Aged Care Provider / Private Hospital

Report on Opinion - Case 97HDC6764

Complaint

A consumer's family complained on 26 May 1997 to the mental health care team at a public Hospital about the care the consumer received while a resident at an Aged Care Facility.

The complaint was forwarded to the Commissioner on 17 June 1997 by the local Regional Health Authority's Manager of Services for Older People. The details of the complaint were as follows:

- *The consumer suffered bruising and other injuries as a result of rough handling and falls.*
- *The consumer was twice strapped into a commode and left unattended.*
- *The consumer was showered at least three times while wearing her hearing aid which twice caused damage to her hearing aid and on the third occasion caused the hearing aid to be ruined.*
- *The consumer was not toileted regularly and had "accidents".*

Investigation

The Commissioner received the complaint on 18 June 1997 and an investigation was commenced. Information was obtained from the following people:

The Consumer's Daughter
The Consumer's daughter-in-law
A Representative, local Regional Licensing Office
The Clinical Manager, The Aged Care Facility / Provider
The Relieving Manager for the Provider's Licensee, Aged Persons Division
The Manager, Aged Care Facility / Private Hospital
The Manager, Services for Older People, local Regional Health Authority

Medical records for the consumer's stay at the Aged Care Facility were obtained and viewed by the Commissioner.

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Background

The Aged Care Facility is part of a private licensed hospital with exempted beds for the elderly.

The consumer was admitted to the Aged Care Facility ("the Provider") in mid-January 1997, at which time her admission assessment was completed by the provider's Clinical Manager. The consumer was suffering from senile dementia of Lewy Body type. The Commissioner was advised by the consumer's daughter-in-law that when the consumer was first at the Facility, the consumer's husband would ring their family and "tell them how bad things were". When the family visited the consumer at the Facility themselves, they were particularly concerned by the grade of care given to the consumer which they felt was unacceptable. The consumer was discharged into the care of her husband in mid-April 1997. The consumer is now a resident at a Rest Home.

A letter of complaint dated 26 May 1997 was signed by four members of the consumer's family and sent to the Manager of Elder Care Services at the local public Hospital. After a telephone discussion with the consumer's daughter and daughter-in-law, the Manager forwarded this letter to the Manager of Services for Older People at the local office of the Regional Health Authority. In addition to the complaints regarding the services provided for the consumer by the provider, the consumer's family disputed the account which they received for those services.

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Background, ***continued***

In a letter to the consumer's son dated 27 June 1997, the provider's Site Manager responded to the family's complaint. Approximately one week to ten days later the consumer's daughter made telephone contact with the provider's Manager following up on his letter to the family. The Relieving Manager of the Licensee's Aged Persons' Division advised the Commissioner that the provider's Manager and the consumer's daughter "had a long, frank discussion and … [the provider's Manager] felt the issues were dealt with satisfactorily. [He] believed that they went as far as they could in concluding the conversation in an amicable way." The consumer's daughter advised the Commissioner that although she had spoken to the provider's Manager and resolved the issue regarding payment for services the consumer received from the provider, the family was still unhappy with answers relating to their other concerns. The family remained concerned to ensure that the level of care provided to residents by the provider was improved and they sought an apology from the provider.

Outcome of Investigation

Injuries sustained by the consumer

The consumer sustained injuries including bruising and skin scraped off between her fingers, skinned knees and a bruise to her hip. The consumer's family stated in their letter of complaint that the bruise to her hip was "as big as a dinner plate". They also stated that the injuries suffered "left her very frightened."

The provider's Manager advised the Commissioner that the consumer had two falls while she was a resident at the Aged Care Facility.

The records held by provider record that the first fall occurred in early March 1997. An incident report was completed by staff and signed by the provider's Clinical Manager. The report states that *"[the consumer] was found in the doorway of room No 7 after falling. [The] Clinical Manager… was notified. [The consumer] was found to have multiple skin tears to right arm and hand and knee and cut to her left eye (top). Skin tears were dressed with Mepore and her eye has been left open".*

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Outcome of Investigation, *continued*

The care worker's report for the provider on the date of the consumer's first fall, with an entry noted at 1:00pm, states that *"resident was found lying on floor outside Rm 7 at approx 1000 hours. Resident had slipped over inside Rm 7 - as there were bloodstains on lino. Resident sustained skin tears to (L) forehead area, (R) wrist, (R) knee. Resident is favouring her (R) arm and wrist – possibly when she fell the force of the fall was taken with (R) palm of hand."*

The care worker's report for 2 days after this incident noted that *"resident is very drowsy and disorientated this morning. Observed also was resident walking into closed doors - appeared not able to see obstacles - such as chairs, table and not able to walk reasonably straight to avoid above. Checked medications was commenced on Digesic T.D.S on [2 days prior]... Doctor notified of situation"*.

The provider's Manager advised in response to the complaint that the Aged Care Facility's general practitioner requested an X-ray for the consumer because as is often the case with residents suffering from senile dementia, the consumer would not express herself and both the GP and the Clinical Manager were unsure as to whether she was in any pain. The Commissioner was also advised by the provider's Manager that ice packs were applied to the consumer's wrist followed by application of a supportive bandage. There is no mention of this treatment in the incident report or the daily care-workers' reports.

The second fall which gave rise to this complaint occurred in mid-April 1997, when another resident pulled the consumer over onto the floor. The provider's Manager stated in his letter to the consumer's son dated 27 June 1997 that no injuries resulted from this fall. However, the incident report signed by the Clinical Manager on the day of the second fall states: *"[the consumer] pulled over by another resident @ 1500 hours and has sustained a skin tear to (R) hand and graze to (L) knee"*. The care worker's report for that day states that *"[the consumer] was pulled over by [another resident] this afternoon @ 1500 hours and has a skin tear on (R) hand and graze to (L) knee. There may appear more bruises as time goes on"*.

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Outcome of Investigation, ***continued***

The provider's Manager stated in his letter to the consumer's son dated 27 June 1997, that "*apart from the injuries as a result of the first fall I could find no evidence of rough handling. The large bruise mentioned in your letter was not sighted by our staff who have an obligation to report such incidents*".

The Commissioner was also advised by the provider's Clinical Manager in her letter dated 18 November 1997 that *"unfortunately resident contact and falls do occur in the Dementia Unit, no matter how safe the environment we try to ensure for all the residents"*.

There is no further evidence in the consumer's clinical notes that she suffered any other injuries or bruises.

Use of restraint while using a commode chair

The consumer's family complained that the consumer being strapped into a commode was "inhumane" and that she was left unattended so long that *"she was fighting to get out and there was no-one there."* The letter dated 26 May 1997 goes on to state that *"the next time when our father arrived, he could not find her, she was in someone else's room tied in a commode and left and none of the staff knew anything about it"*.

In the Manager's letter to the family dated 27 June 1997, he notes that the use of a restraint within the Facility is contrary to policy and says *"..I would hope fervently that restraint has not been used in this case. However we seek you[r] guidance as to when this restraint occurred as we consider it a serious issue that we will continue to investigate if you can help us with further information"*.

In a letter to the Commissioner from the Clinical Manager dated 18 November 1997, the Commissioner was advised that restraint of the consumer did occur on two occasions *"without informed consent of the family"*. The Commissioner was advised that *"the policy on restraints at the [Facility] is quite specific. At no time is a resident to be restrained whether with medication, belts, bedrails, tables and cot-sides without prior consultation with the family, medical practitioner and the Clinical Manager."*

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Outcome of Investigation, ***continued***

The Commissioner was advised that this aspect of the complaint had been followed up with an internal investigation by the provider's management into why the restraint was used and by whom. The two staff members concerned had reviewed the restraint policy with the Clinical Manager and alternative ways of handling the consumer's difficult toileting behaviour had been discussed.

The Clinical Manager also advised the Commissioner that *"going to the toilet was very stressful for [the consumer] and she would not sit on the toilet for long enough to allow action to take place, and would get up during a bowel motion and make a mess everywhere or would still be urinating"*.

While management at the Facility have acknowledged that restraint of the consumer did occur, there is no record in the clinical notes of when this happened, and the consumer's family have not provided the Commissioner or provider with the dates on which they observed or became aware of these incidents. There is also no record of the discussions held with the staff members concerned.

Damage to hearing aid

The consumer wore a hearing aid. Her family complained that she was showered by staff at the Facility while wearing this and on two occasions the hearing aid was damaged and had to be fixed. The third time this happened the hearing aid was ruined and the consumer's family estimated that it would cost $780 to replace it.

The Commissioner was advised by the provider's Clinical Manager in her letter dated 18 November 1997 that at no time did the family complain to her regarding the hearing aid being lost or damaged. The Clinical Manager advised that she frequently checked the hearing aid to make sure it was in working condition, and that after the consumer was showered in the mornings it was fitted into her ear. The initial assessment carried out in late January 1997 states that it was necessary to *"put hearing aid in after showering in a.m. Wears hearing aid, to be removed in evening and kept in medication room"*. However, this instruction does not appear to have been referred to in the consumer's nursing plan or care plan. The consumer's nursing care plan, which all staff were required to read, specifically states under the heading "what you can do to help", to *"ensure hearing aid is in correctly and battery is operating. Anticipate needs"*.

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Outcome of Investigation, *continued*

The Clinical Manager advised the Commissioner that *"on a number of occasions [the consumer] did remove the hearing aid and we would become aware, quite quickly, that this was so due to her behaviour and when communicating with her she showed frustration and anxiety - not hearing us. We always managed to find the hearing aid - either in her room or on a chair or in a pocket."*

There are no entries in the consumer's clinical notes regarding her hearing aid, other than those noted on her assessment and care plan.

Toileting

The consumer's family complained that *"she was not taken to the toilet regularly and so had accidents"*. The complaint does not provide any more specific details. The clinical notes do not record any accidents.

It was noted on the consumer's initial admission assessment form completed in mid-January 1997 that she was dependent with respect to toileting. The Commissioner was advised by the Clinical Manager that on the consumer's first admission a continence assessment was not carried out, as there was not sufficient time, but that on readmission a continence assessment was carried out for the consumer to try to ascertain the most appropriate times to toilet her. Specific times for toileting were set. The assessment notes that despite regular toileting, the consumer was still incontinent at times.

On the consumer's care plan dated mid-February 1997 and signed by the Clinical Manager, entries for the consumer to be toileted are noted at 9:00am, 11:00am, 1:00pm, 4:00pm, 7:00pm and 9:00pm. Attached to the care plan is a chart for staff reference and under the heading *"what you can do to help"* is the entry *"2-3 hourly toileting. Initiate and assist to complete task"*. Under the same heading is a note to *"maintain dignity"*. A nursing care plan was also prepared. This plan states under the nursing diagnosis heading of *"Potential for altered bladder/bowel elimination"* that the objective was to *"maintain bowel/bladder habits"*.

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Outcome of Investigation, ***continued***

Included in the nursing care plan under the heading *"Nursing Intervention"* to achieve the stated objective is the entry *"continence assessment, schedule toileting programme: one staff to assist and cue client to toileting, to wash client after periods of incontinence"*. The care plan also refers to toileting under the heading of what could be done to help the consumer sleep.

In his letter to the family dated 27 June 1997, the provider's Manager advised that:

"The consumer was toileted as often as was possible or practical. In such a short time of admission particularly in the early days of residency incontinence issues do occur, as staff need time to become aware of residents' toileting patterns. We endeavour at all times to meet the dignity and privacy requirements of this part of the resident's life, but from time to time we cannot be in the right place at the right time to prevent such accidents."

Further, the Commissioner was advised by the Clinical Manager in a letter dated 18 November 1997 that *"[e]ven with the scheduled times there were the occasional accidents, but for 99% of the time we were successful. One staff always attended to the toileting as [the consumer] did not initiate this activity. During the night, we toileted [the consumer] at 12 midnight and 5am – even with this [the consumer] often got out of bed and was incontinent. We proceeded to use Tena disposable pads at nighttime to keep her dry. Also, it enabled her to sleep undisturbed longer and more comfortably."*

The Commissioner was further advised by the Clinical Manager that *"we believe that [the consumer] was treated with care, dignity and respect at all times while she was a resident at [the Aged Care Facility]. We continued to assess [the consumer] and on those assessments put in place [a] personalised care plan to appropriately give her quality of life and manage her Dementia.*

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Code of Health and Disability Services Consumers' Rights

RIGHT 3
Right to Dignity and Independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

RIGHT 4
Right to Services of an Appropriate Standard

…

2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*
3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*

Opinion: No Breach

In my opinion the provider did not breach Rights 3, 4(2) and 4(3) of the Code of Rights in respect of the consumer's two falls, damage to her hearing aid and her toileting regime.

Injuries

I am satisfied on the basis of the incident forms and evidence presented to me that the consumer's two falls were accidental. The notes with respect to the consumer's falls are very thorough and I am satisfied that on the two occasions when she fell, all proper steps were taken to ensure that her care needs were met and her pain was minimised. She was given pain relief, seen by the resident general practitioner and x-rays were arranged. I am also satisfied that the completion of incident forms and follow-up procedures (including repeated attempts to contact the consumer's son to notify him of the consumer's first fall) were appropriately observed. There is insufficient evidence to support a claim that the consumer was at any time handled roughly by the provider's staff.

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Opinion: No Breach, ***continued***

Hearing Aid

There is insufficient evidence to indicate that the consumer was showered while wearing her hearing aid and that this caused damage to the hearing aid or caused it to be ruined. However the consumer's care plans do not clearly record the procedure to be followed by staff in respect of the consumer's showering regime and the care and use of her hearing aid. I would highlight the importance of including all important requirements on residents' nursing plans and of all the provider's staff being made aware of the requirements particular to each patient in their care.

Toileting

I am also satisfied that the toileting regime implemented for the consumer was appropriate in the circumstances and was properly and fully detailed in her notes. I note that the care plans recorded for the consumer acknowledged and sought to maintain her right to dignity and independence, and were specifically designed to meet her needs in relation to an aspect of her daily life which she found stressful and difficult.

Therefore, in my opinion, insofar as these three aspects of the complaint are concerned, the consumer was provided with services which complied with relevant standards and which were provided in a manner consistent with the consumer's needs. Further, her right to dignity and independence was observed.

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Report on Opinion - Case 97HDC6764, continued

Opinion: Breach

In my opinion on the two occasions when the consumer was restrained in a commode the provider breached Right 3 and Right 4(2) of the Code of Rights as follows:

Right 3

The consumer was entitled to be treated in a manner that respected her dignity and independence. Given the consumer's dementia and hearing difficulties and her consequent dependence upon those caring for her on a daily basis, extra caution should have been taken by staff and management at the Facility to ensure that her dignity was maintained as far as possible in all the circumstances. In my opinion, restraining the consumer on a commode and leaving her unattended demonstrated a disregard for her personal dignity and was a breach of Right 3 of the Code of Rights.

Right 4(2)

The provider's Clinical Manager acknowledged that the consumer was strapped to a commode on two occasions without the consent of the consumer's family, and that this practice was in breach of the provider's policy.

The consumer found toileting stressful and in my opinion the restraint caused additional and unnecessary stress, not only to the consumer, but also to her family who witnessed these incidents. It is unacceptable that these incidents involving the commode occurred despite the implementation of a clear and precise toileting regime specific to the consumer, in conjunction with a wider policy on the restraint of patients.

While an internal investigation involving the staff responsible for this incident was undertaken, the details of the investigation, including the name of the persons responsible, was not able to be produced for review. I can only assume it was not documented. I accept that the policy was reviewed as an outcome, however, it is the practice that is at issue, not the policy. No evidence was provided that lessons were learnt from the incident to ensure that it cannot re-occur.

Accordingly I have formed the opinion that Right 4(2) of the Code was breached, as the service provided to the consumer failed to meet the relevant standards set by the provider.

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Report on Opinion - Case 97HDC6764, continued

Additional Comments

Right 10 - Right to complain

The manner in which the consumer's family's complaint was dealt with by the provider's management did not in itself give rise to a complaint. However, on the basis of the information provided to me it is clear that although the provider's management and the Licensee's staff took the complaint seriously and undertook an internal investigation, the complaint was not dealt with in the manner required by Right 10 of the Code of Rights.

For example, I note that within two days of receipt of the family's complaint letter, the Licensee's Manager contacted both the consumer's daughter-in-law and daughter by telephone and, as a result of their discussions, forwarded the letter of complaint to the local office of the Regional Health Authority. However, the family did not receive a response to their complaint from the provider's management until the Manager wrote to them one month later, on 27 June 1997.

Following receipt of that letter, the consumer's daughter contacted the provider's Manager by telephone to discuss matters. While the provider's Manager believed that all issues had been dealt with satisfactorily, from the consumer's daughter's point of view the family remained dissatisfied with the Manager's responses in respect of the services provided. On balance, it is my view that at this stage the complaint had not been resolved and it was incumbent upon both the provider's management and the Licensee to continue to pursue matters to a satisfactory conclusion which addressed all of the family's concerns and which kept the family informed of the progress of the internal investigation.

In this regard, I note that Right 10(6) of the Code of Rights requires every provider, unless an employee of a provider, to have a complaints procedure in place which ensures that a complaint is acknowledged in writing within five working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period. I also note that the consumer must be kept informed of any relevant internal and external complaints procedures. I am not satisfied that such steps were taken by either by the provider or the Licensee when dealing with this complaint.

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Report on Opinion - Case 97HDC6764, continued

Vicarious Liability

Given that the particular staff members responsible for the incident involving the commode have not been identified and are not identifiable, I have decided that liability for the breach of the Code of Rights rests with the provider's management and the Licensee, in accordance with section 72 of the Health and Disability Commissioner Act 1994. Accordingly my recommendations are directed to the provider's Manager and Clinical Manager, and the management of the regional office of the Licensee.

Actions

My recommendations are as follows:

- The provider's Manager and the Licensee are to apologise in writing to the consumer's family acknowledging the inappropriateness of restraining the consumer. These apologies are to be sent to the Commissioner who will forward them to the family.
- The provider's Manager is to ensure that all staff are regularly updated and/or trained in respect of procedures for toileting residents and the specific policy of non-restraint for residents. Further, the importance of proper, detailed record keeping by staff and management in rest homes must be emphasised to all staff in the course of their training. Staff training and reviews are to include providing each member of staff with a copy of the Code of Health and Disability Services Consumers' Rights and ensuring that each staff member reads this and is aware of their responsibilities under the Code.
- Management must ensure full incident reports are completed on all investigations where policy is not complied with. Documentation is essential to ensuring quality improves and staff performance addressed.
- Management must transfer all key elements of an assessment onto the individual's care plan to ensure the summary utilised by carers is correct.
- Regular reviews of care-plans and individual charts should be completed. In particular toilet charts should be kept up to date.

The provider, in conjunction with the Licensee, is to review their complaints procedures to ensure that they comply with the Code of Rights. A copy of the complaints procedure is to be provided to the Commissioner within three weeks of receipt of this opinion.

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Other Actions A copy of this opinion will be forwarded to the Ministry of Health and the Health Funding Authority. A copy of this opinion, with all identifying features removed, will be provided to the regional office of the Licensee for distribution to all facilities for the elderly which they manage, with the instruction that all staff and managers must read it.