A Rest Home

Rest Home Owner, Mr B

Rest Home Manager, Ms I

A Report by the

Health and Disability Commissioner

(Case 02HDC16226)

Parties involved

Miss A	Consumer
Mr B	Rest Home owner / Provider
Mrs C	Friend of consumer
Mrs D	Cousin of consumer
Mrs E	Friend of consumer
Mr F	Friend of consumer
Mrs G	Complainant
Mrs H	Cousin of consumer
Ms I	Rest Home manager / Provider
Dr J	General Practitioner
Ms K	Rest Home caregiver
Ms L	Rest Home caregiver
Ms M	Rest Home caregiver

Complaint

On 4 November 2002 the Commissioner received a complaint about the services provided to the late Miss A by Mr B, owner of a rest home. The complaint was summarised as follows:

The rest home and Mr B, licensee, did not provide services of an appropriate standard, which respected the dignity and independence of Miss A between May and September 2002. In particular Mr B:

- *pulled and pushed Miss A by her wrists in an inappropriate manner*
- *hid Miss A's walking aid so that she was unable to mobilise*
- *placed Miss A's walking aid in such a manner that she was restrained from moving*
- *failed to attend appropriately to Miss A, leaving her cold and naked except for an incontinence pad, in the lounge late at night.*

An investigation was commenced on 9 January 2003.

Information reviewed

- The rest home's clinical records relating to Miss A
- Copies of relevant policies and procedures from the rest home
- Clinical records relating to Miss A from the two public hospitals

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- Ministry of Health Quality Audit report relating to the rest home

Independent expert advice was obtained from Mrs Jan Featherston, a registered nurse with experience in aged care facilities.

Information gathered during investigation

Overview

Miss A had been living at home up until a fortnight before her admission to the rest home on 24 August 1999. She was 89 years old. The fortnight prior to her admission to the rest home Miss A had been living with her friends, Reverend and Mrs C, who were concerned that she was not looking after herself, and took her into their home.

During the time that Miss A was in the rest home her condition deteriorated from a frail but independently functioning person to one who was dependent on the staff for most of her daily living requirements. Miss A was visited regularly by a number of friends and was highly regarded by the staff of the rest home.

Miss A's next of kin was her cousin, Mrs D. Mrs D lives out of town and, because of ill health, did not often visit Miss A. However, she was in contact with the rest home and Miss A's friends, Mrs E, Mr and Mrs F and the Reverend and Mrs C, who informed her about Miss A's condition.

Mrs G, who was a resident at the rest home, alleged that the rest home owner, Mr B, was rough when he guided Miss A to her chair, pushing and pulling her, which caused bruises to her hands and wrists. Mrs G also stated that Mr B restrained Miss A by placing her walking aid in front of her so that she could not move, and that he would hide her walking aid so that she could not wander. On one occasion in July 2002 Mr B did not attend to Miss A when she had wandered into the lounge of the home late one night without any clothing.

Mrs H, Mrs D's daughter, said: "I would not like to think that all the good things that were done for [Miss A] at [the rest home] were overlooked by this incident."

The rest home

The rest home is owned by Mr B. The nurse manager is Ms I. The rest home is an older style rest home, licensed to accommodate 18 low-level care residents. The rest home has a procedure for staff to record falls, accidents, injuries or unusual incidents involving residents, staff and visitors on a Special Incident Report. There are policies in place to guide staff in the care of the elderly. Resident care plans and implementation are documented in Care Plans, a Quality of Life Programme, Monthly Nursing Evaluations and the daily nursing notes.

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Mr B

Mr B is a registered psychiatric nurse who has owned the rest home for 13 years. During that time he has been employed in various positions with national healthcare organisations, most recently in charge of a 70-bed long-term eldercare facility. Three years ago Mr B started full time as the executive manager at the rest home, and he also worked there as a caregiver. Mr B primarily worked the night shift, and frequently worked double shifts from 4pm through to 8am the following morning.

Mr B informed me that his duties on night shift were to check catheters, give out medicines, heat and serve the evening meal, and organise residents who needed assistance to go to bed. He also prepared and served supper, and watched television or played cards with the residents who settled later in the evening. Mr B stated that a second staff member worked between 5pm and 7.15pm to assist with the evening meal and settling the residents. The morning shift starts at 7.30am.

Miss A

When Miss A was admitted to the rest home, her admission assessment (written by Mrs C, Miss A's friend, who was the registered nurse for the rest home in 1999) described her as follows:

> "She is a very determined little lady and lets you know in no uncertain terms what she likes and doesn't like as the morning staff soon learnt today when she refused to be in the same room as [a resident] playing her piano accordion. [Miss A] is a musician and taught music (piano) for years and was playing the church organ just over a month ago.
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> …
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> She can walk with a walking frame for short distances but often needs the wheelchair especially to the table. Was incontinent in the hospital, but with regular toileting during the day and night I have had no problems at all."

Miss A was an unconventional and individualistic person. She was highly regarded by the staff at the rest home, as is reflected in the nursing notes. However, during the time she was at the rest home her physical and mental abilities began to fail and staff found that she was becoming increasingly dependent.

The nursing note for 27 January 2000 (five months after her admission to the rest home) recorded that Miss A had asked to be taken to her house "to get some of her things. She told me that she didn't think she could ever go back there to live but was very happy at [the rest home]."

The monthly evaluation for May 2000 noted, "No change with [Miss A] – continues to delight everyone."

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In October and November 2000 Miss A had three episodes where she temporarily became semi-conscious, disorientated and incontinent. Dr J, general practitioner, was notified and requested that Miss A's condition and blood pressure be monitored and reported to her.

On 25 May 2001 the nursing notes recorded:

> "[Miss A] is beginning to fail. Doesn't remember her bath days, is dressing incorrectly. She is becoming confused on several occasions. Still turns her hearing aid off then says she can't hear."

In May 2002 Miss A became incontinent of faeces. Staff discussed the management of this problem with Dr J. Dr J informed me that Miss A developed the habit at this time of performing manual removal of her faeces. She said that the staff managed this problem by giving Miss A a quarter of a glass of prune juice daily to ensure regular bowel function, and supervising her in the toilet until her bowel was clear.

In August 2002 Miss A was noted to have an increasing number of falls and an increase in skin tears as a result. The skin tears were Steri-stripped and padded, and protective bandages applied to Miss A's forearms and lower legs to prevent further injury.

On 15 September Miss A fell between the locker and her bed while attempting to use her walking frame. Mr B contacted Dr J because he thought that Miss A had sustained a fracture of her hip in the fall. Dr J examined Miss A and arranged for an ambulance to transport her to another hospital for a diagnostic x-ray of her hip. The x-ray confirmed a fractured neck of femur and Miss A was transferred to the public hospital for surgery.

Following the surgery Miss A was transferred back to the second hospital, but her condition deteriorated and she died on 27 September 2002.

Mr B pulled and pushed Miss A by her wrists in an inappropriate manner

Mrs G alleged that on a number of occasions she saw Mr B pulling Miss A by her wrists, and pushing her back into her chair until he was ready to put her to bed. These actions resulted in bruising and skin tears to Miss A's forearms.

Mr B stated that Miss A had a habit of walking towards people with her arms outstretched, not necessarily to hug the person, but usually as a signal she wanted something. He said that he would take Miss A's hands and lead her a short distance by walking backwards himself. He said that he did not hold her by her wrists and did not push her.

Ms I, nurse manager, stated that Miss A did not resist when staff were guiding or directing her around the rest home. The staff at the rest home were instructed how to guide the residents by supporting with a hand under the elbow, and also by holding their hands and walking backwards to guide them forward.

The records show that Miss A did sustain numerous bruises and skin tears to her forearms and legs, which were thought to be a result of her bumping into furniture and fittings. The staff used Tubigrip stockings to encase her lower arms and legs to protect her from injury.

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Dr J informed me that Ms I and the registered nurse were meticulous in their treatment of any bruising or skin tears and would report any significant injuries.

Ms I informed me that Miss A's mobility was good in the early days of her admission to the rest home but, over time, as her condition deteriorated, she bumped into furniture and fittings, which caused bruising to various parts of her body. Ms I said that Miss A would regularly try to get in and out of bed on her own, and staff thought that some of her bruises were sustained in this way.

Mr and Mrs F, Mrs E, and Reverend and Mrs C regularly visited Miss A at the rest home, and all stated that they did not see any unusual bruising. Mrs E reported that she had noticed the "bandaging" on Miss A's forearms and legs and queried this with the staff. She said that she was satisfied with their explanation that the bandaging was to protect Miss A's skin from bruising and tears.

Mr B hid Miss A's walking aid
Mrs G informed me that Mr B hid Miss A's walking aid to stop her wandering.

Mr B explained that the only time that Miss A's walking frame was taken away from her was while she was in the dining room for a meal. Mr B stated that Miss A was "not very good at meals". She had to be reminded about meals and sometimes she would look at the food, stand up and walk away. If she was reminded and guided back to her chair, she would sit and eat a little bit and then wander off again.

Mr B said that a number of the residents had walking frames, and the walkers in the dining room created a "falls hazard" for other residents walking in and out. He confirmed that Miss A's frame was placed next to the dining room wall and returned to her after she had finished her meal.

Other staff members acknowledged that they removed Miss A's walking frame from her immediate vicinity at meal times. This practice was not confined to Miss A. A number of other residents also "parked" their walking frames beside their tables and they were also moved from the dining room until the meal was finished, to ensure the safety of other residents moving in and out of the room.

Ms K, diversional therapist and caregiver, also stated that Miss A's walking frame, like all the other residents' frames, was removed from the dining room during meals because it was a hazard.

Mr B placed Miss A's walking aid in such a manner that she was restrained from moving
Mrs G informed me that Mr B turned around Miss A's walking frame so that the bar with the bag attached was against her shins. Mrs G said that this would "fasten her to the chair, and that was when she used to get bruises on her shins".

Mr B denied that Miss A was ever restrained by any method. He said that she did not require restraint. She was provided with a Thompson walking frame, with wheels and bars to assist her mobility.

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Ms I stated that the rest home has a restraint policy which stipulates that if restraint is required it is to be discussed with the doctor and authorisation is to be in writing. The policy is based on the Ministry of Health's Procedural Guidelines for Physical Restraint, June 1993.

Ms I said that Miss A was not restrained because although she wandered about she was not disruptive. There was one occasion when Ms K reported to her that during the afternoon shift she had put Miss A in a chair with a table in front to restrain her. Ms I said that she advised Ms K that there was no need or authority to restrain Miss A.

Ms I stated that Miss A would often use her frame inappropriately. She would sometimes turn the walker back-to-front, walk with it to her chair and sit down so that the frame would be against her legs. The walker had wheels and Miss A was able to push it away if she needed to. Miss A liked to sit with her legs up over the frame, and she would turn the frame on to its side so that she could do this.

Ms L, caregiver, and Ms K also informed me that Miss A would often turn her walker around herself and put her feet up on the middle bar, which was her preferred way to sit when in her chair in the lounge.

Mr B failed to attend appropriately to Miss A late one night

Miss A had a tendency to remove her clothing when she became too warm. Staff often had to remind her that it was more usual to be fully clothed in areas accessed by other persons. She also frequently sought reassurance at night that there were other people about. Staff informed me that they were accustomed to seeing her wander into the lounge at night or peep out of her door to locate staff. Once she had ascertained that she was not alone she would happily go back to bed.

I was informed that on the night of 16 July 2002 Miss A was sitting naked in the lounge, while Mr B continued to watch television. Mrs G stated that she approached Mr B, who was sitting in the lounge watching television, to ask him for two Panadol. She said that she did not notice Miss A at first as she was sitting in a chair behind a large pile of washing. When Miss A saw Mrs G she stood up and extended her arms. Mrs G saw that Miss A was naked and, assuming that she was distressed, crossed the room and took her hands, which were very cold. When Mrs G told Mr B that Miss A was cold, he replied, "She is always falling everywhere." He then got out of the chair to tend to Miss A and Mrs G left the room. Mrs G stated that she had been sufficiently concerned to note this incident in her diary. Her diary record for 16 July 2002 states:

> "… I had radio national on till 9pm, then I couldn't get to sleep for noise of TV in lounge. I finally got up and asked [Mr B] for 2 Panadol and he switched off the TV. He wasn't watching it. ([Miss A] was naked.) I finally got off to sleep."

In his response to my provisional opinion, Mr B stated that Mrs G was mistaken as to the time that this incident occurred. Mr B said that it could not have been at 9pm as noted in Mrs G's diary because other residents were usually still up watching television at 9pm, and the washing (Mrs G made reference to Miss A being obscured by a washing basket) is only

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done at night. Mr B stated that Miss A was not naked, but was wearing a "full brief of disposable incontinence variety". He stated:

> "It is prejudice to state that [Miss A] must not appear in front of any other person or accidentally be seen by any other person in a partly undressed state because she must be suffering a violation of her privacy and respect. She clearly did not agree with this prior to her dementing illness. Another individual is stating <u>their opinion</u> of what they believe to be dignified and respectful."

Mr B said that at the time of this incident, between 3am and 4am, he was sitting in the main lounge, which is where the night nurse sits. He stated:

> "It's not the only time that [Miss A] came to the lounge with no clothes on. … In the last few months of her life she became quite confused but only in certain areas.
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> …
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> She would come out of her room and walk around and usually see that it was dark or talk to the nurse and go back again. She sometimes did it two to three times in a night but sometimes not at all.
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> …
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> On this occasion she came out and she had her nightdress off already and it had blood on it. I saw straightaway that she had a skin tear, quite a large one in the leg. … After April she started getting skin tears, so it wasn't unusual. This one was particularly losing a lot of blood, and she had been trying to wipe it with her nightie which was probably why her nightie was off and she was coming to see me.
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> …
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> Anyway, I saw it and I said, 'Boy, this has got to be fixed quickly.' She would have lost a cup of blood because of the trail of it from the room, and she is a tiny, tiny woman. So I came to get the trolley, was rushing back and I was dressing the wound. I didn't give her a new nightdress because there was no one watching her, and only me.
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> …
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> Anyway my feeling was priority for the wound. While I was doing it another resident came through the lounge on her way to the toilet and said to me, '[Miss A] has got no nightie on', and I said, 'No. True. No. She's had an accident.' She heard me but didn't respond to that. I was on my knees at the time doing it, and [Miss A] had her nightie clasped to her front, but I hadn't given her a new one. The resident said again, '[Miss A's] got no nightie on.' You know, like I was deaf, and I said to her again, 'No. I'm afraid she's had an accident. She's bleeding.' There was a puddle of blood forming on the carpet. I don't know how she couldn't see it."

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There are only four entries in the nursing notes for Miss A for July 2002. There is no mention of the above incident, and no report of a skin tear to her leg for that month. There is, however, reference in June to an ulcerated area on Miss A's right shin, which took the best part of the month to heal. There are no Special Incident Reports completed for July 2002 for Miss A regarding a skin tear.

Dr J informed me that staff at the rest home contact her if there are any significant problems relating to her patients. She said that there is nothing in her notes for Miss A for July 2002. Dr J said, "[Ms I] and the registered nurse, are meticulous in their attention to skin tears and bruises." She said that they use a Tullegras dressing or Steri-strips to quickly heal minor tears, but large or deep skin tears would always be brought to her attention.

In his response to my provisional opinion, Mr B acknowledged that he failed to document Miss A's skin tear, which is an omission he cannot explain. His explanation for the skin tear not being reported by other staff was that Ms I was on holiday, and the registered nurse, who only works part time, would not have attended to the tear.

Mr B said that his decision to dress the wound in preference to clothing Miss A was a "professional judgement". He said he is a "senior registered nurse with many qualifications and as such is entitled to make judgements of a professional nature".

Mrs G was concerned about Mr B's manner, particularly when dealing with the female residents, and one night she spoke to the night nurse, Ms L, about her concerns. Ms L confirmed that Mrs G spoke to her at the beginning of October 2002 when Mr B was on holiday. She said that Mrs G told her that she just wanted to talk to someone about her concerns and asked her not to tell anyone. Mrs G told her that she had seen Miss A sitting in the lounge one night without any clothes, and that she thought that Miss A was being dressed in dark stockings to cover the bruises on her legs. Ms L suggested to Mrs G that she speak with Ms I and Ms K about her concerns. Ms L informed Ms I about the conversation the following morning.

Ms I informed me that on 9 October 2002 (while Mr B was on holiday) Mrs G complained to her that she was concerned that Mr B had left Miss A sitting in the lounge one night with only her pants on. Ms I stated that this was the first she knew about the incident. She documented the details of Mrs G's complaint and decided to talk to Mr B about it when he next telephoned.

Ms I talked about the incident with Mr B, and he told her that he dealt with what he thought at the time was the most important part of the issue, and once he had dressed Miss A's leg he put her nightie on. Ms I told him that if it had been her or another member of the staff they would have put a rug round Miss A before tending to the wound. Ms I said that she was concerned about the hours that Mr B was working, and spoke to him about this. She said that since this incident Mr B has reduced the number of hours he works each week.

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Ministry of Health audit

The Ministry of Health requested that a Verification Audit (VA) be carried out at the rest home following the Issues Based Audit (IBA) conducted in January 2003 (in response to notification of this complaint), which identified some Significant Findings. The VA was held on 11 April to ensure that the service provided by the rest home complied with the contractual obligations set out in the terms of the Health and Disability Service agreement and that the rest home had addressed the Significant Findings. There was evidence that the rest home had begun to address issues identified in the IBA, as follows:

- Staff report that they are now more aware of the complaints process
- Mr B continues to participate in resident care, but now ensures that female residents are assisted by female staff
- Incident reporting and other residents' assessment tools are under review and are in the process of being finalised.

However, work on developing policies and procedures for restraint, privacy and dignity, and challenging behaviour is behind schedule. This is being followed up by the Ministry of Health.

Independent advice to Commissioner

Mrs Jan Featherston, an independent nursing advisor with experience in the care of the elderly, reviewed the details of the complaint, Miss A's clinical records and statements obtained from the rest home staff, and provided the following advice:

1) Mr B placed Miss A's walking aid in such a manner that she was restrained from moving

Mrs Featherston stated that the story that staff gave to explain Miss A's habit of sitting with her walker turned on its side so that she could rest her feet, was too unusual not to be true. The notes show that Miss A was mobile and used a walker with wheels. It is impossible for a walker with wheels to be used to restrain someone. Mrs Featherston advised that in her opinion it appears that there was no inappropriate restraint of Miss A by her walker.

2) Mr B pulled and pushed Miss A by her wrists in an appropriate manner

Mrs Featherston advised that it is often appropriate to hold patients by the hands to guide them when walking. Staff are taught to guide by supporting by the elbow or using a belt or walker to mobilise a patient. Mrs Featherston said that there are many times when a demented patient will not know what to do with either a walker or a belt. It is often appropriate to walk backwards holding the patient's hands, so that the patient can look into the caregiver's face for reassurance. Mrs Featherston said that in her opinion the day staff would have recorded bruising if it had been observed. She noted that staff bandaged Miss

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A's forearms in an attempt to preserve her skin integrity, and commented that the use of properly designed arm shields with Velcro closures might have been more appropriate. Mrs Featherston stated that it appears that there was nothing inappropriate in the manner that Mr B guided Miss A by holding her wrists and hands.

3) Mr B failed to attend appropriately to Miss A leaving her cold and naked except for the incontinence pad in the lounge late at night

Mrs Featherston noted that Mr B and Ms I have never denied that Miss A was left naked for a period of time on this occasion. Mrs Featherston said that it was inappropriate to leave someone sitting with no clothes on and it would be common practice to dress the patient before attending to the problem. She advised that privacy and dignity should be preserved first unless the situation is a medical emergency. It is the nurse's call in each situation.

Mrs Featherston observed that Miss A had a number of skin tears, which is understandable considering her weight and food intake. Although Mr B stated that Miss A was bleeding freely from a skin tear and that his priority at the time was to attend to this, there is nothing in the notes to indicate that there was a significant skin tear to Miss A's lower legs around 16 July 2002.

General comments
Mrs Featherston commented that in the early and middle stages of dementia, a resident can withdraw if frightened by something. Mrs G spent a number of years working in aged care facilities. Despite this experience it appears that she misinterpreted some of the situations she observed at the rest home.

Response to Provisional Opinion

In response to my provisional opinion, Mr B stated:

> "Thank you for your letter of 5 June 2003 with your provisional opinion in relation to the complaint made about the care of resident [Miss A]. I wish to take the opportunity to correct information given and dispute some findings.
>
> I note that you are considering a possible breach of the Code in relation to [Miss A's] care on a night in July.
>
> I wish to make the following points and observations:
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> 1. [Miss A] had a history prior to her dementia of being unconventional in relation to clothing, in that she did not care if she was seen in a state of semi undress. …
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> 2. It is established good practice that persons who enjoyed certain habits or behaviours prior to a dementing illness should be allowed to continue their preferences after they are affected by dementia. Therefore, [Miss A's] prior behaviour and behaviour

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in the rest home of removing her clothing to sunbathe, etc., should be respected as her desire and a norm for her. It has been confirmed by staff and [Reverend and Mrs C's] family that this was the case.

3. It is prejudice to state that [Miss A] must not appear in front of any other person or accidentally be seen by any other person in a partly undressed state because she must be suffering a violation of her privacy and respect. She clearly did not agree with this prior to her dementing illness. Another individual is stating <u>their opinion</u> of what they believe to be dignified and respectful. You cannot tell another person they are feeling lack of dignity or respect when clearly their previous behaviour shows they are not.

4. Your complainant is making this observation of lack of dignity because the Caregiver is a male. It is therefore gender biased. If the Caregiver was female there would have most probably been no complaint.

5. Your complainant has previously complained about a male at a previous Rest Home.

6. [Miss A] was not naked in the lounge. She was wearing a 'full brief' of the disposable incontinence variety. Therefore the complaint is that her breasts were exposed. If one reads the documentation from your complainant, originally the complaint was acknowledging a state of semi-undress. The word 'naked' should not be used, as it is incorrect.

7. You have now, for the first time, allowed me to read a comment made by your complainant. You state it is an entry in her diary of 16 July. It is a great pity that this information was not revealed at the discussions with staff, as it contains a lot of discrepancies that staff can rectify. I suggest that staff are now asked about this.

   The discrepancies are:

   a) That your complainant entered the lounge at 9.00pm and saw [Miss A]. The incident occurred around 3.00 to 4.00am, not at 9.00pm. This has a major impact on the likelihood of anyone else seeing [Miss A].

   b) At 9.00pm there are still other residents watching TV in the lounge. No mention is made of them. Why did they not see [Miss A]?

   c) The television set is routinely on at 9.00pm for residents to watch. It is not on at 3.00am.

   d) Your complainant saw 'a large pile of washing'. The washing is not done by 9.00pm. It is done in the middle of the night.

      The 'diary entry' of your complainant has multiple discrepancies that indicate a confusion between times. At 9.00pm it is correct that the television set would have been on and that residents would be watching it, at the end of supper.

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At 3.00 to 4.00am it is correct that 'washing' (linen to be folded) would be in the lounge, the television off, and definitely no residents.

8. Your complainant is stating that [Miss A] was seated 'naked' in the lounge at 9.00pm. This is clearly very unlikely when one considers that a number of other residents would still be there, watching television.

9. Your complainant's 'diary entry' is confused and not factual.

10. My decision to dress a wound rather than put clothing on a resident is a professional judgement. It is 'the Nurse's call in each situation' (quote from your professional nurse advisor). The decision is made under stress, not with the benefit of hindsight. In my opinion the wound was the priority, not the re-clothing of the patient, particularly when you consider that at 3.00am the lounge of a small Rest Home could hardly be considered a 'public place' as has been stated in your correspondence. It would be highly unlikely for any resident to enter the lounge between 3.00 to 4.00am.

11. I am a Senior Registered Nurse with many qualifications and as such am entitled to make judgements of a professional nature.

12. If it is inappropriate to allow [Miss A] to partially expose her breasts, you must be saying that it is appropriate to allow a skin tear to continue to bleed. You suggest she be returned to her room. It would be negligent to allow a resident to lose blood in this way while you cover her and walk around. The Nurse cannot cover [Miss A] up at the same time as dressing the wound. One action has to precede the other.

13. I am concerned about your report on Page 9 [10], Section 3 where your Advisor, Mrs Featherston is commenting about the appropriateness of [Miss A] being 'left naked for a period of time ...' this presents a false picture for Mrs Featherston to comment on. [Miss A] was <u>not</u> naked. The 'period of time' was one to two minutes while the dressing trolley was brought to the lounge. The expression used in your correspondence several times 'a period of time' seems to indicate something inappropriate. The actual time that expired is one to two minutes. The dressing trolley is about 30 metres away.

14. I failed to document [Miss A's] skin tear. This was an omission I cannot explain, but can guess that it was due to other priorities. It has been mentioned that [Mrs I] (Manager) was meticulous in her attention to skin tears. She was on holiday at the time, so that explains her not attending, reporting to the Doctor, or commenting on this skin tear. The Registered Nurse works part-time and would not necessarily have treated this skin tear. One must remember that [Miss A] was prone to skin tears. This is not a unique situation. …"

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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 applicable to this complaint:

RIGHT 1
Right to be Treated with Respect

2) Every consumer has the right to have his or her privacy respected.

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.

Professional Standards

The Old People's Homes Regulations 1987

37. Obligations of the licensee and manager –

(2) Every manager of a home shall take all reasonable steps to ensure at all times –

(a) That the residents are adequately cared for with respect to their everyday needs: …

Standards of Care for Old People's Homes (Ministry of Health, 1996)

THE RIGHT TO BE AN INDIVIDUAL
Standard 3

The Licensee or manager should:

(1) Encourage staff to respond to the individuality of each resident, and make sure the running of the home is flexible enough for this to happen.
(2) Ensure the privacy of the individual is respected.

…

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Privacy
Individual privacy is a basic right and should be respected.

…

… If you and your staff are able to see your elderly residents as fellow citizens with the same feelings and needs as your own and treat them as you would wish to be treated yourself, you will be well on the way to providing the best possible care.

Opinion: Breach – Mr B

Failed to attend appropriately to Miss A on 16 July 2002
During the late evening/early hours of 16 July 2002 Miss A was semi-naked in the rest home lounge. Mrs G, a resident in the home, stated that Mr B sat watching television and that he left Miss A sitting, dressed only in incontinence briefs, in one of the lounge chairs. Mr B agreed that for a period of time Miss A was semi-naked in the lounge when she came out of her room holding her nightdress, which was blood-stained from a skin tear on her lower leg. He said that his priority was to attend to the skin tear. There is a significant discrepancy between the two accounts of this incident.

Mr B said that the wound was bleeding to the extent that the blood was pooling on the carpet. This would indicate a serious skin tear. Mr B initially informed me that he recorded this incident in the nursing notes at the time. However, when he found that there was no record of a skin tear for that date, he stated that in his concern to attend to the situation he had overlooked noting the incident in the clinical records. This may have been the case, but Dr J, Miss A's general practitioner, informed me that she had no record of Miss A sustaining a significant skin tear on or around that date. She said that the more serious skin tears were always reported to her. Ms I and the registered nurse were meticulous in their attention to resident bruises and skin tears. Mr B stated that Ms I was on leave when this incident occurred and the registered nurse worked part time only, which could account for them not recording a skin tear for Miss A at this time. However, there is no evidence in the nursing notes written by other staff in the following days that Miss A sustained a skin tear around this date.

Responding to my provisional opinion, Mr B stated that there were a number of issues that needed to be taken into account when deciding whether his actions on the evening of 16 July breached the Code. He said that Miss A was comfortable about being seen without clothes, there was no likelihood of any other resident observing her owing to the late hour and, if the caregiver on duty had been female, there would not have been a problem.

In my view Mr B has not taken into account that Miss A was a frail, vulnerable elderly woman who, because of her demented state, was unable to exercise choice in the situation. Ms I and Ms K stated that they would not have left Miss A semi-naked for any period of time, but covered her before attending to her skin tear.

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Under Right 3 of the Code, disability services consumers are entitled to have services provided in a manner that respects the dignity and independence of the individual. I accept my expert advice that a resident's privacy and dignity should be preserved first unless the situation is a medical emergency. I do not accept that this was an emergency situation requiring immediate attention. I accept that Miss A may have been comfortable about being seen without clothing and frequently wandered at night. However, irrespective of Miss A's unconventional behaviour, there was no excuse for her to be left sitting semi-naked at night in an area that could be freely accessed by other residents of the home.

The 'Standards of Care' for rest homes affirm that individual privacy is a basic right and should be respected, and that elderly residents should be treated in the same manner as caregivers would want to be treated. Regulation 37(2)(a) of the Old People's Homes Regulations 1987 states that the owner and manager of the home has an obligation to ensure that residents are adequately cared for in respect to their everyday needs. Immediately Miss A entered the lounge without her night-clothes, Mr B should have covered her (for example, with a rug) before returning her to her room.

In my opinion, Mr B did not respect Miss A's privacy, or provide services in a manner that respected her dignity, and failed to comply with legal and other relevant standards. In these circumstances, Mr B breached Rights 1(2), 3 and 4(2) of the Code.

Opinion: No breach – Mr B

Mr B pulled and pushed Miss A in an inappropriate manner

Mrs G stated that she observed Mr B on a number of occasions pulling Miss A by the wrists, and also pushing her back into a chair. She said that Mr B's actions caused bruising and skin tears to Miss A's wrists and forearms.

Mr B denied that he did this, but conceded that he did, at times, lead Miss A by holding her hands, walking backwards to guide her. The staff at the rest home were instructed how to guide the residents by supporting with a hand under the elbow, and also by holding their hands and walking backwards to guide them forward. Ms I stated that Miss A did not resist when staff were guiding or directing her around the rest home.

The records show that Miss A did sustain numerous bruises and skin tears to her forearms and legs, which were thought to be the result of bumping into furniture and fittings and getting in and out of bed unaided. The staff used Tubigrip stockings to encase her lower arms and legs to protect her from injury. Dr J informed me that Ms I and the registered nurse were meticulous in their treatment of any bruising or skin tears and would report any significant injuries.

Miss A's friends, who visited her regularly, did not notice any unusual bruising. Mrs E had noted the bandages to Miss A's arms and was satisfied with Ms I's explanation that the bandages were to preserve Miss A's skin integrity.

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My independent advisor stated that it is often appropriate to hold residents' hands to guide them when they are walking, and that staff are taught to guide by supporting by the elbow or by the use of a belt or walker to mobilise a resident. My advisor said that there are many times when a demented resident will not know what to do with either a walker or a belt and that in these circumstances it is often appropriate to walk backwards holding the resident's hands, so that he or she can look into the caregiver's face for reassurance. My advisor noted that staff bandaged Miss A's forearms in an attempt to preserve her skin integrity, and commented that the use of properly designed arm shields with Velcro closures might have been more appropriate. My advisor considered that the day staff would have recorded bruising to Miss A if it had been observed.

I accept my expert advice that there was nothing inappropriate in the manner of Mr B's guiding of Miss A, and that in this respect Mr B did not breach the Code.

Mr B hid Miss A's walking aid
I was informed that Mr B hid Miss A's walking frame to prevent her from wandering. Mr B (and other staff members) did remove Miss A's walking frame from the dining room at meal times for the safety of other residents moving in and out of the room. This practice was not confined to Miss A. A number of other residents also "parked" their walking frames beside their tables, and they were also moved until the meal was finished. The difference in Miss A's case was that she had to be actively encouraged to remain at the table to eat a meal and would frequently get up and move around the room during meals.

Mr B primarily worked the night shift. There is sufficient evidence from the clinical records, and the staff who cared for her during the day, that Miss A had access to her walking frame apart from during meals. In my view there is no substance to the allegation that Mr B hid Miss A's walking frame in a manner that did not respect her dignity and independence. Accordingly, in this respect, Mr B did not breach the Code.

Mr B restrained Miss A in a chair with a walking frame against her legs
Mrs G informed me that Mr B turned around Miss A's walking frame so that the bar with the bag attached was against her shins when she was sitting in her chair in the lounge. Mrs G said that this would "fasten her to the chair, and that was when she used to get bruises on her shins".

The rest home has a restraint policy, based on the Ministry of Health's Procedural Guidelines for Physical Restraint, June 1993. Although the policy does not appear to be appropriate to the care of the frail elderly in a rest home setting, it does stipulate that if restraint is required it should be discussed with the doctor and authorised in writing. Ms I stated that there was no reason for Miss A to be restrained.

My advisor stated that the story that staff gave to explain Miss A's habit of sitting with her walker turned on its side so that she could rest her feet was too unusual not to be true. Mrs Featherston said that the notes show that Miss A was mobile and used a walker with wheels. It would be highly unlikely for a walker with wheels to be used to restrain someone. My advisor commented that despite Mrs G's experience of working a number of

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years in aged care facilities it appears that she misinterpreted some of the situations she observed at the rest home.

I accept my expert advice that there was no inappropriate restraint of Miss A using her walking frame. There is no evidence that Mr B took any action to compromise Miss A's ability to mobilise independently. Accordingly, in this respect, Mr B did not breach the Code.

Actions taken

The rest home and Mr B have taken the following actions:

- Staff awareness of the complaints process has been raised.
- Mr B continues to participate in resident care, but now ensures that female residents are assisted by female staff.
- The rest home's policies and procedures for restraint, privacy and dignity, and challenging behaviour are being reviewed. Incident reporting and other residents' assessment tools are under review and are in the process of being finalised.

Further actions

- A copy of this report will be sent to the Nursing Council and the Ministry of Health Licensing Office.
- A copy of this report, with details identifying the parties removed, will be sent to Residential Care New Zealand and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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