Caregiver, Mr D

Registered Nurse, Ms C

A Rest Home

A Report by the

Deputy Health and Disability Commissioner

(Case 08HDC00469)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Overview

In July 2007, Mrs A, who had been a resident at a rest home for three years,[1] fainted while being transferred using a standing hoist. While Mrs A was secured in the hoist when she fainted, three staff were needed to lift her out of it and lower her onto the ground. As a result of this incident, Mrs A suffered minor injuries to her arms and legs. Mrs A's transfer plan was subsequently changed from using standing hoist transfers to sling hoist transfers.

On 9 November 2007, despite the previous changes to her transfer plan, Mrs A was transferred using a standing hoist. During the transfer Mrs A again fainted. It appears that Mrs A either fell, or was dropped onto the ground, landing on her knees. Mrs A was later found to have bilateral femoral fractures. She died a short time later in hospital.

Complaint and investigation

On 15 January 2008, the Health and Disability Commissioner (HDC) received a complaint from Ms B about the services provided to her mother, Mrs A, by caregiver Mr D, Registered Nurse Manager Ms C, and a rest home. The following issues were identified for investigation:

The appropriateness of the care provided to Mrs A by caregiver Mr D between 1 July and 30 November 2007.

The appropriateness of the care provided to Mrs A by registered nurse Ms C between 1 July and 30 November 2007.

The appropriateness of the care provided to Mrs A at the rest home between 1 July and 30 November 2007.

The investigation was delegated to the Deputy Commissioner, Rae Lamb. Information was obtained from:

Ms B	Complainant/daughter
Mr D	Provider/Caregiver
Ms C	Provider/Registered Nurse
Ms E	Caregiver
The rest home	Provider

Independent expert advice was obtained from Aged Care Nursing advisor Jan Featherston (see Appendix).

[1] Mrs A had been a resident since 23 December 2004.

Information gathered during investigation

Background
Mrs A, then aged 89, was an insulin-dependent diabetic, with osteoporosis and ischaemic heart disease. She required assistance for most cares, and was mobile with a self-propelling wheelchair. The rest home unit where Mrs A was resident has 26 hospital level beds.

First fall
In July 2007, Mrs A's lifting and transfer plan (last updated on 1 February 2007) stated: "Use the standing hoist for all transfers".[2] This was also documented in her care plan. The rest home advised that a copy of the lifting and transfer plan is kept in patients' lifestyle notes, as well as on the inside of their wardrobe door.

On 7 July 2007, while being transferred using the standing hoist, Mrs A fainted. She was subsequently lifted out of the frame by three staff members and lowered to the floor. As a result of this fainting episode, Mrs A suffered bruising and two skin tears to her left arm and leg. The incident was attributed to a "?vasovagal[3] followed by a ?[transient ischaemic attack][4]".

Following this incident, the Unit Nurse Manager, Ms C, immediately changed Mrs A's transfer plan from standing hoist to sling hoist transfers.[5] In contrast to a standing hoist, a sling hoist supports the patient's entire bodyweight in a full body sling. The patient is lifted and suspended by the hoist throughout the transfer.

Ms C documented this change in Mrs A's lifestyle notes on 7 July. She noted: "sling hoist to be used in the future for moving [Mrs A] — 2 person transfer". Staff were advised of this change to Mrs A's transfer plan during daily handover for the next week following the change. Ms C advised that a note was also put in the staff communication diary, which staff are encouraged to read on a daily basis. However, the care plan was not updated.

On 12 July, Mrs A was reviewed by her doctor, who noted: "needs full sling hoist now and 2 attendees".

On 13 July, Ms C had a telephone conversation with Mrs A's granddaughter. During this conversation, Ms C discussed the incident, including what steps had been taken to prevent a similar incident occurring again. A record of this conversation in Mrs A's lifestyle notes states:

[2] A standing hoist is used to assist a patient to stand. A strap is positioned around the patient's back for support.

[3] Fainting episode.

[4] Temporary disturbance of the blood supply to the brain causing brief neurological dysfunction.

[5] Ms C's role is Unit Nurse Manager. However, between 4 October and 26 November 2007 she was working as the Acting Nurse Manager.

> "In response to ensuring that [Mrs A] remains safe while in transit from bed/chair–return [Mrs A's] lifting plan had been reviewed. [A] sling hoist is to be used at all times to minimise any further risk of falls. … Due to the potential in relation to safety the reviewed lifting plan was put in place immediately."

On 31 July, a physiotherapist reviewed and updated Mrs A's lifting plan. The physiotherapist agreed with the change to a sling hoist transfer. However, she recommended that only one staff member was required for the transfer. The updated plan was then placed in Mrs A's lifestyle notes. Ms C advised that a copy was also placed on the inside of Mrs A's wardrobe door.

In contrast, Mrs A's family do not believe that the updated transfer plan was ever placed on the inside of Mrs A's wardrobe. They stated that the old plan requiring a standing hoist was still on the inside of the wardrobe door the day after Mrs A died and that Ms C apologised to them for not updating the plan in the room. The rest home explained that it appears that a copy of the new transfer plan had been placed on top of the old plan, but this was removed after Mrs A died. The original updated plan was kept at the front of the lifestyle notes.

Rest home policy

The rest home Code of Conduct states that every employee must "comply with policies and procedures set down for your work and your workplace. This includes observing safety procedures and, where appropriate, using, as recommended, the safety equipment that is provided." Furthermore, it states that "your supervisor or manager is entitled to give you lawful and reasonable instructions relating to your work and you, in turn, are required to follow these. … Our written policies and procedures count as instructions."

The policy for the use of hoists states: "Hoists to be used for designated residents according to their transfer plan …"

Mr D

Mr D had been employed by the rest home for approximately five and a half years as a caregiver. He worked the morning shift (7.30am–2pm) on a four-day on, four-day off roster.

Like many caregivers, Mr D has had no formal nursing or caregiving training. The rest home advised that at the time of Mr D's employment all new staff received a minimum of 13 hours' orientation, which included the use of hoists and orientation to all policies and procedure manuals. In addition, it advised that all new staff attend a safe handling inservice training session with the physiotherapist within four weeks of starting their employment.

Mr D advised that he had attended a number of inservice training sessions, which included training on lifting and the use of hoists, throughout his employment at the rest home.

Mr D had known Mrs A for approximately 10 years prior to her moving into the unit. He had been involved in Mrs A's care for approximately three years while she was a resident.

Ms C advised that on one occasion, shortly after the incident in July 2007, she found Mr D outside Mrs A's room with a standing hoist. She stated:

> "On one occasion after July 2007 that I recall, I was concerned to find that [Mr D] was entering [Mrs A's] room with a standing hoist. I apprehended him and reminded him that [Mrs A] required a sling hoist and that the plan needed to be followed to ensure both her and his safety."

Ms C recalls that at this time Mr D questioned her about how necessary it was to follow the changes made to the patient transfer plans given how well they know each patient. Ms C recalls that another caregiver, Ms E, was also present during this conversation. Ms C reinforced to them that they needed to follow the plans in place because these were there to ensure the safety of both staff and the patient. Ms C advised that this was a general reminder, and not specific to Mrs A, as there had been a number of recent changes to patient transfer and care plans. Ms C stated:

> "I remember being stopped in a corridor by two senior care workers asking me whether or not they do have to follow the changes in the care plans and the equipment to be used. This was outside the door of [Mrs A's] room but in a corridor with five rooms off it. In conversation both the support workers felt that they knew best in relation to the people that they supported and felt that they could continue doing as they had been in the past. We talked about how people change over time and how their care requirements can be subtle, especially when you work with folk on a continual basis. I told them that they were required to follow any changes made to the care plans and I left the conversation feeling as though they understood that as people's care requirements changed so the plan of supporting complex needs changed also. I did remind the care workers that lifting plans were there to be followed and that I expected that they would follow the plan of care as would everyone else.

Ms E does not recall this conversation. However, she advised that caregivers are constantly reminded of the importance of following the correct procedures, and she was not aware of Mr D, or any other caregiver, using the incorrect hoist.

The rest home incident reporting policy requires all "accident and near miss incidents involving residents and clients … will be reported and analysed in order to identify and reduce risk".

Because Ms C did not actually see Mr D using the incorrect hoist, she did not follow up the matter further with him, nor did she document it in an incident report. Ms C recalls that Mr D "was a bit put out and did not appreciate the reminder", but stated:

> "I did not follow up with [Mr D] in regard to lifting and transfers as I believed that as the senior care worker, with the added responsibility of being the 'Health and Safety' representative for the units, which the Carers would respect and adhere to a verbal reminder to ensure the safety of the residents at all times."

However, Ms C does recall Mr D being present, as part of a group handover, on at least two occasions when she gave a general reminder in relation to general care requirements.

Mr D agrees that Ms C did speak to him on one occasion after Mrs A's transfer plan had been changed, reminding him that he needed to follow the changes. However, he recalls that this was when Ms C actually saw him using the standing hoist to transfer Mrs A. Mr D stated that at this time "I explained [to Ms C] that I made an assessment as to how [Mrs A] was each day as other Carers had done and it was common practice to use the standing hoist on those days as [Mrs A] disliked the sling hoist. I said I believed I had the experience with [Mrs A] to do this." Mr D advised that in response to this explanation, Ms C "simply shrugged her shoulders and left without comment".

Mr D agreed that he was aware that Mrs A's transfer plan had changed. On 12 July 2007, Mr D recorded in Mrs A's lifestyle notes that "[Mrs A] is now using a Sling Hoist". However, he advised that Mrs A disliked the sling hoist and that as Mrs A became stronger, staff began to use the standing hoist again. Mr D stated that he was never given a formal warning about using the standing hoist rather than the sling hoist to transfer Mrs A.

Mr D also advised that he would often find that either the slings or the sling hoists were unavailable and/or in need of repair. Furthermore, he stated:

> "We very often worked short staffed and this meant we would have to make compromises and depart from what would have been ideal. This I believe [led] to a culture in which (even if we were not short on a particular day) things that might have been done at such times and had worked well would creep into day to day methods."

Mr D advised that he was acting in what he "sincerely believed" to be Mrs A's best interests. He stated: "I took what I truly felt were the safest steps available to me when caring for her." It was his belief that Ms C knew he regularly transferred Mrs A using the standing hoist.

27 September 2007
On 27 September 2007, the "resident review summary sheet", which is included at the front of the lifestyle notes, was updated to include the change to a sling hoist.

9 November 2007
The rest home advised that on the morning of 9 November, the unit had a total of 22 residents and there were five careworkers, one registered nurse, and one student nurse

on duty. It also advised that there were seven hoists (three standing and four sling hoists) available on the unit. It stated:

> "Based on our experience of the Aged Care Residential Sector, one hoist for every 8 hospital residents is recognized as good practice."

Mr D recalls that around 10am on 9 November, while in the dining room having morning tea, Mrs A asked to go to the toilet, which was always "very urgent" with Mrs A. Mr D advised that he wheeled Mrs A into her room and then, using the standing hoist, assisted her to transfer onto the commode.

Mr D explained that it is "extremely difficult and time consuming" to put a sling, to be used for the sling hoist, underneath a person while he or she is sitting in a wheelchair. Because Mrs A did not already have a sling under her, Mr D decided to use the standing hoist.

After she had finished, Mr D assisted Mrs A off the commode to clean her. Using the standing hoist, Mrs A was lifted into a standing position, supported by the sling behind her back. While he was doing this, Mr D noticed that Mrs A had fainted. Mr D explained that he then supported her and helped to lower her to the floor. He stated:

> "There was no time to call for help. I got behind [Mrs A] and supported her weight with my thighs. I reached round and got hold of the control unit and slowly lowered her down to the floor while continuing to support her weight. While I was doing this I couldn't see [Mrs A's] legs at all. Once she was fully down I saw that her legs were bent back from the knees down. I went straight to the RN on duty to report it."

The registered nurse on duty recalls Mr D informing him that Mrs A had had another "fainting fit". When the registered nurse asked how she was, Mr D stated that she was lying on the floor, but that she was "ok" and that he had lowered her gently onto the ground.

The registered nurse advised that when he arrived in Mrs A's room he saw that Mrs A was lying on the ground. He recalls Mr D telling him that after she had fainted he had helped to lower her onto the floor. Mr D told the registered nurse that Mrs A's knees had "buckled" while he was helping her onto the floor, but that he had helped pull them out from underneath her. The registered nurse then assisted to clean Mrs A and, using a sling hoist, transferred her back onto her bed. He recalls that Mrs A was complaining of pain in her legs.

The incident form completed by Mr D states:

> "[Mrs A] fainted after huge [bowel motion] on hoist. Lowered her gently to the floor but hadn't noticed that her legs from her knees down [were] stretching backwards. Hurt herself around the knee area. Green standing hoist with blue soft belt."

Mrs A's doctor was called. He reviewed Mrs A shortly after she was put back onto her bed. He noted that Mrs A was complaining of pain in her legs. He noted a significant amount of swelling and deformity of her femurs and queried whether she had fractured both her femurs. He subsequently contacted the Emergency Department registrar and Mrs A was later transferred directly to the public hospital.

Public hospital
Following her arrival at the public hospital, Mrs A was reviewed by a registrar and X-rays were taken of both her legs. This confirmed bilateral distal femoral fractures.

Mrs A was admitted under the orthopaedic service. However, after discussions with her family, it was decided not to proceed with surgery because of the high risk. The decision was therefore made to make Mrs A comfortable. Mrs A died in hospital shortly afterwards.

At the Coroner's request, an orthopaedic surgeon reviewed Mrs A's X-rays and clinical notes. In a report to the Chief Medical Officer at the District Health Board, the orthopaedic surgeon stated:

> "Despite the osteoporosis, I am of the opinion that these fractures have occurred as a result of a fall whereby the patient hit the floor with both knees bent. The description 'was lowered gently to the floor' would probably not have caused such displaced fractures despite the presence of osteoporosis and the presence of metal in the femur.
>
> In summary, I can confirm that these fractures were sustained by a fall with axial loading of both femurs through the knees as they hit the ground and that the energy forces involved were probably moderate rather than high, but have resulted in a fracture because of the underlying osteoporosis."

Action taken
Following the incident in November 2007, Mr D immediately went on leave pending a formal investigation. He subsequently resigned.

Following the completion of its investigation, the rest home identified areas it felt required review and developed an action plan to address these areas. However, the rest home stated:

> "While the changes referred to in this Action Plan are undoubtedly improvements upon the existing system, it remains our belief that regrettably, none of those changes comprise practicable steps that would have prevented the incident on the 9th November."

The action plan included:

— A documentation audit looking specifically at resident Lifestyle and Lifting and Transfer plans.

— Orientation policy review to include a more comprehensive coverage of back care and lifting and transferring.

— Review of its staff training to ensure that all staff are up to date with its compulsory lifting and transferring policy. The rest home also put in place a register to centrally monitor staff training. It reviewed its inservice training policy to ensure all staff had completed its compulsory transfer and lifting training.

— Review of its policy for hoist service and checks to ensure that its hoists are inspected annually.

— The rest home also communicated to all staff, during a full staff meeting, the need for all staff to work to prescribed nursing and caring procedures. This was also done during lifting and transfer training sessions. This information was also communicated to all its nursing and careworker staff in all of the rest homes owned by the rest home.

Department of Labour
On 12 November 2007, the Department of Labour (DoL) commenced an investigation under the Health and Safety in Employment Act 1992 into this incident. At the completion of its investigation DoL concluded that Mr D was aware of the rest home policies and procedures for lifting and transferring patients but chose not to follow them. It also considered that the rest home management "failed to take all practicable steps to ensure they were followed". However, DoL decided not to proceed with legal proceedings.

Mrs A's family
Mrs A's family are very upset that this incident could have been allowed to happen. They are particularly concerned that Mr D was allowed to continue to transfer Mrs A using a standing hoist after her first fall, even when he had been specifically reminded of the change. They consider that the the rest home should have had a process in place to prevent this from happening.

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) are applicable to this complaint:

RIGHT 4

Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

Response to provisional opinion

Mr D

Mr D does not accept that Mrs A either fell or was dropped onto the ground. Mr D reiterated that he lowered Mrs A onto the ground. He believes that Mrs A's fractures were caused by her weight going through her legs as he lowered her as he was unable to see that her legs were trapped underneath her.

Mr D's lawyer submitted that Mr D's obligation was to follow the lifting plan. Mr D does not believe that Mrs A's lifting plan was ever updated. Therefore, Mr D's lawyer submitted that Mr D did not breach the requirements of the lifting plan.

Mr D's lawyer advised that Ms C had spoken to Mr D on two or three occasions about the need to use the correct hoist with Mrs A. Mr D reiterated that Ms C did see him going into Mrs A's room on one occasion but did not take any formal action in relation to enforcing the requirement to use a sling hoist. Furthermore, Mr D maintains that it was common practice to transfer Mrs A using the standing hoist. Mr D's lawyer stated:

> "[Mr D] was aware of at least three of the morning staff and one other afternoon shift worker who are known to [Mr D] to have used the standing hoist for [Mrs A]. Accordingly, it appears that the practice was widespread. [Mr D] did not make any secret of the fact that he would use a standing hoist when he felt it appropriate but no action was taken against him at the time, neither educational nor disciplinary."

Mr D's lawyer advised that while Mr D may have been one of the more senior members of staff, he was not a "senior care giver" as stated by Ms C. Furthermore, he stated that Mr D was not a Health and Safety representative.

In relation to Mr D's concerns about working short staffed in the Unit, Mr D's lawyer advised that Mr D, as the union representative, had raised these concerns with management on previous occasions.

He also submitted that while there may have been seven hoists on 9 November, these were used for the whole hospital, or they were unavailable owing to cleaning or repair. Mr D does not believe that there were any more than two sling hoists and two standing hoists available at the time of the incident. Furthermore, Mr D was not aware that the sling hoist needed to be operated by two staff members.

Mr D's lawyer also advised that Mr D has now retired and is no longer working as a caregiver. He advised that Mr D does not intend returning to work as a caregiver.

Mr D had already sent a letter to Mrs A's family expressing his sympathy for their loss. In the letter he discussed his longstanding friendship and respect for Mrs A. He

also expressed his regret for what happened, stating that it will "always weigh heavily" with him.

Ms C
Ms C disagrees with Mr D's assertion that Mrs A became stronger following her fall in July. She advised that Mrs A's condition had been declining and she was not becoming stronger.

Ms C reiterated that she was never aware of Mr D, or any other caregiver, using the incorrect hoist. She explained that she spends much of her time in her office and therefore relies on her team of registered nurses. Ms C stated:

> "I was certainly never aware that [Mrs A's] lifting/transfer plan was not being followed and I would have been remiss in my duty of care to [Mrs A] had I known and done nothing about it. This would also have been contrary to my practice of trying to be proactive and getting the best out of people. The registered nurses who work with the caregivers on a daily basis never alerted me to the fact that any lifting/transfer plans were not being followed. "

In relation to her failure to update Mrs A's care plan, Ms C stated:

> "I acknowledge and take responsibility for the fact that [Mrs A's] care plan had not been updated. The plan was not of good quality as it had not been reviewed for some time. It was assigned to a nurse to do but this had not occurred and I ought to have been more vigilant in following it up."

Ms C advised that she has made a number of changes to her practice including ensuring that lifestyle plans are kept up to date and reviewed on time. Lifestyle notes are also checked and updated at the time and all staff are made aware of any major care requirement changes. Ms C advised that she also ensures that the designated registered nurse also maintains responsibility for updating and reviewing the lifestyle support plan when clinical review takes place.

Ms C also ensures that education records are kept up to date. Any staff member who does not complete the compulsory education is followed up and disciplinary action taken where appropriate.

Caregivers are also monitored closely. Ms C is now vigilant about monitoring and documenting any conversations or concerns in relation to staff actions.

Ms C reiterated her sympathy for Mrs A's family for their loss.

Mrs A's family
Mrs A's family reiterated their belief that Ms C was aware that Mr D had knowingly been using the wrong hoist. They are concerned that Ms C did not take any action, particularly as Mr D has no formal training. They do not believe that Mr D should

have been allowed to make his own decisions about whether he complied with the transfer plan or not.

Department of Labour
The DoL advised that the conclusions it drew were based on the interviews it conducted with staff during the course of its investigation.[6] It advised that they did not have conclusive evidence about whether Ms C actually saw Mr D transferring Mrs A using the wrong hoist. However, they concluded that she most likely had, based on Mr D's submission.

Key points

1. Mrs A was an 89-year-old woman who had been a resident at a rest home for approximately three years. Mrs A had a number of co-morbidities and required assistance to transfer.

2. In July 2007, Mrs A experienced a vasovagal (fainting) episode while being transferred using a standing hoist.

3. As a result of this fainting episode, Mrs A's transfer plan was changed from standing hoist transfers to sling hoist transfers. This change was communicated to staff in the lifestyle notes and in the staff communication diary, as well as during morning handover for approximately one week following the change. On 31 July, Mrs A's lifting plan was updated by the physiotherapist to reflect this change. On 27 September 2007, the resident review form (which is situated at the front of the lifestyle notes and care plan) was updated to reflect the change.

4. The care plan was not updated and there is dispute over whether the copy of the lifting plan inside Mrs A's wardrobe door was updated. The family advised that the old plan was still there the day after Mrs A died but the rest home advised that the updated plan was placed on top of the old plan on Mrs A's wardrobe door and was removed shortly after she died.

5. Nonetheless, it is clear that Mr D knew that the transfer plan had been changed. I note that on 12 July 2007 Mr D documented in Mrs A's lifestyle plan "[Mrs A] is now using a sling hoist".

6. Furthermore, shortly after the transfer plan was changed, Ms C reminded Mr D of the change to Mrs A's transfer plan.

7. It is unclear whether Ms C actually saw Mr D transferring Mrs A using the incorrect hoist at this time. While Mr D recalls that Ms C saw him transferring

[6] HDC obtained a copy of the DoL interview transcripts.

Mrs A using the wrong hoist, Ms C recalls giving Mr D the reminder while he and another caregiver, Ms E, were standing in the corridor after she saw Mr D outside Mrs A's room with a standing hoist. Ms C advised that this conversation was just a general reminder in response to Mr D and the other caregiver asking if it was necessary to adhere to the changes made to care plans.

8. Ms E does not recall this conversation. However, she advised that the nursing staff were constantly reminding them of the importance of following the transfer plans. Ms E was not aware of any caregiving staff using the incorrect equipment.

9. Ms C advised that because this was a general reminder, and she was not aware that Mr D was actually going into Mrs A's room at the time, she did not follow up directly with Mr D. However, she recalls reminding staff, on at least two occasions when Mr D was present, of the importance of following a patient's transfer plan.

10. It appears that Mrs A did not like being transferred using the sling hoist.

11. Mr D advised that he would make an assessment on a day-to-day basis in relation to how best to transfer Mrs A depending on how she was feeling that day. He considered that he knew Mrs A well enough, and had sufficient experience, to be able to make this judgement. Mr D does not believe he was the only staff member who did this.

12. On 9 November 2007, Mrs A suffered another fainting episode while being transferred by Mr D using a standing hoist. Mr D was trying to get Mrs A off the commode chair. He had used the standing hoist to put her on the commode because her need was urgent.

13. It is unclear how Mrs A was put onto the ground. Mr D reported that, after he noted that Mrs A had fainted, he "gently lowered her onto the floor". However, Mrs A was later found to have bilateral distal femoral fractures suggesting that she fell to the floor, landing with moderate force on her knees. The orthopaedic surgeon believed she fell.

14. Mrs A was subsequently admitted to hospital and placed on comfort cares. She later died in hospital.

Opinion: Breach — Mr D

Mr D was an experienced careworker who had worked at the rest home for approximately five and a half years. The rest home has provided evidence that Mr D underwent sufficient training and orientation when he first started working at the rest home. Mr D also underwent additional ongoing in-service training throughout his time at the rest home. I am satisfied that Mr D was familiar with its policies and procedures and, in particular, received adequate training on lifting and transferring patients.

However, in my view, Mr D failed to exercise reasonable care and skill in transferring Mrs A on 9 November 2007. Mr D knew that Mrs A's transfer plan had changed. This is evidenced by his statement in her lifestyle notes on 12 July 2007, which state "[Mrs A] is now using a sling hoist". Furthermore, he had been reminded by the registered nurse manager of this change on more than one occasion. He chose not to follow this instruction, choosing instead to make his own judgements on Mrs A's function on a day-to-day basis. That Mrs A disliked the sling hoist is not an excuse for not following policy.

As a result of Mr D choosing not to follow Mrs A's new transfer policy, Mrs A suffered serious injuries. I do not accept Mr D's explanation that he "gently lowered Mrs A to the floor". Evidence suggests that Mrs A fell onto her knees and this, coupled with her osteoporosis, contributed to her injuries. I note the comments of the orthopaedic surgeon:

> "In summary, I can confirm that these fractures were sustained by a fall with axial loading of both femurs through the knees as they hit the ground and that the energy forces involved were probably moderate rather than high, but have resulted in a fracture because of the underlying osteoporosis."

Mr D's decision to use a standing hoist on the morning of 9 November cannot be excused by his explanation that the situation was urgent. Although Mrs A may have required immediate attention, Mr D should have sought assistance from another staff member. While I accept Mr D's submission that staffing was short at times, the rest home has provided evidence that there were sufficient staff numbers on the Unit at the time of this incident. I note Ms Featherston's advice that in her opinion, based on the information provided by the rest home "there was an adequate number of staff to provide care for hospital level patients". Furthermore, I do not accept that having had to work short staffed on occasions in the past led Mr D to use the wrong hoist on this occasion, particularly given his comment that he decided which hoist to use based on his day-to-day assessment of Mrs A.

Similarly, I do not accept Mr D's explanation that there were not enough hoists available at any one time. I note Mr D's submission that he does not believe that there would have been more than two sling and two standing hoists available to the whole hospital on 9 November. However, the rest home advised that seven hoists, including four sling hoists, were available on the Unit on 9 November. I note Ms Featherston's advice that "[t]his number of hoists in my opinion would be more than adequate to meet the patient and staff needs."

Overall, I believe that Mr D knew he should not be using the standing hoist to transfer Mrs A. I acknowledge the difficulties in working in a busy rest home and accept that it can be time consuming transferring a patient by sling hoist, particularly if there is no hoist either available or close by. However, in my view Mr D should have know better and I do not accept Mr D's reasons for not following the documented transfer plan. Accordingly, I conclude that Mr D breached Right 4(1) of the Code.

Opinion: No breach — Ms C

Following Mrs A's fainting episode in July 2007, Ms C changed Mrs A's transfer plan. In the circumstances, this was an appropriate action to minimise the potential for harm.

Ms C took adequate steps to ensure this change was communicated to all staff. This included clearly documenting the change in Mrs A's lifestyle notes and the staff communication diary, as well as ensuring instructions were given to staff during morning handover. The resident review form was not updated until 27 September 2007. While Mrs A's transfer plan was also replaced on 31 July to reflect this change, there is some doubt about whether the copy of the transfer plan on the wardrobe was changed. Additionally, Ms C did not update Mrs A's general care plan. Clearly, this was not optimal. As noted by Ms Featherston:

> "There is the risk when not updating the care plan straight away that staff will not go back more than a couple of pages to review what is written in the clinical notes."

However, as noted earlier, Mr D has confirmed that he was aware of the change.

I am unable to determine whether Ms C actually saw Mr D using the incorrect hoist to transfer Mrs A. Certainly, had Ms C been aware of Mr D using the incorrect hoist, she should have taken steps to formally report the incident and to ensure Mr D did not repeat the practice. Ms C agrees that she would have been "remiss" had she not done so. There were no other reported incidents of staff using the incorrect equipment. I am also satisfied that staff had been adequately educated on the implications of not doing so. Furthermore, I have found no evidence that it was common and accepted practice for carers to transfer Mrs A with the standing hoist, rather than the required sling hoist. Indeed, information provided by other staff suggests that they have been regularly reminded of the importance of following the documented transfer plan.

Ms C stated that when she provided a reminder to Mr D about the correct way of transferring Mrs A, she was aware that he "did not appreciate the reminder". In light of Mr D's clear reluctance to follow the transfer plan, and his assertion that he was experienced enough to make his own assessment about the patient's ability, I consider that it would have been wise for Ms C to have been more vigilant about following up this matter with Mr D even if she was unsure that his intention was to transfer Mrs A using the standing hoist.

While I consider that aspects of the care provided by Ms C could have been better, in the face of conflicting information I am satisfied that Ms C took appropriate steps to ensure the transfer plan change was communicated to all staff, including Mr D. I note Ms Featherston's opinion that "the care provided by RN [Ms C] was of an acceptable

standard". I have also carefully considered Ms Featherston's advice about the failure to update Mrs A's care plan and the risk associated with this. It is my view that, given the other documentation, the failure to change the care plan does not, in itself, justify a finding that Ms C breached the Code.

Opinion: No breach — The rest home

Vicarious liability
Under section 72 of the Health and Disability Commissioner Act 1994 (the Act) employers are liable for acts or omissions by an employee unless they prove that they took such steps as were reasonably practicable to prevent the employee from breaching the Code.

As Mr D was an employee of the rest home at the time of this incident, consideration must therefore be given as to whether it is vicariously liable for his breach of the Code. Under section 72(5) of the Act, it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent acts or omissions leading to an employee's breach of the Code.

I am satisfied that the rest home provided Mr D with adequate training in lifting and transferring patients. Similarly, I am satisfied that the rest home had adequate staffing and equipment available to staff. There is no evidence to suggest that staff were working in an unsafe environment.

Direct liability
I do have some concerns about whether it was common practice for caregiving staff to make their own judgement on how to transfer Mrs A. Had the nursing staff known that this was happening, I would have expected it to have been reported and appropriate action to have been taken by the rest home. However, as discussed above, I have not been provided with any conclusive evidence to suggest that nursing staff were aware that this was actually occurring. Furthermore, I am satisfied that as soon as the rest home discovered that Mr D had incorrectly transferred Mrs A on 9 November, a full investigation was commenced and Mr D went on leave pending the outcome. This was correct action in the circumstances.

I consider that this case is a good example of the difficulties faced in rest homes, particularly in relation to the amount of responsibility placed on unqualified caregivers. I trust that this case will serve as a reminder of the need to provide adequate support to staff and reinforce the importance of ensuring that there is full compliance with policies and procedures. I am pleased that the rest home has already taken steps to educate the staff at all of its facilities of the importance of adhering to policy changes.

Conclusion
Overall, I am satisfied that as soon as the rest home was aware of the incident, appropriate action was taken. I am also satisfied that the rest home had adequate staffing and equipment for the number of residents. I therefore conclude that the rest home did not breach the Code.

Non-referral to Director of Proceedings

I consider this case borderline for a referral to the Director of Proceedings.

My expert advisor, Ms Featherston, viewed Mr D's departure from standards as mild, due to the fact that he had no intention to cause harm to Mrs A. Mr D reported the incident immediately, has been open about his decision not to follow the lifting plan, and has expressed his regret for what occurred. Mr D has sent an apology to Mrs A's family. Furthermore, Mr D is now 70 years of age and has retired from working as a caregiver.

However, Mr D's disregard of the changes to Mrs A's transfer plan was serious with very severe consequences. Mrs A had already fallen following a previous fainting episode. A plan was in place to keep her safe, and it was directed by Mr D's manager, a registered nurse. Mr D knew the plan but chose not to follow it. However well intentioned, this was not acceptable. Furthermore, medical evidence suggests that Mrs A fell rather than being lowered to the floor as Mr D has reported.

Having carefully considered all the information, on balance I have decided not to refer Mr D to the Director of Proceedings. In my view the public interest and any public safety concerns will be sufficiently achieved by holding Mr D accountable for breaching the Code, and publishing an anonymised version of this report on the HDC website. Little more would be achieved by the additional step of disciplinary proceedings.

Recommendations

I recommend that the rest home provide a copy of the results of the recent documentation audits, together with a report on what further action the rest home has taken following completion of the second audit.

I recommend that the rest home provide an update on the actions taken in light of this report, including reminding all of its registered nursing staff about the importance of updating patient general care plans, and complying with policies.

The results of the audit and update report should be sent to HDC by **30 January 2009**.

Follow-up actions

- A copy of this report will be sent to the Coroner, the Department of Labour, and the Nursing Council of New Zealand.

- A copy of this report, with details identifying the parties removed except the names of my expert advisor and the rest home, will be sent to the District Health Board and the Ministry of Health (HealthCERT).

- A copy of this report, with details identifying the parties removed except the expert who advised on this case, will be sent to New Zealand HealthCare Providers, and the Association of Residential Care Homes, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix

Expert Advice report

1. To advise the Commissioner whether, in your opinion, caregiver [Mr D] provided [Mrs A] with an appropriate standard of care and, if not, explain how the care he provided deviated from appropriate standard.

[Mr D] had been a caregiver for [Mrs A] for approx 3 years. He also knew her socially before her admission — from his statement to [the Health and Safety Inspector] [Mr D] had known [Mrs A] for 14–15 years [statement dated 26 March 2008].

It would appear from the documentation supplied that [Mr D] had provided adequate care in the proceeding 3 years before the incident.

Following [Mrs A's] fall from the standing hoist in July 07, the transferring policy was changed to transferring [Mrs A] with the sling hoist. This information was passed on to care staff by several different methods:

1. Documentation on the transfer and mobility form — kept in the wardrobe door of the patient's room.

2. Verbal hand over to all staff — done regularly for one week.

There is adequate supporting evidence that caregiver [Mr D] should have known of the change in policy.

[Mr D] states in an interview with [the Health and Safety Inspector] that it was common practice for staff to use the standing hoist 50% of the time, and that staff would judge how [Mrs A] was on a particular day as to what hoist staff would use.

[Mr D] was also a member of the Health and Safety Committee and as a member he would have in my opinion been aware of the implications of not following instructions from senior staff.

The events surrounding the incident as stated by [Mr D] are that [Mrs A] required to move her bowels in a hurry and that the quickest way to achieve this was to use the standing hoist. Following a large bowel motion [Mrs A] then collapsed and slipped/fell to the floor causing # femurs.

It is my opinion that had the change in hoist plan been followed by [Mr D] then [Mrs A] would not have fallen hence resulting in her injuries.

I believe that [Mr D] failed to provide an appropriate standard of care and services to [Mrs A]. This lapse was caused by simply not following documented instructions.

2. To advise the Commissioner whether, in your opinion, RN [Ms C] provided [Mrs A] with an appropriate standard of care and, if not, explain how the care he provided deviated from appropriate standard.

Standards of care can be measured in a number of ways. For this situation I have viewed RN [Ms C's] job description and what would be normal good practice in any aged care facility.

I have also taken into account the competencies from the Nursing Council of New Zealand for a registered nurse. These competencies are set by council and all RNs are expected to meet these to hold their registration.

There is nothing in any supporting documentation apart from Care plans review that indicates that RN [Ms C] failed to provide an adequate standard of care.

In relation to the incident for [Mrs A] which occurred in July 07 an action plan was documented and support was sought from other health professionals. This is clearly documented in [Mrs A's] clinical notes and instructions were given to all staff as to how to transfer [Mrs A].

Her mobility care was to change from a standing hoist to a sling hoist. The process that staff undertook was to change the mobility plan. This plan was available for all staff in [Mrs A's] wardrobe.

The general care plan was not evaluated to include the sling hoist although this was documented on the evaluation review form on the 27/09/07.

There is also documented evidence in the clinical notes that staff were aware of this change. There is the risk when not updating the care plan straight away that staff will not go back more than a couple of pages to review what is written in the clinical notes.

Having read all the supporting information, including the interviews with [the Health and Safety Inspector], I am of the opinion that the care provided by RN [Ms C] was of an acceptable standard.

3. To advise the Commissioner whether, in your opinion, caregiver [the] Rest Home provided [Mrs A] with an appropriate standard of care and, if not, explain how the care it provided deviated from appropriate standard.

In reviewing standards of care from individual facilities there are several issues which are taken into account.

Staffing — obviously staffing numbers are vitally important when identifying care issues. Without an appropriate number of staff, care and duties can not be carried out to a reasonable standard of care.

[The rest home's] letter to HDC states that [the Unit] had 22 patients on the 9th November 2007 [letter dated 4 April 2008]. In his statement [in the section numbered 9 (a)] he states the staff who worked in the unit on the AM shift — that number is:

1 Registered Nurse

4 Care givers

1 Student Nurse

In [section 9(b)] he states that there were 5 care staff and 1 RN. There is some confusion but I am assuming that the number of staff was:

1 RN and 5 caregivers.

If that is correct then it is my opinion that there was an adequate number of staff to provide care for hospital level patients.

Staffing with hoists

It is my experience that hoists are able to be used with one nurse who is competent in the use of such equipment. Each individual patient is different and there are certainly some patients who require two nurses to carry out a transfer safely. These patients would be patients who were very rigid and would be a risk of knocking their limbs as the hoist would be turned. Other patients would be patients who have no mobility at all and very large patients.

The number of nurses that would be required should be documented on a mobility plan.

Equipment — Without adequate equipment staff are unable to carry out the required care for individual patients. Most hospital level patients have some mobility issues in that they are no longer able to weight bear or mobilize safety and independently. All aged care facilities in my experience have policies and procedures which indicate and notify staff how a particular patient is to be moved and transferred. This ensures that staff carry out care to minimize and prevent injury to themselves and the patients.

[The rest home] has indicated that the [Unit] had 7 types of Hoists available on the 9th November. This number of hoists in my opinion would be more that adequate to meet the patient and staff needs.

It is completely impractical to have a hoist for every patient who requires one.

Staff generally know who needs what piece of equipment and set their routine out around availability of equipment. It would be highly unusual in my experience for every patient to require hoisting. Hence it is common practice to have a number of different hoists, for different patient requirements.

I am of the opinion that the [Unit] had an adequate number of hoists for the number of patients they were caring for.

Education
I have only been able to view [Mr D's] education in-service training record. This consisted of an orientation programme. This was 13 hours. This covered a number of clinical and non clinical issues. It is usual practice for new staff to be buddied with an experienced staff member.

The extra education that [Mr D] undertook was listed.

This education list is not dated nor does it include the hours attended but does include a wide variety of topics. It is noted that lifting and back care was attended x 3.

I am of the opinion that the education attended by [Mr D] would be adequate and relevant to his job.

Compliance Issues

All aged care facilities have to meet a variety of standards. Audits are undertaken to ensure compliance to these standards. The information I have does not include the audits that had been undertaken, so I am assuming that [the rest home] has met the requirements for these.

It is noted that [the rest home] has obtained tertiary level in relation to ACC. Meeting this level in my opinion indicated that the processes for staff education and safety reach a high standard.

Care Plans

Care plans are the key document which directs patient care. These are also read in conjunction with the clinical integrated notes, and any reviews.

The care plan was documented and the date of documentation was the 7/06/05.

The plan identifies issues of care. Those identified are:

1 Social Roles
2 Emotional Cognition
3 Mobility
4 Bathing
5 Dressing
6 Grooming
7 Personal Hygiene
8 Nutrition
9 Risk Management
10 Social Interaction

11 Safety Management
12 Settling
13 Elimination

Under each of the headings there is Goal and an Intervention column. This is completed appropriately in my opinion.

There is a column for Evaluation and date and signature.

Not all of the headings have been evaluated on. The only evaluations are in headings

1 Risk Management (dated 3/7/06)
2 Settling (dated 7/12/05–Feb 07, March 07)
3 Elimination (dated 21/2/07)

There is a resident Review Summary Sheet Dated the 27/9/07. This sheet comprises of two pages the first being general care issues. The areas that have been reviewed are:

1 Treatment Goals
2 Mobility/ Physiotherapy
3 Infections/Incidents
4 Pain Management
5 Nutritional Status
6 Elimination
7 Consent
8 Activities
9 Family Concerns
10 Other
11 Blood tests and Investigations

The other side of the review sheets is for interdisciplinary team member to fill in if they were not at the review.

The care plan although completed well and appropriately at the time lacks evaluation and updating. I would be very surprised if [Mrs A's] care needs had not changed since the documentation of the plan on the 7/06/05.

The section dealing with mobility had not been updated, but the review form had been.

I am of the opinion that the care plan was adequate in terms of Needs, Goals and Interventions but barely adequate in terms of evaluation and updating. Although the clinical notes do show that staff had documented concerns and review of cares, these notes get filed and staff and members of the interdisciplinary team generally do not go back over old notes to review care. All changes should be documented in the care plan which is always available for staff to read and follow.

I did not review policies which would have to outline how often care plans are to be updated but the general rule of thumb is no longer than 6 monthly and certainly when a patient's condition changes.

I am of the opinion that the lack of review and updating would be viewed as mild by my peers.

Accident Investigation

There are required policy and procedures to follow when an incident has taken place.

The documentation presented shows that [the rest home] did carry out an investigation into [Mrs A's] falls. The clinical notes show that [the rest home] did contact the family on the 9/11/07 and subsequently after that.

It is my opinion that the investigation and communication was adequate.

In reviewing all of the documentation I am of the opinion that [the rest home] provided an appropriate level of care for [Mrs A].

Summary

I am of the opinion that [Mrs A's] accident was a direct result of the incorrect sling being used by caregiver [Mr D]. While obviously not intentional the accident resulted in 2 [fractured] femurs.

There is conflicting evidence that several of the staff used the standing hoist. I am not able to form an opinion as there is no documented evidence in the clinical notes as to what hoist was used on a daily basis.

Additional comment from Ms Featherston

Ms Featherston advised that, in her opinion, Mr D's departure from the appropriate standard of care would be viewed as mild.

In addition to this, having reviewed the DoL report, Ms Featherston stated that she stood by her advice and that she considers that Ms C took all reasonable steps to ensure the change of transfer plan was communicated to all staff. Similarly, Ms Featherston considered that the rest home had adequate policies and procedures in place, as well as sufficient equipment.