Rest Home

Report on Opinion - Case 97HDC6494

Complaint

The Commissioner received a complaint about treatment the complainant's mother, ("the consumer"), received from the provider, a rest home. The complaint is that:

- When admitted to a new rest home the complainant noticed:
    - When combing the consumer's hair it was falling out due to being dirty
    - The consumer had a fungal infection on her skin
    - The consumer had sores on feet which they now know are ulcers
- The complainant has also observed that the consumer is now being bathed once a day whereas at the provider rest home they would only bath her once a week saying that she was too difficult.
- One of the nurses observed when they took the consumer to the toilet that she was slapping herself, cowering, and telling herself to hurry up.
- The provider rest home would not let the consumer eat in the dining room. She is now eating in the dining room and the complainant says the consumer is extremely hungry.
- The complainant also recalled that she asked the provider rest home to look at the consumer's cold water tap as the pipe was in the sun and the water was sometimes as hot as the hot tap, but no one ever looked at it.
- The staff often left her without a drink and when the complainant got her one she gulped it down. She seemed dehydrated.
- The complainant also requested a security lock be put on the window and this was never done.

Investigation

The Commissioner received the complaint on 9 June 1997 and an investigation was undertaken. Information was obtained from:

The Complainant
The Manager, Provider rest home
The Principal nurse, the Provider rest home
The Manager, the consumer's new rest home

Resident records and nursing notes were requested and viewed.
An investigation officer visited the provider rest home.

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Details of Investigation

In early October 1993, the consumer, an 84-year-old lady, was transferred from hospital to the provider rest home. The provider home is a 58 bed, stage 2 residence, which opened in 1993. The home has no secure dementia unit.

In October 1993, the consumer's transfer summary from hospital records the consumer's mental state as very confused and that she was "a lovely lady who becomes disoriented easily *Can become aggressive when she is confused and upset. Does not like showers, but washes well in a bowl. Independent with washing, dressing and toileting. Gets the 'munchies' at times; she then enjoys a sandwich. It may take [her] a week or two to settle in, if she is able to do what she likes she will settle in quicker."*

On discharge from hospital, the consumer's SNL level was assessed as between level 2-3.

During the investigation, The provider manager said that at the provider rest home the consumer was a challenging resident who was gentle and loving toward staff when her self cares were completed but physically and verbally abusive towards staff and other residents when faced with something she did not like.

During the investigation, the provider manager said the consumer's condition deteriorated from about March 1997. In mid-March 1997, the resident notes at the home record that the consumer was finding life difficult and that she became irritated very quickly. Instructions were noted for staff not to confront or challenge the consumer and to report incidents.

By May 1997, there were many recorded complaints from staff and other residents about the consumer's behaviour. In mid-May 1997, one complaint concerned the consumer going into another resident's room, touching things and refusing to leave. This behaviour was repeated on the following day and prompted a request to the CARE team to reassess the consumer's condition.

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Details of Investigation, *continued*

In late May 1997, the consumer was reassessed as SNL level 4 by a community health nurse for the Crown Health Enterprise. The community Health Nurse recorded that the consumer had behaviour which fluctuated from being pleasant to very stroppy. These behaviours were worse in the late afternoon and early evening ("Sundowner's syndrome") and the health nurse recommended a small dose of Haloperidol for those times. The health nurse recommended that the consumer be transferred to a rest home with a secure dementia unit.

The provider manager asked the consumer's family to find another place for the consumer, as the home could no longer provide for the consumer's developing dementia.

During the investigation, the provider manager said that the provider home now has a policy to obtain an undertaking from prospective residents that if there are unacceptable social behaviours due to dementia that impacts upon other residents, then that person will have to leave. This policy has been a developing one since the provider home was formed in 1993.

During the investigation, the provider manager said most residents are lucid and regard the facility as their home. The principal nurse said that the consumer's dementia developed to the point where her behaviour conflicted with the needs of other residents. The principal nurse said the provider home does not have a problem working with difficult residents but in the consumer's case they had exhausted their solutions.

In the first week of June 1997, the consumer's daughter transferred her mother to a new rest home. This new home is a Stage 2 rest home with a secure dementia unit.

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Details of Investigation, *continued*

The consumer's hair was washed weekly in the bath and set every alternate week by the hairdresser, who said the consumer did not have any abnormal hair loss. The hairdresser stated that from about March 1997, following a perm, the consumer became more difficult to handle and refused to come to the salon, sometimes threatening to knock her head off with her walking stick.

From March 1997, as the consumer was uncooperative in the hair salon, the consumer had her hair washed on a weekly basis in the bath. Two enrolled nurses informed the Commissioner that they washed the consumer's hair at least once a week in the bath. One nurse said she did not notice any abnormal hair loss. Both caregivers describe difficulties in washing the consumer's hair due to the consumer's behaviour.

In the first week of April 1997 the care plan records that the consumer had her hair washed in the bath on alternate weeks or when considered necessary by caregivers.

The principal nurse at the provider home stated that at times the consumer was noted to have red moist areas in her groin and under her breasts and these areas were treated with pevaryl powder and gauze squares when they were found.

The consumer had a daily foot soak in her room. In late February 1997 the nursing care plan records that the consumer had a large corn on the ball of both feet which needed podiatry care. The podiatrist came about once every 4-6 weeks. During the investigation the provider manager said that they were dissatisfied with the standard of care provided by the original podiatrist and changed podiatrists and have a new podiatrist coming every 4-6 weeks and they are happy with his standard.

During the investigation the principal nurse said that the consumer's feet were deformed with Paget's disease which caused her toes to rub on top of each other and ulcers developed on the pressure points. The principal nurse said that at the provider home the consumer had a habit of stuffing her shoes with toilet paper, which caused rubbing on her heel. There was a developing area on the consumer's heel when she left the provider home.

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Details of investigation, *continued*

The discharge notes from hospital record that the consumer did not like to be showered.

In late February 1997, the consumer's care plan notes record she was to be bathed twice weekly in the spa bath with a supervised daily wash in her en suite on non bathing days. It is recorded that two people would be required for the task, as the consumer could become aggressive. During the investigation, the provider's principal nurse said that the consumer was very difficult and would lash out and pinch at those trying to undress her although she calmed down when in the bath.

In the first week of April 1997, the consumer's resident evaluation record states, *"[she] now needs to be bathed twice weekly."*

As part of the investigation, the consumer's resident notes were viewed and it was clear that in some areas the notes had been amended. The reference to bathing has been changed from once weekly to twice weekly, supervision regarding washing in the en suite, and teeth cleaning twice daily have been added to the patient notes. There is no date or signature as to when these amendments were added or by whom. During the investigation, the principal nurse said that it is a junior nurse who writes the plan which is checked by the provider's principal nurse who then makes amendments. The provider's principal nurse stated categorically that these changes were not made in response to the complainant's complaint. This was confirmed by the provider manager who advised that such amendments reflect responsible supervision of staff and close attention to the care of residents.

The transfer summary from hospital records that the consumer gets the 'munchies' at times and then enjoys a sandwich. During the investigation the principal nurse said that the consumer would hoard food in her room and would go into the kitchen on occasions for food and regularly ate outside hours in the dining room.

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Details of Investigation, *continued*

From sometime in March 1997 until her transfer to the new home, the consumer did not eat in the dining room with the other residents. The principal nurse said that this decision was made as a solution to the consumer's increasing interference with the other residents. The nurse said the other residents refused to eat at the same table as her and showed increasing intolerance of the consumer's behaviour.

The notes record examples of the consumer's behaviour:

- […] January 1997, *"[the consumer] chased me with her walking stick while taking her lunch tray"*
- […] March 1997 *"[the consumer] kept coming down to the dining room and sitting at table five. Tried to hit myself and [another person] with her walking stick".*

The principal nurse said that as a solution, the consumer was given her main meal on a tray in the A Wing lounge where she could see the caregivers and the caregivers could see her. If there was entertainment on in the lounge the consumer was included.

The cold water pipes are installed under the roof. During the investigation, the provider manager said that on a very hot day if the roof warms the cold water can become quite warm but not as hot as the hot water. The provider manager agrees it is too hot to drink and on those days they take cold drinks to the residents in their rooms. The provider manager said they have recognised this as a problem and leave a jug of cold water and a glass in residents' rooms.

During the investigation, the provider manager said she agreed that putting a lock on the window would be a good precautionary measure and that they have tried to do this. The windows are narrow aluminium and as one option resulted in a cracked window and another in damage to the window frame they are now exploring other options.

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Details of Investigation, *continued*

The consumer's new rest home

The manager of the consumer's new rest home records that on admission the consumer looked *"very unkempt with a fungal infection on the skin, ulcers on both feet, hair matted together and falling out when combed."*

In the first week of June 1997, the manager of the new home examined the consumer and recorded, *"general poor hygiene. Plan: needs general cleanup."* It was noted that the examination was limited by the consumer's co-operation.

In June 1997 the admission notes at the consumer's new home do not record any skin infection. In the first week of June 1997 the manager recorded that the consumer needed a general cleanup but there is no specific reference to a skin infection. The manager of the rest home reports a skin infection but no specific site.

The consumer was reported to be extremely hungry on admission to the new home. The manager recorded the consumer's weight as 35 kg. I am informed that at the new home the consumer has been eating in the dining room since admission and displays socially acceptable manners. Since her admission the consumer has put on a further 5 kilograms.

On admission to the new home the manager recorded that *"[the consumer] had a total of five ulcers on her feet. Some were quite deep and sloughy. These ulcers had been present prior to discharge from [the provider home] however did not appear on her transfer letter."*

The manager of the consumer's new home reported that since admission, the consumer has not required her walking stick and is fully mobile.

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Code of Health and Disability Services Consumers' Rights

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

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.

Provider Compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.
2) The onus is on the provider to prove that it took reasonable actions.
3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Opinion: Breach

In my opinion there has been a breach of Right 4(2) and Right 4(3) of the Code of Health and Disability Services Consumers' Rights.

The standards of adequacy of care with respect to residents of rest homes are laid out in the "Standards for Care for Old People's Home Guidelines." Standard 4 of the guidelines states *"that the licensee or resident manger should ensure there is a staff plan for a good standard of personal care and cleanliness for residents. The bare minimum is at least one bath or shower a week, wash hair at least once a week and more often if required."* While the provider home met these minimum requirements regarding the consumer's personal care, the decision to reassess her needs was not taken early enough, resulting in an overall deterioration in her health.

For 3 months from March 1997 until May 1997, the consumer's dementia and associated behaviours deteriorated and the provider home staff found it increasingly difficult to handle her basic daily needs. The consumer was difficult to deal with when she was confronted with something she did not want to do such as bathing and hair washing.

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Opinion: Breach *continued*

The provider home caters for persons with a high level of independence and the consumer's increasing dementia and associated behaviours brought her into conflict with other residents. This resulted in the consumer eating her meals away from the main lounge and provided a solution to the immediate problem, although not an ideal one.

The problems with the consumer's interaction with other residents reached a head by mid-May 1997 and prompted a reassessment of the consumer as SNL 4 one week before her transfer to her new home. The decision to transfer the consumer to a rest home with a different mix of residents and a secure dementia unit was necessary.

The consumer arrived at her new home with general poor hygiene and in poor physical condition. The consumer's condition on transfer indicates that prior to her transfer the consumer was not being provided with care that was consistent with her needs. While the provider home's staff have acknowledged they were not equipped to care for the consumer, this does not remove the responsibility of the provider home to ensure that the consumer was provided with the service she needed. Once it was confirmed that the consumer's SNL level had increased and she required level 4 care, the provider home had an obligation to ensure that she received this care.

In a situation like this a transfer to an appropriate rest home must occur as quickly as possible after the resident's needs alter and before any deterioration in a resident's physical condition.

In my opinion, the provider home had an obligation to ensure the consumer was provided with care which was consistent with her needs. This did not occur and resulted in the poor condition in which she was transferred.

Further, the provider home had an obligation to seek an assessment much earlier. It was inappropriate for both the consumer and the other residents to wait 3 months, causing disruption to daily routines and isolation for the consumer.

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Actions

I recommend that the provider rest home takes the following actions:

1. Provides a written apology to the complainant for their failure to provide services consistent with the consumer's needs resulting in her poor condition on transfer. A copy will be retained on file.
2. Refunds the cost of the consumer's contribution to her last week of care. This is to be sent to my office with the letter of apology and will be forwarded to the complainant.
3. Familiarises all staff with the Code of Health and Disability Services Consumers' Rights and confirms to the Commissioner that this is done.
4. Ensures that in future any amendments to a resident's care plans and other documentation are signed and dated indicating who made the amendment and when.
5. Reviews care plans when residents are reassessed as requiring a higher level of support.
6. Establish and implements a policy for reassessing residents' needs levels when behavioural changes occur to ensure residents always receive appropriate care.

A copy of this opinion will be sent to the Regional Licensing Office and the Health Funding Authority for their information.