Caregiver, Ms B

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 05HDC05218)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Ms B	Provider/Caregiver
Mrs C	Provider's mother
Mr C	Provider's father
Dr D	Quality and Risk Facilitator and Director of Nursing, a District Health Board

Complaint

On 12 April 2005 the Commissioner received a complaint from Ms A about the services provided by caregiver Ms B. The following issues were identified for investigation as follows:

- *The appropriateness of Ms B's actions when providing care support to Ms A between 2002 and 2004. In particular, whether Ms B complied with relevant professional, legal and ethical standards regarding:*

  — *caregiver/client boundaries*
  — *Ministry of Health funding for care support*
  — *financial dealings with Ms A.*

An investigation was commenced on 8 June 2005.

Information reviewed

Information was received from:

— Ms A
— Ms B
— Mrs C, Ms B's mother
— Mr C, Ms B's father
— Dr D, Quality and Risk Facilitator, a District Health Board
— Quality and Safety, a second District Health Board
— The Unit Manager, a Mental Health Unit

Financial statements from a bank and finance company were supplied by Ms A.

Summary

This complaint raises important issues in relation to the setting of boundaries in a caregiver/client relationship. It is about a caregiver who provided residential care support to a mental health services consumer. The caregiver allowed an inappropriate relationship to develop with her client, and unwisely entered into a financial agreement in relation to a motor vehicle. She also failed to account properly for the services she provided, which raised doubts about the validity of financial transactions with her client, and of a payment by the Ministry of Health of $645.00 for carer support services. For the reasons set out below, I have formed the opinion that the caregiver's actions were in breach of the Code of Health and Disability Services Consumers' Rights.

Information gathered during investigation

Ms A
Ms A is a registered nurse who works for a residential care facility as a Quality and Risk Manager. She suffers ongoing mental health problems and has from time to time required periodic support from a respite care service.

Ms A recalled events in January 2004: "I was hypomanic and mental health services were providing a lot of respite care, where one of their employees came to my house to care for me. [Ms B] was a regular carer of mine and I felt I had gotten to know her well." Ms A complained that Ms B took advantage of their relationship and exploited the situation for financial advantage.

A District Health Board
The District Health Board ("the DHB") Director of Nursing, Dr D, stated that the DHB provides a home-based or residential caregiver service as an option for mental health clients who would otherwise require admission to acute inpatient services. A range of service options is available to the eligible person and his/her caregivers, which includes the provision of staff with appropriate skills to supervise the person in either his or her home, supervised accommodation or a dedicated respite facility.

Health care assistant staff sign a job description when joining the respite care service, and an information document is provided to all staff who undertake respite care duties.

Dr D provided copies of the DHB's "Health Care Assistant [the respite care service]" job description, issued January 2004 (attached as Appendix 1); "Information for Staff Caring for Mental Health Clients in a Respite Setting" issued August 2003 (attached as Appendix 2); and "Adult Respite Services, Service Type Description for Adult Crisis Respite", issued February 2001 (attached as Appendix 3).

The Board's document "Information for Staff Caring for Mental Health Clients in a Respite Setting" under the heading "Maintaining your boundaries" states:

" • During these placements it is quite normal to develop a bond with the client, but please do not give them your phone number or any personal details. …

- It is also unwise to borrow or lend personal possessions.

- Do not, under any circumstances, be involved with a client's finances."

Dr D stated that the DHB offers care support in acute respite situations only. Dr D, when asked about the guidelines and job description in place in May 2003 when Ms B was engaged, advised that although the documents she supplied were dated after Ms B was engaged, they are "much the same" as the documents available in May 2003. (The 2003 documentation has been archived and has not been provided.) Dr D stated that Ms B "was well aware, whatever she says, of her responsibilities as a carer".

Ms B

Ms B commenced employment with the DHB as a Health Care Assistant with the respite care service in May 2003. During the period complained about, 2003 to 2004, Ms B was frequently assigned to provide respite support care to Ms A at her home and at a residential care facility.

The role of the Health Care Assistant – respite care service is to support clients by ensuring that they have enough rest and food and that they take their medications. The carer is required to check on the client regularly, particularly if self-harm is suspected. Respite carers receive two days of training, and learn skills relating to defusing situations and managing difficult behaviours. Supervision and monitoring of respite care is the responsibility of the client case manager and/or the Crisis Team.

There is discrepancy in the circumstances of Ms B becoming Ms A's respite support person. Ms B states that she knew Ms A socially from early 2002. However, Ms A states that she met Ms B for the first time when she became her respite carer, and did not know Ms B prior to that time.

Ms B stated that Ms A approached her in early August 2003, and said that she was entitled to ten days' care, which could involve a friend to support her in times of stress. Ms A suggested that Ms B should nominate herself as Ms A's support person. Ms A told Ms B that she would contact her when she required support. Ms B stated: "[A]s I had no knowledge of what care [or] support entailed, I trusted … her explanation for the need of her cares and support."

In response to the provisional opinion, Ms A stated that it is incorrect that she was allocated ten days' carer support in August 2003. She said that that allocation was not made until later.

Ms B stated that there were times when Ms A became stressed and was unable to receive the respite care she required because she had used her allocation of respite days or there were no respite care service staff available. On these occasions Ms A would contact Ms B, who would provide the support in her "own time". Ms B stated that Ms A would contact her "at odd times of the night stating how she wanted to take her own life and needed someone to see her and wanted [Ms B] to be with her". Ms B stated that during late 2003, she provided care for Ms A during the evenings and overnight.

Ms B recalled that Ms A "continued to seek support" from her. However, Ms B had "personal issues going on" and told Ms A she was unable to continue to support her.

Motor vehicle

Ms A stated that one of her "hypomanic ideas" when she was unwell at the end of 2003 was to purchase another car, and that although her Corolla was worth about $2,000, "I sold it to [Ms B] for $1,000". Ms A believes Ms B took advantage of her when she was in a vulnerable state, purchased the car for a low price and then failed to pay for it as agreed. Ms A is unsure of the dates when the events occurred, because she was so ill at the time.

Ms B stated that during December 2003 and January 2004 Ms A had financial pressures and "put a lot of pressure on me to help solve her financial problems. This pressure influenced my decision to agree to buy her car."

Mr C, Ms B's father, stated that it was actually he and his wife who agreed to purchase the car, after talking with their daughter. Ms B told her father that Ms A had financial problems and was selling the car for $700. Ms A wanted $200 cash and the remaining $500 to be deposited into an account number that she would provide. Mr C queried the low price and was told that the car needed extensive panel work resulting from an accident. Mr and Mrs C agreed to purchase the car for $700, "to help out with [Ms A's] situation", although Mr C believed the car was probably worth $500". Mr C said that he spent weekends working on the car to repair and replace the damaged panels. Mr C estimated that he spent $1,500 in labour and parts for the car. He had just finished the repairs when the car was repossessed from their home. (Ms B was overseas visiting family from February to May 2004.)

Ms A stated that the first she knew that there was a problem relating to the sale of the car was when she received a letter from a lending agency, some weeks after the sale, to say that she was in arrears on her loan repayments. Ms A had expected Ms B to make payments directly to a lending agency. Ms A said that she spoke to Ms B (who was caring for her at a time-out respite facility) about the missed payments and was reassured by Ms B's response. Ms A said that she heard nothing more from the finance company and assumed that the payments were being made as arranged.

When Ms A was an inpatient at a mental health unit in September 2004 she saw Ms B, who was working there at the time. Ms A spoke to Ms B about the car payments

and Ms B again reassured Ms A telling her that the car was "all paid off". Ms A said that she assumed that this was the case, and it was not until a lawyer for the finance company visited her sister on 1 November 2004, about her outstanding debts, that she realised the payment had not been made.

There is discrepancy in the information provided about the arrangements made between Ms A and Ms B's family regarding the repayments. Mrs C stated that she paid five fortnightly payments of $100.00 into a bank account number given to her by Ms A. Ms A believes that Mr and Mrs C were to make the repayments directly to the lending agency. Whatever the arrangements, there is evidence that Ms A's debt with the lending agency continued until August 2004 when the car was repossessed.

$140.00 deposit

Ms A stated that while she was receiving respite care at a residential care facility her carer was Ms B. Ms A recalls that Ms B "spent a lot of time explaining her desperate financial situation. Although my own situation was dire, I felt pressured and transferred $140.00 into her account." Ms A's bank shows that on 10 February 2004 an internet transfer of $140.00 was made to "[Ms B's bank account]".

Ms B stated: "I acknowledge the transfer of $140.00 into my bank account on February 9th 2004." She confirmed that she was providing respite care to Ms A at this time. Ms B stated that Ms A knew her mobile and home telephone numbers and telephoned to ask her to purchase cigarettes and chocolates on her way to work.

Ms A was at this time preparing policy updates for an aged care facility, and asked Ms B to photocopy material for her for the project. Ms A was unable to do this herself as she was recovering from a broken ankle. She confirmed that Ms B provided her mobile telephone number, but not her home telephone number.

Ms B explained that she was working two jobs at this time to save money to travel overseas to join her husband. She refused to take Ms A's ATM card to withdraw the money Ms A owed her for the purchases and the photocopying. Instead, Ms B gave Ms A her bank account number so that Ms A could deposit the money into Ms B's account. Ms B said that because there was a "high level of trust, I do not bother to document this".

I have seen no evidence that supports Ms B's contention that the $140.00 deposit was reimbursement for goods paid for by Ms B on Ms A's behalf. Ms A states that she gave the $140.00 to Ms B because Ms B was in a dire financial situation.

Respite care payment

The respite care service is available to clients who suffer from chronic mental health issues. The client's case manager assesses the client's need for respite care hours per month, and this allocation is capped, to encourage the client to self-manage.

Ms A stated that while Ms B was providing her respite care Ms B "convinced me to arrange pre-payment of 10 days care support, and then only provided one day of this care despite numerous requests".

After Ms B returned from overseas in May 2004, Ms A contacted her, stating that she needed Ms B to complete the outstanding respite hours. Ms B believed that there was only one more day owing from the ten-day period. Ms A told Ms B that the remaining hours needed to be completed before reimbursement could be made; the claim period was about to expire and, if the hours were not completed, it would affect Ms A's respite support arrangements.

Ms B said that she completed the outstanding hours in June 2004. She stated:

> "I was able to provide this after completing a 3.00pm – 11pm shift while she was in a hotel at […]. I cannot recall the date, but it was early June 2004. …
>
> As this was in my own time, I did not document the exact dates and times."

Ms B stated that after completing the outstanding hours, Ms A gave her the claim form and "without reading the date/time, I signed this and handed it back to [her]". Ms B stated that she received reimbursement for the respite care in late June 2004.

Ms A provided a copy of a letter sent to Ms B by the Ministry of Health, dated 2 November 2004, informing Ms B that on 29 June 2004, $645.00 had been credited to her bank account for a "Recent Carer Support Claim" for the period 22 May 2004 to 1 June 2004. The reference for the claim was HFA number "[…]".

The District Health Board – Complaint by Ms A
Ms A stated that in September 2004, she became "very, very ill" and was admitted to a mental health unit for six months.

On 5 November 2004, while an in-patient at a mental health unit, Ms A informed the unit's Psychiatric Liaison Team about the above events. Her complaint was not formally logged, but the information was passed to the respite care service. The respite care service manager discussed the issues with a senior mental health nurse, and it was agreed that the matter was a personal one and that Ms A should make a complaint to the Police.

In December 2004, the matter came to the attention of Dr D, who agreed that Ms A needed to seek remedies through formal channels, but considered that Ms B had acted inappropriately. Dr D attempted to contact Ms B to discuss the matter. When a telephone message and two letters (dated 24 January and 3 March 2005) requesting an urgent meeting (as part of a formal DHB investigation) were not responded to by Ms B, Dr D advised Ms A to complain to the Health and Disability Commissioner. Dr D instructed the respite care service that Ms B was not to be employed again. Dr D advised:

> "I accept that [the DHB] has responsibility to employ and manage reliable and responsible staff. We aim to do this at all times. On review of the selection process, there was no reason to suspect any of this potential problem and due recruitment process was followed. I have since made sure that all staff, working in [the respite care service] with respite situations, [are] reminded about boundaries and the inappropriateness of asking and receiving money and gifts.
>
> I am sympathetic to the situation [Ms A] finds herself in but don't believe I can do more than I have done. It is not [the DHB's] role to seek reimbursement of the money in the situation where she has taken action but she did so trusting the caregiver. I understand that [Ms A] has received counselling from her support team about what actions she might take once well. I am regretful that one of the staff employed by [the DHB] was unprofessional and allegedly breached the boundary of care worker and 'friend'. This took advantage of [Ms A] at a time when she was vulnerable."

Ms B's response to investigation

Ms B believes that Ms A's motivation in making the complaint is "anger towards myself for not being there for her at times when she has requested my services". Ms B stated that the support she provided to Ms A consisted of evenings and overnight stays. She would talk to Ms A and encourage her to use distractions and other coping skills to deal with her distress. Ms B stated that Ms A "had the capacity to present herself as a colleague and a friend", while being a client, and had "extensive years of knowledge and experiences and familiarity about putting pressure on people".

Ms B disputes Ms A's allegations, but acknowledges that she made errors of judgement. Ms B stated:

> "[U]pon reflection concerning the past decisions, when making judgements by working with the complainant, I understand that I should never [have] had any transactions with her, and I acknowledge it was poor professional judgement on my behalf."

Code of Health and Disability Services Consumers' Rights

The following Right in the Code of Health and Disability Services Consumers' Rights is applicable 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.

Opinion: Breach — Ms B

Under Right 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A had the right to have the health services she received from Ms B provided in accordance with the relevant professional standards. Although Ms B, as a caregiver, does not belong to any professional organisation, she is bound by the standards set out by her employing authority, the District Health Board ("the Board").

The Board requires that its health care assistants who provide mental health respite services "understand and observe professional care boundaries", and it provides staff with information about maintaining boundaries. This includes not divulging their personal details to clients, not borrowing or lending personal possessions, and not becoming involved with their client's finances.

Professional boundaries
Ms B commenced employment as a respite carer with the Board's respite care service in May 2003. The respite care service provides a home-based or residential service as an option for mental health clients who would otherwise require admission to acute inpatient services. Ms B became Ms A's respite carer in early August 2003.

Ms B stated that when Ms A suggested that she nominate herself as a support person, she had "no knowledge of what care [or] support entailed". This is difficult to believe, as Ms B had started working as a respite carer for the Board three months earlier, and the respite care service expects staff to have completed a mandatory training course.

The Board provides guidelines for staff caring for mental health clients in this situation. The Board's August 2003 document "Information for staff caring for mental health clients in a respite setting" states: "During these placements it is quite normal to develop a bond with the client … while you do often give a bit more of yourself to some clients there are still boundaries." The guidelines advise against carers providing personal telephone numbers or other personal details to clients. The Health Care Assistant respite care services Job Description (January 2003) specifies

that the carer "Understands and observes professional care boundaries" and "Does not become over involved with a client", and that the carer "Will request a client change if they feel this is occurring".

The respite care service's Director of Nursing, Dr D, advised that although the job description and guidelines she provided were not in place when Ms B was engaged as a caregiver in May 2003, the documentation supplied to Ms B was "much the same". Dr D stated that Ms B was "well aware" of her responsibilities.

Ms B stated that during the time she was providing respite care to Ms A, she had "gotten to know [Ms A] on a professional and personal basis". At times of stress Ms A would contact her as she needed someone to be with her. Ms B stated that she often supported Ms A in her own time. It is clear that a relationship of friendship developed between Ms B and Ms A. Ms B stated that Ms A had "extensive years of knowledge and experiences and familiarity about putting pressure on people" and therefore placed her in a position in which she felt she was pressured to perform tasks outside her role.

Ms B was engaged to care for Ms A because Ms A was unwell, and it was Ms B's responsibility to maintain a professional relationship. There is no dispute that Ms B gave Ms A her telephone number, and that there was blurring of the client/carer boundaries. In my view, Ms B unwisely became enmeshed in a relationship with her client, whom Ms B also viewed as a colleague and friend. Ms B felt that she was disadvantaged in this situation by Ms A's "extensive" knowledge and experience. However, Ms B had been instructed in her training to be aware of becoming over-involved in a client's life, and to request a change of client if this should occur. Ms B had a responsibility to report her concerns to her supervisor.

By failing to maintain clear client/carer boundaries when providing respite care to Ms A, Ms B did not comply with the relevant standards set out by the Board, and thereby breached Right 4(2) of the Code.

Financial dealings

In January 2004, when Ms A was particularly unwell, she decided to upgrade her car and offered to sell it to Ms B. Ms A had borrowed from a finance company using her car as collateral. Ms B admits that she and her parents entered into an agreement with Ms A to purchase her car at the beginning of 2004. The exact worth of the car, and whether Ms A received the agreed purchase price, is disputed by the parties. The agreement was that Ms B and her family pay Ms A $200 cash, and the remaining sum would be paid in instalments to cover the outstanding debt to the finance company.

Ms A alleges that this money was not paid to her as agreed. Ms B's mother stated that she paid the money owing into a bank account specified by Ms A but the car was repossessed by the finance company in April 2004. (Ms B left New Zealand shortly after Ms A transferred ownership of the car, and did not return until May 2004.) Ms A stated that she received notification from the finance company in the early part of 2004 that she was in arrears, and raised this with Ms B, who assured her that the

money had been paid. Ms A stated that until November 2004, when a lawyer for the finance company called on a family member regarding her outstanding debts, she was unaware that the money had not been paid.

Ms A complained that Ms B took advantage of her position as respite carer in February 2004 when she told Ms A about her "desperate financial situation". Ms A felt pressured into giving money to Ms B. A sum of $140 was transferred from Ms A's bank account to Ms B's bank account on 10 February 2004. Ms B confirmed that $140 was paid into her account by Ms A, but said it was money Ms A owed her for purchases she made for Ms A on her way to work, and for the photocopying Ms A needed when she was recovering from a broken ankle.

The Board document "Information for staff caring for mental health clients in a respite setting" states that the carer must not use his or her own money on the client, and not "under any circumstances, be involved with a client's finances".

It is clear that Ms B unwisely became personally involved in her client's financial affairs. She acknowledged her breach of professional boundaries when she stated: "I understand that I should never [have] had any transactions with her, and I acknowledge it was poor professional judgement on my behalf."

Care support claim

Ms A stated that Ms B convinced her to arrange pre-payment for services she did not provide. Ms B stated that she provided evening and overnight support to Ms A at her request "in my own time, I did not document the exact dates and times" and provided Ms A with the required support hours. Ms B admitted that when Ms A gave her the claim form to sign she did so without checking the dates and times entered because she "trusted" Ms A. Although there is evidence that Ms B was paid $645 for carer support on 29 June 2004, I have not been provided with any documentary evidence to support the testimony of Ms B or Ms A.

I accept Ms B's statement that she trusted Ms A and responded to her need for care and support. She had become personally involved with her client. She should never have entered into any financial arrangements with Ms A. The fact that Ms A was mentally unwell, and that her ability to make informed judgements may have been affected, made it even more improper to enter such an arrangement. Ms B also failed to keep accurate records of her duties, and signed a claim form without reading the details. These actions were irresponsible. I do not believe that Ms B intended to take advantage of Ms A's situation. However, her actions were not in accordance with her employer's standards, and breached Right 4(2) of the Code.

Opinion: No Breach — The District Health Board

Vicarious liability
Under section 72(2) of the Health and Disability Commissioner Act 1994, employers are responsible for ensuring that employees comply with the Code. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the things that breached the Code.

Ms B was employed by the District Health Board (the Board). As an employer, the Board is potentially vicariously liable for Ms B's breaches of the Code. In the job descriptions for health care assistants providing mental health respite services, the Board specifies its expectation of professional behaviour. Information was provided to health assistants about the importance of maintaining boundaries, and areas were outlined where staff could potentially expose themselves to risk.

The Board accepts that this case highlights the need to review its policies for staff in relation to professional boundaries, and has done so. I am satisfied that in the circumstances the Board, as an employer, took such steps as were reasonably practicable to prevent Ms B's lapses from occurring, and is therefore not vicariously liable for her misconduct.

Comment

It appears that supervision of the respite care service Health Care Assistants at the District Health Board is not well structured and is left to the responsibility of the team or manager who approved the care. In Ms A's situation the supervision of Ms B was not satisfactory. Ms B sometimes did not provide the care she had agreed to, and there were also occasions when it appears that she provided support when Ms A had used her allocated allowance. I acknowledge that Ms B had to take some responsibility, but this situation might not have occurred if the care being provided had been more formally monitored. I recommend that the DHB review its processes for overseeing the respite care being provided to mental health clients.

Recommendations

I recommend that Ms B apologise in writing to Ms A for her breaches of the Code. The apology is to be sent to the Commissioner's Office and will be forwarded to Ms A.

Follow-up actions

- A copy of my report will be sent to Ms B's current employer.

- A copy of my report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 1

Health Care Assistant

Date: January 2004

Job Title : **Health Care Assistant - Mental Health Respite**

Department : **Bureau**

Reporting To : **Bureau Manager**

KEY TASKS	EXPECTED OUTCOMES
The Health Care Assistant provides care for mental health clients in a community setting according to District Health Board's policies.	• Is aware of their client's: - Mental Health assessment and diagnosis; - Health history, both mental and physical; - Risk and cultural assessment; - Social situation; - Signs and symptoms; - Aims of management plan. • Clients' needs are identified, documented and reported to their community team. • Care is safe, responsive to changing needs, client centred and collaborative in respect of family and community team. • Maintains a basic understanding of mental illness. • Client/ family is assisted to participate at all levels. • Safety of the physical environment is maximised. • Manages rapidly changing situations, using good commonsense and de-escalation skills. • Reports and seeks guidance from the assigned community team where new/ changed situations arise. • Provides general assistance with a client's activities of daily living wherever necessary.
Understands and observes professional care boundaries for health care assistants which are the basis for therapeutic relationships.	• Introduces themself to the client on arrival and shows their DHB identification badges. • Adheres to management plan at all times. • Does not leave personal contact details with clients or attempts to contact a client or family after an assignment has finished. • Promotes client's independence. Does not become over involved with a client or their families. Will request a client change if they feel that this is occurring. • Provides a therapeutic and physically safe environment for clients, ensuring that confidentiality is maintained.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Health Care Assistant

KEY TASKS	EXPECTED OUTCOMES
Care reflects values and policies and promotes the interests and rights of consumers.	• Feedback from consumers, peers and employer indicate an acceptable standard. • Contributes to promotion of quality mental health respite service. • Is able to identify and report unsafe care and contribute to it's resolution • Areas where improvement is indicated, as highlighted by performance appraisal, are addressed.
Services are delivered in accordance with the Mental Health Service and the Teams philosophies, priorities and objectives.	• Completes mandatory training as stipulated in the Training and Development and team policies. • Philosophies and values are known and supported. • Consumer rights and responsibilities are actively supported. • All conduct is ethical and confidential. • Safety standards are known and met.
To be responsible and accountable for all actions undertaken in the course of duties.	• All documentation is legible, dated and signed with name and designation clearly written. • To provide a therapeutic and physically safe environment for clients, ensuring that confidentiality is maintained.
To recognise the principles of the Treaty of Waitangi while acknowledging cultural and social difference of all groups	• [redacted]'s commitment to biculturism is honoured. • Practice demonstrates understanding of the Treaty of Waitangi and its principles of partnership, protection, participation and self-determination are implemented in working with Maori clients/ whanau. • This understanding is translated into practice that respects all cultures, genders, ages, disabilities, beliefs, sexual orientation and other differences. • Cultural advice is sought. • Works co-operatively with culturally appropriate staff. • Attends Workshop.

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Health Care Assistant

KEY TASKS	EXPECTED OUTCOMES
Demonstrate a commitment to personal and professional development.	• Attends mandatory education days i.e. challenging incidents and respite study days. • Bureau educator is liaised with regarding education opportunities as required.
To work as an effective team member	• Observe and identify roles, functions and philosophies of the community team. • Maintain active communication with the community team and relevant agencies.
To recognise individual responsibility for workplace Health and Safety under Health and Safety Act 1992	• Health and Safety Policies are read and understood and relevant procedures applied to own work activities. • Workplace hazards are identified and reported, including self-management of hazards where appropriate. • Can identify Health and Safety Representative for area.

VERIFICATION:

Employee: _____

Department Head: _____

Date: _____

JOB DESCRIPTION - Health Care Assistant, I *Page 3*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Appendix 2

Information for Staff Caring for Mental Health Clients in a Respite Setting

Introduction

Purpose

The purpose of this document is to provide information for bureau staff caring for mental health clients in a respite setting.

Scope

The categories of personnel covered under this policy are Registered Nurses, Registered Midwives, Enrolled Nurses and Health Care Assistants (often referred to as nurse aides, hospital aides, or care assistants).

Thank you

Thank you for agreeing to work as a respite staff. This is challenging work and we appreciate that it is a special person able to do this work.

Definitions

For the purposes of this document, the following definitions apply.

Term	Definition
staff	staff are employees of and work according to their availability.
CATT	Community Assessment & Treatment Team. 24 hour services based at
Duty Manager	The Duty Manager for the current shift, in any inpatient facility (e.g.
Mental Health Treatment Teams	Specialist Community Mental Health teams available Monday to Friday 0800-1630

Continued on next page

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PATIENT CARE

Information for Staff Caring for Mental Health Clients in a Respite Setting

Accepting a Shift

Accepting the shift

- The co-ordinators will have received the order for a respite placement. They receive a range of details that assist them in deciding who is most appropriate to deal with the situation.
- When you receive the call you should get as much information about the client and situation as you can so that you know what you are about to undertake. Do not accept any assignment that you do not have the skills and knowledge to provide safe client care and assessment.

Information Needed

You need to know

- Where you are going – address and look it up on a map before going and contact phone number
- The name of the person being cared for
- The client's treatment team
- The client's presenting problems
- The client's risk factors
- Goals and interventions
- Any special instructions
- Who else is in the house/ unit
- The client's medications regime, and who is responsible for administer medications
- If there are any cultural/ safety issues.

Preparation

- Dress warmly in winter as some people have little heating.
- Dress comfortably with good footwear.
- Take along the following:
  - Mobile phone if you have one
  - Food in your own container
  - Water or soft drink and makings for a hot drink
  - Extra toilet paper as the house may not have enough
  - Pen and paper.
- Have the contact phone numbers of the Duty Manager and the CATT Team with you to call if required.
- Have enough petrol in your car to not get caught out in an area you are not familiar with.

Classification: tha
Draft Date: 27.08.03
RP : 12 mths
Issued by:
Authorised by:

Information for Staff Caring for Mental Health Clients in a Respite Setting
DRAFT
Page 5 of 15

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

Information for Staff Caring for Mental Health Clients in a Respite Setting

Understanding the Care Plan

Understanding the care plan

- There should always be a file containing a management plan, relevant information for the family regarding respite care and clinical notepaper. It will also contain a medication chart if the client is receiving medications (with drug information on actions and side effects).
- If your shift is a continuation of care, you will have a verbal hand-over from the previous respite. It may be appropriate to have the hand-over outside, or slightly away from the client, use your discretion. **Keep the client in your line of sight at all times.**
- You need to understand the reason for the respite care e.g. self-harm, deterioration in illness, potential harm to others and their clinical condition, safety issues, family involvement, and behaviours requiring attention.
- If you are the first shift to cover a client you may be asked to come to the hospital to pick up the management plan.
- Check whether you are required to administer medications. Sign for medications only if you administer them. If you see the client take medication you may enter "self- medicated" and sign as witness.
- Health care assistants are not to administer medications.
- Try to promote an environment where the client is able to relax. It may be that they wish to watch TV or read or listen to music. Talk in neutral terms. Do not ask probing questions. Be aware of professional boundaries. Keep the client calm and open in their communication if possible. Encourage the client to have a meal and fluids.
- The respite care plan is to be accessible for the client to read.
- At the conclusion of respite the file should be returned to the managing team or CATT and filed accordingly.

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Information for Staff Caring for Mental Health Clients in a Respite Setting

Suggested Guidelines, Continued

Dealing with visitors

The client is encouraged to remain calm. If the visitors are limited in number and appear to keep the client calm then they may remain. If they begin to cause some disruption, politely ask them to leave.

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Information for Staff Caring for Mental Health Clients in a Respite Setting

Respite in Motel Accommodation

Motel accommodation, food and phone calls

- Some clients are more appropriately placed in motel accommodation for respite care. If there is no food available at the unit, meals may be ordered through Spotless.
- Do not use your own money on the client. CATT do not routinely provide meals to clients in respite. The mental health team arranging the respite care should ensure that the client has adequate food or the means to obtain it before going into the respite facility. Liaise with the CATT team to order meals and food.
- It should also be clear that telephone calls made from the motel are to be paid for by the client upon leaving respite.

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Information for Staff Caring for Mental Health Clients in a Respite Setting

Keeping Safe, Continued

Maintaining your boundaries

- During these placements it is quite normal to develop a bond with the client, but please do not give them your phone number or any personal details.
- Please maintain your own independence for food and fluids.
- It is also unwise to borrow or lend personal possessions.
- Do not, under any circumstances, be involved with a client's finances.
- It is not appropriate to contact a client after you have left the assignment or keep their personal contact details.
- You are part of the treating team and while you do often give a bit more of yourself to some clients there are still boundaries.

Concerned

If concerned by changes in your client's behaviour, mood or interactions that you have observed, please report the events to

- The Mental Health Treatment Team
- Or after hours CATT phone and ask for CATT depending on the client's location
- or the Co-ordinators
- Do not hesitate to call the Duty Manager who will arrange assistance for you at any time of the day or night.

Calling for assistance

- In the file there will be urgent contact numbers. If unable to contact anyone, contact the Duty Manager at on ( ), or if necessary the police (**111**) or the Oncall Co-ordinator available through Hospital telephonist.
- For your own professional safety, should an incident occur, contact the Duty Manager and arrange to fill out an incident form. You may need to debrief after a shift. If so, please call the Duty Manager and she will arrange support for you.

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Issued by:
Authorised by:

Information for Staff Caring for Mental Health Clients in a Respite Setting **DRAFT** Page 13 of 15

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Information for Staff Caring for Mental Health Clients in a Respite Setting

Handing Over

Handing over

- At the end of the shift, document your observations in the client file.
- Provide a clear handover to the person relieving you.

No Relief

If staff member does not arrive to relieve you for the next shift, please call the Office at Hospital as soon as possible on

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Appendix 3

SERVICE TYPE DESCRIPTION FOR ADULT CRISIS RESPITE

Adult Crisis Respite **MHRE02**	**Function:** The provision of a home based or residential service as an option for people who would otherwise require admission to acute inpatient mental health services. **Nature of the Service:** A range of options will be developed and maintained by you. These will be implemented in accordance with the particular requirements of the Eligible Person and his/her caregivers. Options will include, but may not be limited to: • provision of staff with skills appropriate to the circumstances, to supervise the person in crisis, whether in their own home or elsewhere; • short-term care in supervised accommodation; • short-term care in specifically dedicated respite facility. Respite usage will be for as short a period as possible during the crisis period. Cultural expertise is to be available in these situations to ensure satisfactory options are considered and to assist with crisis resolution. Treatment will be provided as required during the period of respite care with the aim of quickly resolving the need for crisis service. This service includes the supply of hotel services where required (see description titled Hotel Services). **Key Processes:** Services Users accessing these services can expect, as a minimum, to be able to access all of the following processes: Advocacy, Assessment, Discharge Planning, Hotel Services, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Treatment and Rehabilitation. These processes are described in the Service Specification titled "Process Descriptions". **Access:** Access will be through community based acute treatment (crisis intervention) services.

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Service Specification_Respite.doc

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ADULT RESPITE SERVICES
SERVICE TYPE DESCRIPTION FOR ADULT PLANNED RESPITE

Adult Planned Respite **MHRE01**	**Function:** The provision of a home based or residential service as planned to avoid exacerbation of the risk of need for admission to inpatient mental health services, for people under the care of community mental health teams. **Nature of the Service:** A range of options will be developed and maintained by you. These will be implemented in accordance with the particular requirements of the Eligible Person/Service User and their caregivers. Options will include, but may not be limited to: • provision of staff with skills appropriate to the circumstances, to supervise the person in respite care, whether in their own home or elsewhere; • short-term care in supervised accommodation; • short-term care in specifically dedicated respite facility. Respite usage will be for a planned period. Treatment will be provided as required during the period of respite care, with the aim of quickly resolving the need for respite care. This service includes the supply of hotel services where required (see Process Descriptions document for a description of "Hotel Services"). **Key Processes:** Services Users accessing these services can expect, as a minimum, to be able to access all of the following processes: Advocacy, Assessment, Discharge Planning, Hotel Services, Legal Compliance, Management of Risk, Peer Support, Service Handover, Support, Treatment and Rehabilitation. These processes are described in the Service Specification titled "Process Descriptions". **Services Provided By:** Staff with appropriate qualifications, competencies, skills and experience in meeting the support needs of people with serious mental health problems/disorders. **Access:** The use of respite services will be included as part of the management plan for Eligible Persons where it is anticipated that, from time to time, there will be a need to relieve other caregivers of the sole burden of care. Access is co-ordinated by the usual community key worker.

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