Rest Home

Report on Opinion - Case 97HDC9897

Complaint

The Commissioner received a complaint about the care provided to residents of a Rest Home, and in particular, the care of the complainant's mother. The complaint is that:

- *Due to lack of staff supervision one day in early November 1997, a resident was able to get up onto the roof where he lost his footing and fell to the ground seriously injuring himself.*
- *There is insufficient staff on at night to adequately care for the residents in the event of a fire.*
- *Staff did not take appropriate care of a resident who was seen bleeding from the mouth for a few days but was not taken to the hospital because he did not want to go.*
- *The complainant's mother, who had circulation problems in her legs, was inadequately cared for by the staff at the home, which resulted in her feet turning gangrenous.*
- *When the complainant's mother was taken out of the home in January 1998 she smelt and was in a state of neglect.*

Investigation

The complaint was received from the complainant on 3 November 1997 and an investigation was undertaken. Information was obtained from:

The Complainant
The Manager, Rest Home
The Owners of the Rest Home
A Senior Care-Giver, Rest Home
Two Care-Givers, Rest Home
The Night Nurse, Rest Home
A General Practitioner
A Podiatrist
Building Controls Manager, Local Council

Relevant clinical records were obtained and viewed. A member of the Commissioner's staff visited the rest home.

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Outcome of Investigation

Resident with Bleeding Mouth

In early August 1997 a resident of the Rest Home ("Resident A"), died in his sleep. The Nurse Manager at the Rest Home informed the Commissioner that Resident A had become unwell with a severe dose of influenza in late July. Resident A had attended his general practitioner and obtained a prescription for antibiotic medication. However, his condition deteriorated and he was diagnosed with bronchoconstriction, secondary to a chest infection, when he was seen by a duty doctor four days before he died. Resident A was treated with steroidal medication and given bronchodilators.

Resident A was seen again by his general practitioner two days before his death. The GP noted that this treatment had resulted in an improvement in his condition. At 2:00am on the day he died, Resident A was seen by the night nurse. Resident A seemed well at that time and had a conversation with the Senior Care-Giver. At 4:00am when the Senior Care-Giver returned to check on him Resident A had died.

The Manager stated that shortly after Resident A's death, a resident of the Rest Home informed a staff member that he had been coughing up blood before he died. The Manager further stated that Resident A was well supervised during his illness, receiving all his medication, and that appropriate medical attention would have been sought if any staff member had been made aware that Resident A had been coughing up blood.

Resident's Fall from First Floor Balcony

In early November 1997 another resident ("Resident B"), who had lived at the Rest Home since April 1995, fell from the building's first floor balcony.

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Outcome of Investigation, *continued*

The Manager stated that Resident B was an independent resident who did not usually require staff supervision, despite suffering from a psychiatric disorder. Resident B's medication was altered by his usual doctor's locum in early October 1997 as there was a deterioration in his condition. Staff at the Home supervised Resident B more closely due to these developments.

On the day of his fall, Resident B returned to his room on the first floor after having morning tea. He was then seen to fall from a balcony. Resident B was admitted to Hospital and was later transferred to a larger Hospital for orthopaedic surgery. Following his hospital stay Resident B returned to the Rest Home.

The Local Council Building Controls Manager stated that following Resident B's fall the balcony was inspected and found to comply with the Building Act in all respects. The balcony provides access to a fire escape.

The Complainant's Mother

The complainant's mother ("Resident C") became a resident at the Rest Home in late November 1996. Resident C suffered from dementia and peripheral vascular disease. Because of her circulation problems, elevation of her feet and regular monitoring of their condition was required and it was necessary for her to avoid placing pressure on her feet. Resident C also experienced occasional urinary incontinence.

The Manager informed the Commissioner that Resident C did not show any signs of having gangrene while at the Home. Staff members were all aware of Resident C's poor circulation and great care was taken to maintain the condition of her feet. As part of her care, Resident C's feet were kept elevated and bathed regularly and she received frequent foot massages. Resident C was also attended regularly by a podiatrist while at the Home.

The Manager stated that Resident C was showered every day and her clothing was always clean. She was also toileted regularly and was seldom incontinent. Staff noted that there was a very strong odour when she was incontinent.

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Outcome of Investigation, *continued*

Nursing notes from the Home contain frequent references to toileting Resident C and other efforts made to deal with her urinary incontinence.

In early January 1998 Resident C was removed from the Home by her daughter (the complainant). The complainant signed an acknowledgement to this effect noting that she took full responsibility for her mother's care. The complainant stated that she removed her mother from the Home because she was being inadequately cared for. The complainant further stated that her mother was unclean, unkempt and smelt of urine when transferred into her care.

The day after this, the complainant arranged for a general practitioner to visit her mother and give her a "check-up". The GP had been responsible for Resident C's care since 1995, including the period of time that she was resident at the Rest Home. The GP examined Resident C's feet and did not note any problem with her heel.

Later that month, Resident C was seen by her podiatrist, who noticed that she had blackened heels and advised the complainant to have them looked at by a doctor. In late January 1998 the GP visited Resident C and checked her heels. The GP was unable to determine whether the blackness was due to gangrene or bruising with secondary infection. The GP prescribed antibiotic medication and noted that Resident C would need to be reviewed shortly thereafter.

In early February 1998 the GP saw Resident C again and referred her to Hospital, as the condition of her heels had not improved. That day, Resident C was admitted to Hospital with gangrene. The GP's referral letter notes that Resident C had a history of approximately one week of a black area on her left heel.

The GP stated that Resident C was well cared for at the Home, noting that there was no deterioration of any of her conditions while she was a resident there. The GP further stated that with an underlying vascular condition such as Resident C's, gangrene can occur at any time.

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Outcome of Investigation, *continued*

Fire Evacuation

In mid-January 1998 a fire drill was carried out at the Home by the New Zealand Fire Service. Subsequently, the Fire Service recommended that a fire sprinkler system should be installed. A suggestion was also made by a member of the Fire Service that the Home's neighbour, (the complainant), should be approached to find out whether she would be willing to assist in the event of a fire, until the sprinkler system was installed. The complainant indicated that she would be willing to provide such assistance.

A Ministry of Health Audit Report dated late October 1997 failed to identify any fire risk.

A fire sprinkler system has now been installed.

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.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

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.

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Opinion: No Breach

In my opinion, the Rest Home did not breach the Code of Health and Disability Services Consumers' Rights as follows:

Resident A
In my opinion, the Rest Home did not breach Right 4(3) of the Code with respect to care provided to Resident A before his death.

Resident A's influenza and bronchoconstriction were diagnosed promptly and treated appropriately. He was frequently checked on while he was ill and he was being treated by both his own general practitioner and the duty doctor. I am satisfied that staff at the Rest Home were not aware that Resident A had coughed up blood in the days before his death. I accept the Manager's assurance that medical attention would have been sought if staff had been made aware of this.

Resident B
In my opinion, the Rest Home did not breach Right 4(4) of the Code with respect to supervision of Resident B on the day of his fall.

I note that Resident B had been suffering from an exacerbation of his psychiatric disorder in the weeks before his fall. I also note that his medication had been changed in October 1997 by his usual doctor's locum. Staff supervised him more closely at this time. However, by early November 1997, it was reasonable for the Rest Home staff to have considered that Resident B did not present a danger to himself. I am satisfied that the incident could not have been predicted or prevented by the Rest Home. I have also been informed that the balcony from which Resident B fell complied with relevant safety standards.

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Rest Home

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Opinion: No Breach, *continued*

Resident C
In my opinion, the Rest Home did not breach Right 4(2) or Right 4(3) of the Code of Rights with respect to the care provided to Resident C.

There is no evidence that Resident C was in a state of neglect when she left the Rest Home. There is also no evidence that Resident C was suffering from gangrene. It appears that Resident C only began to develop gangrene in her feet after she left the Home.

The Rest Home staff dealt with Resident C's urinary incontinence in an appropriate manner and this is well documented in her notes. Resident C's general practitioner attests to the fact that she was well cared for while at the Home. It is also noted that the complainant did not notify staff of any dissatisfaction with Resident C's care while she was resident at the Rest Home, despite living next door to it.

Fire Safety
In my opinion, the Rest Home did not breach the Code with respect to fire safety.

A Ministry of Health Audit Report failed to identify a fire risk in October 1997. The need for a fire sprinkler system was not identified until the fire drill carried out by the fire service in mid-January 1998. I am satisfied that the measure proposed by the Fire Service regarding enlisting the aid of neighbours was merely a sensible suggestion. Indeed in my opinion it would have been appropriate for the Home to have approached its immediate neighbours to discuss a combined response to a fire alarm in the absence of the Fire Service suggestion.

There is no evidence that either the New Zealand Fire Service or the Ministry of Health had any significant concerns about fire safety at the rest home. I also note that a sprinkler system has now been installed.