Non-compliance with lifting and transfer policy and failure to report incident (07HDC16959, 20 May 2008)

Rest home/hospital ~ Caregiver ~ Transfer ~ Hoist ~ Fracture ~ Incident report ~ Documentation ~ Standard of care ~ Adequacy of quality care systems ~ Rights 4(1), 4(2), 4(5)

An 81-year-old woman was admitted to a rest home/hospital after being assessed as requiring hospital level care. She was only occasionally able to respond verbally.

One morning, a caregiver noticed that the woman had severe bruising and swelling to her left arm. The caregiver reported this to the registered nurses but no action was taken in relation to this injury until three days later when another caregiver noticed and reported the bruising to senior nursing staff. The facility's general practitioner was asked to visit to examine the woman.

The GP saw the woman that afternoon and arranged for her to be transferred to a private hospital for an X-ray, which confirmed that the woman's arm was fractured. The manager immediately commenced an investigation into the circumstances of the woman's fracture. It was not until eight days later that the caregiver admitted that she had dropped the woman from a lifting hoist.

It was found that by failing to use the correct hoist the caregiver did not provide a service with reasonable care and skill. In trying unsuccessfully to stand the patient alone to dress her, she failed to follow the policy that such transfers are to be conducted by two staff. She did not comply with relevant standards, in breach of Rights 4(1) and 4(2). When she failed to report the accident, she contravened the policy of her employer relating to accident and incident reporting, and deprived the patient of the chance to have her injuries attended to in a timely manner. As a result, the patient suffered the pain of a fractured arm for four days. These actions amounted to a breach of Rights 4(2) and 4(5).

The caregiver was not the only staff member who failed to follow the facility's policies and procedures. Other care staff moved the woman without a hoist and/or without assistance. Four different nurses failed to adequately assess the woman when told about the bruising. Workload was an issue.

It was found that the failure to follow policies and procedures by so many staff demonstrated a culture of non-compliance, and an environment that did not sufficiently support and assist staff to do what was required of them. The rest home failed to provide services with reasonable care and skill and therefore breached Right 4(1).

The caregiver was referred to the Director of Proceedings, who issued proceedings before the Human Rights Review Tribunal. The matter proceeded by way of an agreed summary of facts in which the caregiver admitted a number of key failings on her part. The Tribunal made a declaration that the caregiver's actions were in breach of Rights 4(1), 4(2), and 4(5).

Link to Human Rights Review Tribunal decision:
http://www.nzlii.org/nz/cases/NZHRRT/2009/1.html