Human Rights Review Tribunal
The Director of Proceedings v Jeffrey and Peteleigh Holdings
— 10 August 2004

On 10 August 2004 the Human Rights Review Tribunal made orders by consent, and based on an agreed summary of facts that the defendants were in breach of Right 4 of the Code.

The case concerned the provision of care to an elderly resident (now deceased) at a rest home run by Peteleigh Holdings between October 1998 and January 1999. When the resident was admitted to the Rest Home, he presented with multiple medical problems. On two occasions bruises and unexplained grazes were noted but no incident report was completed.

On 20 December 1998 he fell and a lump formed on the right side of his head. He was seen by a doctor the next day. A working diagnosis of urinary tract infection ("UTI") or possible transient ischaemic attack was made and the resident was prescribed an antibiotic. Following a fall by the deceased on 22 December 1998, Mrs Jeffery authorised the use of restraint, despite the fact that there was no assessment by nursing and medical staff, no consent by the deceased, and no approval by the deceased's family. This was contrary to the restraint policy that was in effect at the rest home.

A further fall was recorded on 26 December 1998. No incident form was completed. On 29 December 1998 the doctor saw the deceased and recorded that there had been a fall on 28 December 1998. An ACC form was completed noting a soft tissue injury to the head, and authorising the use of restraint to prevent further falls. The doctor also prescribed a further antibiotic.

The medication records indicate that neither of the antibiotics was correctly administered, but staff at the rest home maintained that the correct medication was properly administered, and that the medical records were incorrect.

From 29 December 1998 it was noticed that the deceased was having difficulty swallowing and was eating and drinking little. The doctor reviewed the deceased again on 31 December 1998. The deceased remained confused and had fallen again, and his intake of fluids and food was not good.

That night the deceased was found on the floor of his room. The progress notes record extensive bruising. No incident form was completed.

The deceased's care plan was reviewed on 2 January 1999. It was noted that he had lost weight, had a UTI or chest infection and that his confusion had increased. The care plan was not updated to take account of the deceased's repeated falls.

The deceased's daughter visited him on 4 January 1999. He was unable to recognise her or communicate with her. He had a badly bruised hip, a bruised elbow and a black eye.

The deceased's eating problems continued and on 5 January 1999 the doctor wrote to the Ear, Nose and Throat Registrar at Christchurch Hospital requesting an urgent appointment.

An incident report notes that some time between 10pm and midnight on 11 January 1999 the deceased was found on the floor of another resident's bedroom and he had a deep gash above his left eye. An assessment was made that it did not require stitching, and because he had an appointment at the hospital on 12 January 1999, no earlier admission was required.

The deceased attended his outpatient's appointment at Christchurch Hospital on 12 January 1999. He was admitted and found to have acute renal failure due to dehydration. A CT scan taken on 15 January 1999 showed a subdural haematoma to both sides of the head. Surgery to drain the haematomas could not proceed because he was not in a suitable condition. On 17 January 1999 he died of bronchopneumonia.

A complaint was made to the Health and Disability Commissioner, and Mrs Jeffery was notified of the complaint. Following that, Mrs Jeffrey made additions to the deceased's care. Her explanation was the comments were an accurate reflection of occurrences and care given.