Rest Home

Report on Opinion - Case 97HDC3428

Complaint

The Commissioner received a complaint from the consumer's daughter that:

- One evening in early September 1996, the consumer fell down on top of his wheelchair while trying to close a window.
- He was given panadol for pain but could not sleep that night.
- The complainant was told a doctor was not called because the Rest Home does not call a doctor out of hours due to the cost to the family and that most times there is not anything too seriously wrong.
- The next morning the complainant was asked to transport her father to the accident and emergency clinic as the mobile x-ray van would cost the family $30-$35.
- The complainant understands that her father should not have been moved and that an ambulance should have been brought in.
- The consumer was in pain until he received an injection at the accident and emergency clinic.
- The consumer sustained a broken hip and required surgery at a Hospital.
- A doctor should have been called on the evening of the consumer's fall.

Investigation

The complaint was received by the Commissioner on 10 January 1997, and an investigation was undertaken. Information was obtained from:

The Consumer
The Complainant
A Licensee of the Rest Home (also a Registered Nurse)
A Second Licensee, also the Manager of the Rest Home
The Charge Nurse, Rest Home
Two Rest Home Assistants
The Rest Home's General Practitioner

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Investigation, *continued*

During the course of the investigation some of the people involved in the consumer's care were unavailable because they had left the employ of the Rest Home, or could not be located.

As part of the investigation, the consumer's medical records were considered.

Outcome of Investigation

The consumer is a victim of stroke, and had been taking panadol among other medication for the pain of his degenerating hip condition. The consumer was admitted to the Rest Home in early July 1996. The Home is registered with the Ministry of Health as an Old People's Home.

One night in early September 1996 at about 6.45pm the consumer fell on top of his wheelchair while attempting to close a window in his room. At about 7.00pm the consumer was found sitting on the floor by a Rest Home assistant. He was helped by two female Assistants to get back on to his bed and with their assistance was able to hoist himself onto the bed. He was given some panadol pills but these did not seem to relieve his pain.

One of the Assistants completed an incident report in which she noted the consumer refused to see a doctor. The consumer confirms he refused to see a doctor on the night of the fall.

As the medical care was needed after hours, the applicable policy in force at the Rest Home was:

"Medical Service Policy : Medical Care After Hours"

"... It is The Rest Home Policy that:
In the event of a Resident becoming unwell or having an accident that they have access to medical care twenty-four hours a day.

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Outcome of Investigation, *continued*

The Registered Nurse on duty / on call must first assess the need for a Medical Practitioner. Except in the case of a communications break down, then the Senior [Rest Home] Assistant on duty must call a Medical Practitioner if they deem it to be an emergency situation.

After hours Medical Practitioners must report to the Staff on duty prior to attending to the Resident and be prepared to communicate via telephone with the On Call Registered Nurse/Senior Staff Member re diagnosis, treatment and continuing care of any Resident in [the Rest Home] . . .

Any call that results from an accident the doctor is to write out an A.C.C. form.

All visits to Residents by a Doctor are to be documented in the Resident's Medical Notes."

At 10.00pm the Assistant telephoned the Licensee who was the on call Registered Nurse, and told her of the fall.

The Licensee instructed that 2 panadol tablets be given to the consumer if needed. He was given panadol at 12.30am by one of the Assistants. He was also given a massage with oil, which the consumer acknowledged helped to ease the pain. He still had pain when he was moved and a pillow was propped between his legs to minimise any movement.

At about 3.45am the consumer told one of the Assistants that the pain had returned around the hip, thigh and groin area. At 4.00am the Assistant called the Licensee who gave instructions that the consumer be given further panadol. The Licensee also gave instructions that the doctor was to check the consumer that morning and that he was to stay in bed until reviewed by the Charge Nurse later in the day. She asked the Assistant to call if the consumer was still in pain.

Despite the instruction that the consumer was to stay in bed being noted in the records, the consumer was toileted at around 7.00am, and was placed in his wheelchair in the lounge by the Assistant. The consumer advised the Assistant that he had pain in his groin area. The Assistant acknowledged that she had not read the progress notes as they get read at a staff meeting at 8.00am, and she was on a medication round before that.

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Outcome of Investigation, *continued*

The Rest Home's General Practitioner was notified of the fall by the Home's Charge Nurse at 9.00am that morning.

After the Charge Nurse had contacted the GP, she phoned the complainant to inform her of her father's fall and to ask if she was available to take her father to the accident and emergency clinic. The complainant was informed of an alternative option of ringing the mobile x-ray van at a cost of $30-$35 to the family.

The complainant asked how her father was, and the Charge Nurse replied that he was "OK". The Charge Nurse said in her letter dated 6 September 1996 to the complainant:

"When I arrived at work [two days after the consumer's fall] I made my assessment of his [the consumer's] health status by his demeanour as he was moving about the Home in his wheelchair and did not convey that he was in pain… I viewed him twice. Both times he was up and in his wheelchair mobilising himself and seemed okay."

The Charge Nurse told the complainant that the consumer would have to wait for the doctor but she thought there should be an x-ray done to see if there was anything broken. The complainant acknowledged that the cost of an x-ray van was a factor in deciding she would transport her father, but she was not reassured by the Charge Nurse's response and wanted to see how her father was for herself. She asked that her father be kept where he was because she was going to arrive soon.

The GP saw the consumer briefly at 9.20am and requested that an x-ray be done. By the time the complainant arrived at the Rest Home from her home 20 minutes away, she found out that the doctor had already visited.

The complainant saw her father in his room crying. He told her that he was in pain and that he had a fall the night before, when he was attempting to close a window. He said that when he landed, he heard a crack in his left hip. He also said that he could not sleep all night because of the pain.

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Outcome of Investigation, *continued*

When the complainant went to get assistance from the Charge Nurse, she found the Charge Nurse was in a meeting. The complainant then wheeled her father to her car but needed assistance, as she could not get him into the car. The complainant then went and sought help from two rest home assistants. It took approximately 20 minutes to get the consumer into the car. The journey to the Medical Centre took approximately 2 minutes.

On arrival at the Medical Centre the complainant went inside to get someone to assist her with getting the consumer out of the car. The consumer's pain had increased. While he was still in the car, a nurse from the Accident and Emergency Clinic assessed the consumer's condition. The nurse immediately suspected a fractured hip. It was difficult to get the consumer out of the car and assistance was necessary. The x-rays taken at the clinic confirmed that the consumer had fractured his femur. The consumer was given an injection of painkillers and he fell asleep.

The consumer was transferred by ambulance to a Hospital Accident and Emergency Department where more x-rays were taken. He was operated on that night.

The first Accident and Emergency Clinic made a complaint to the Rest Home about the way in which the consumer was transported to the clinic by the complainant instead of by ambulance. The consumer now resides in another rest home.

Code of Health and Disability Services Consumers' Rights

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.

...

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

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Opinion: Breach

In my opinion, the Rest Home has breached Right 4(2), Right 4(4) and Right 4(5) of the Code as follows:

Right 4(2)

The patient notes, which were required to be read by the morning staff, clearly instructed that the consumer was to stay in bed until he was seen by a GP. Staff did not read the notes prior to commencing the morning shift and moved the consumer which was a failure to deliver services of an appropriate standard. Further there is no evidence of any persons undertaking a physical examination of the consumer and in the circumstances this should have occurred.

Right 4(4)

The consumer had a degenerating hip condition. When the consumer fell on his hip, staff should have recognised the risk of further damage and taken appropriate action to physically assess him and ensure that a doctor be called in to see him. The Rest Home staff failed to identify the potential risk to the consumer. The delay in seeking medical advice could have compromised the effectiveness of the consumer's later treatment.

Even if the consumer's hip had not been broken at the time of the fall, clear written instructions stated he was not to be moved.

In failing to call an ambulance to transport the consumer to the Medical Centre, the Rest Home also did not provide appropriate services. Had an ambulance been called, the ambulance officers would have transported the consumer in a manner that minimised his potential harm. The consumer's pain became worse at the Medical Centre after having been put into and taken out of the complainant's car.

The fact that the consumer was operated on that night indicated the seriousness of the consumer's condition.

Right 4(5)

The Rest Home did not co-ordinate with the Medical Centre, as there was no evidence of a call from the Rest Home to the Centre to advise of the consumer's circumstances. Further, the co-operation and transfer of data between various providers was insufficient to ensure ongoing quality care to the consumer.

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Actions Taken

In a letter dated 6 September 1996, the Rest Home Management apologised to the complainant for the way the consumer was transported to the Medical Centre. The Rest Home Management has since amended the policies regarding after hours care. All residents with suspected fractures are now transported by ambulance.

Future Actions

I recommend that the Rest Home:

- develops and implements a policy that ensures all staff have read the previous shift's notes before they go on duty.
- trains all staff regarding the obligations under the Code including the obligation to ensure co-operation and quality service.

A copy of this opinion will be sent to the Health Funding Authority and the Ministry of Health National Licensing Office.

Suggestion

While not a matter that was complained about, I note that as part of the documentation that was obtained during the investigation, the Rest Home has an information leaflet called the "Code of Residents' Rights and Responsibilities".

Clause 1(3) of the Code of Health and Disability Services Consumers' Rights states that:

1. Consumers have Rights and Providers have Duties:
1) Every consumer has the rights in this Code.
2) Every provider is subject to the duties in this Code.
3) Every provider must take action to -
a) Inform consumers of their rights; and
b) Enable consumers to exercise their rights.

In meeting this obligation, providers must take reasonable actions to ensure consumers are not misled. Any statements should ensure that residents at the Rest Home are aware that the law does not apply to consumer "responsibilities". While neither the Health and Disability Commissioner Act 1994 nor the Code of Health and Disability Services Consumers' Rights dictates the precise form of the information the consumer must receive, I suggest that the Home's leaflet is amended to ensure that leaflets on residents' rights correctly reflect the Code of Rights, and consumers understand that the law does not apply to the responsibilities listed by the Rest Home.