capacity to extend myself to the demands of it, I find it an immense struggle to
cope with the utterly dysfunctional and dictatorial way the management shows. Most of the staff express their huge frustration about the leadership-style, but none of them dares speak out, which creates a pressure within the work-evironment that is so wrong!

When I was trained, the nurse told me, as I commented on the shocking skin-conditions of many of the residents, that they had an outbreak of scabies a month earlier, but, no worries, they treated everybody, and all is clear. But: the majority of the residents gets constantly some kind of lotions for skin-irritations, which don't do a thing!
Anyway, after 2 weeks (working there), I contracted the scabies, had it checked first by a chemist, later by the nurses of my GP, they all recommended that treatment was needed, and that I very likely had contracted it from the resthome.
Of course I had to inform the manager, [redacted] I mentioned the likelyhood of the resthome

being the scource, which she vehemently denied, it could just as well have been my mother, who had been in hospital (this was months ago, and she has a skin like a baby), or my children from school (my daughter is at uni,and was in sememster-break), that's all she could say.
A week later 8 residents were found again with scabies.
I contracted them again after another week...or "just" needed a second treatment..?!
Only yesterday I read in an information-sheet about scabies in our resource-room, that all linen/clothes etc of the infected person has to be washed in hot water, the chemist told me that as well.
The resthome washes (the clothes,as most of them are bright colour) it in cold water.
Last week, I started having new itches, same as first time round!!

The manager comes down on us like a ton of bricks, when it comes to follow rules, but this shows what her standard is.

The other, very recent, and equally shocking event was: I was going to take a dinner-tray to a resident, but found her sitting in her bed, covered with a thin blanket, the room filled with an undescribable stench of poohs, stacks of towels with faeces next to her bed. The manager happened to also come by, trying to make sense of the resident's upset (she was beside herself!), but asked me, to "quickly bring her tray, so she can eat, and clean her up after"!, I couldn't believe this, but attempted to do it. When I came with the tray, the resident naturally shouted at me, "how can she expect me to eat now ?? Look at this" >> she was sitting in heaps and lakes of poohs!!
I went to inform the manager, that I won't serve food, the resident refused for the obvious reason, [redacted] only comment "well, then wash her, and give it to her later".
I was so utterly stunned about this horrendous event, how "management" handled this! But unfortunately had to be even more stunned about the after-effect, it had for me personally: As this was the first such laundry-scenario for me, I asked for instructions, (the mountains of faeces had to be brushed off under running water, then the towels soaked in Nappisan for less than 2 hrs. Then put them in an plasticbag >in the green sack to the other towels....only I had forgotten to tie the sack twice, so the soak ran out (after my shift had ended).
This afternoon we had inservice-training about waste-management.
The next day, I found a note from [redacted] on my timesheet that this was an unacceptable incident, with me failing to follow procedures, a copy of this note would go on my file!!

3 weeks ago, I had an accident at work, during dinnerserve, slipped on the kitchen-floor in a puddle of water, fell on my back. Obviously that water shouldn't have been there (another staffmember had seen it!), it was on my request, quickly blotted away. I had to leave 3 hrs early, as I needed to go home and rest, it was a very nasty fall. I know, that during the first 6 months we don't get sick-pay, but I reckon, this would have been an avoidable work-related accident, as since that day, there is a mat on that spot in the kitchen!
But I did not get paid for this time!

Many residents tell me, how they sense, dread the rushed, stressed "running" of the place.
>>dinner-serve for ~60 people in 40 min!!
These are just samples, it's "only" been 7 weeks.

I would like to think, you are the appropriate address for my concerns, if not, would advise me, where to turn to>

Thanking you, with kind regards
[redacted]

Waitemata
District Health Board
Best Care for Everyone

DHB Board Office
Planning and Funding
Level 2, 15 Shea Terrace
Private Bag 93-503, Takapuna
Auckland 1332
Telephone: 09 486 8920
Facsimile: 09 441-8957

24 September 2013

[redacted]
Email: [redacted]

Dear [redacted]

Re: Anonymous allegation about the care provided at the Waratah Retirement Home

Thank you for contacting Waitemata DHB about your concerns regarding the standard of care being delivered to residents at the Waratah Retirement Home. The DHB has investigated the allegations and our findings are outlined in this letter.

The allegations of poor assessment, management and containment of scabies were substantiated. In addition, the lack of a systematic framework for ensuring polices, procedures and guidelines were up-to-date revealed a lack of structure and process to guide the safe and effective delivery of care.

1) **The skin conditions of residents**
The management of skin integrity was assessed by registered nurses who employed recognised assessment tools. This was documented in the clinical notes of residents and was evident in resident care plans. However, the policy, procedure and guidelines were inadequate to guide clinical care and inform service delivery.

2) **Management of incontinence**
The assessment and management of urinary and faecal incontinence was evidenced in basic assessments and resident care plans. However, procedures related to bowel management were found in the infection control manual.

3) **Management of scabies**
An outbreak of scabies in January 2013 was inadequately managed resulting in scabies being present in the facility for 9 months. Policy, procedure and guidelines sighted in the infection control manual were insufficient to provide guidance on containment and outbreak management. Although staff had sought the advice of a Dermatologist this advice was not carried out.

4) **Management of staff rosters**
The staff roster and associated risk matrix for determining skill mix to match acuity and high needs lacked clear processes of clinical decision making.

The DHB has recommended liaison with the Gerontology Nurse Specialist regarding the urgent clinical containment and management of the scabies outbreak.v In addition, the Quality and Professional Development Nurse Leader for Age Residential Care was made available for advice on the development of a systematic framework that reflects evidenced based practice.

The DHB intends to monitor the progress of the identified issues until they are resolved.

Thank you again for bring this matter to our attention. If you require any further information, or would like to discuss the content of this letter with Waitemata DHB, then please do not hesitate to contact [redacted] Health of Older People Programme Manager on 09 486 8920 ext.3467 or [redacted]@waitematadhb.govt.nz

Yours sincerely,

Dr Debbie Holdsworth
Director Funding
Waitemata District Health Board