Provision of care to intellectually impaired woman in residential care (10HDC00420, 19 December 2012)

Disability services provider ~ Residential care ~ Intellectual impairment ~ Respect ~ Recruitment ~ Orientation ~ Disability training ~ Behaviour management plan ~ Restraint ~ Supervision ~ Vicarious liability ~ Rights 1(1), 4(1), 4(2), 4(4)

This case is about the care provided to a woman at her home, a residential facility for people with physical and intellectual impairments. The facility was governed by a board of trustees (the Board).

The woman had an intellectual impairment, autism, epilepsy and was limited in her ability to communicate. A caregiver used inappropriate force by dragging the woman across the floor by her legs and then by her arms, causing carpet burns to the woman's back. The caregiver had little training in the management of the residents and the policies in place at the facility were inadequate.

At the time of the incident, the manager of the home was in a personal relationship with the caregiver who dragged the woman. In response to the incident, the manager inspected the woman's carpet burns, made a doctor's appointment, spoke with a staff witness, advised the caregiver how to better manage such a situation in the future, and spoke to staff about the incident at a staff meeting. However, she did not inform the woman's parents or the Board about the incident.

It was held that the caregiver's actions were both unkind and disrespectful and that he breached Right 1(1). In addition, the caregiver did not provide services to the woman with reasonable care and skill, breaching Right 4(1).

By failing to have adequate recruitment processes, orientation and staff training, the manager put the woman at risk of being harmed and, accordingly, breached Right 4(4). By failing to notify the Board and the woman's family of the incident, and by failing to ensure there was an appropriate management plan in place on how to manage the woman's challenging behaviour, the manager failed to provide services to the woman with reasonable care and skill and breached Right 4(1) of the Code. The manager also failed to take reasonable steps to reduce the use of restraint and to ensure that, when practised, restraint occurred in a safe and respectful manner. Accordingly, the manager failed to comply with the Health and Disability Services (Restraint Minimisation and Safe Practice) Standards (the Restraint Standards) and breached Right 4(2).

The Board was found vicariously liable for the manager's breaches of Rights 4(1) and 4(2) for failing to take reasonable steps to ensure the woman's behaviour management plan was appropriate and to ensure the manager complied with the Restraint Standards. The Board's lack of supervision, guidance and monitoring of the manager's performance, together with the lack of adequate policies, contributed to the unsafe system existing in the facility and the failure to provide services of an appropriate standard. Accordingly, the Board breached Right 4(1).