Social Worker / Service Provider Organisation

Report on Opinion - Case 97HDC7047

Complaint

The Commissioner received a complaint from two brothers about the services their sister ("the consumer"), received while in the care of a provider organisation's residential home. The complaint is that:

- *The consumer is a resident of a residential home operated by the provider organisation.*
- *On a day in late March 1997, while at the home, the consumer was left unsupervised and was badly burned by hot bath water.*
- *Rather than phoning an ambulance, the consumer was taken by staff to an accident and emergency clinic. Some time elapsed between the burning and the transfer to the clinic due to, among other factors, the fact that the other three residents of the home were also taken in the van to the clinic along with the consumer.*
- *Once assessed at the clinic the consumer was immediately transferred to hospital.*
- *The consumer required extensive skin grafting to the affected areas and was seriously ill as a result of the burns suffered.*
- *Subsequent to the burning it was found that the home's hot water cylinder thermostat was set at 80 degrees.*

Investigation

The complaint was received by the Commissioner on 11 June 1997 and an investigation was undertaken. Information was obtained from:

The Consumer's brothers / Complainants

The General Manager, Provider Organisation

The Chief Executive Officer, Provider Organisation

Staff member on duty, Provider Organisation

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Information Gathered During Investigation

The consumer is a 54 year old woman resident of the provider organisation's residential home. At the time of the incident the provider's home had four residents. The home has continued to have less than five residents and therefore is not registered under the Disabled Persons Community Welfare Act.

The consumer's personal file says that she requires *"full supervision"*. The personal file was held at the home at the time of the incident, which is the subject of this complaint ("the incident"). The file was part of the residential home's manual which was designed to provide specific information for staff in relation to the running of the house, the residents and their care.

The provider advised the Commissioner of the identity of the sole staff member on duty at the home on the day of the incident. A second staff member was in the adjoining flat. At approximately 6.00pm the consumer went to her room to gather her clothes and prepare for a bath. The staff member on duty ran the bath and then went to the lounge.

Following the incident, the provider carried out an internal investigation to establish the cause of the consumer's accident and to review the procedures followed by staff at the home. The provider's general manager advised the Commissioner that during the course of the investigation interviews were carried out with:

- the staff member/social worker on duty at the time of the incident;
- the second staff member on duty in the adjoining facility who was called for assistance;
- a fellow resident of the home; and
- the community services manager for the home who was contacted by the staff following the incident and who met the consumer and the staff at the accident and emergency clinic.

In addition, the provider's regional service adviser, regional manager, and a services manager visited the home as part of the investigation.

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Information Gathered During Investigation, *continued*

The provider's internal investigation revealed that the staff member on duty knew that the consumer required full supervision. Notes taken during a meeting with that staff member in early March 1997 in relation to the incident record the following:

Interviewer (regional service manager): *Had you read the "Welcome to the Home" folder?*

Social worker: *Yes she has read red[sic] folder.*

Interviewer: *So you were aware then that [the consumer] required full supervision when bathing, getting food etc?*

Social worker: *While* [the consumer] *requires supervision in most areas, I respect her privacy. If she goes to the toilet I don't stand there and watch her, but you need to supervise her."*

The social worker says that the consumer's usual routine is to have dinner, and afterwards to gather her clothes, and go for a bath. The social worker says that at approximately 6pm on the day of the incident she sent the consumer to her room, as usual, to gather her clothes prior to her evening bath. The social worker says that she went to the lounge to read and write a report and to also keep watch over other residents.

While in the lounge, the social worker heard screams from the bathroom. The social worker ran to the bathroom and found the consumer on the floor.

The provider's internal investigation revealed that the thermostat controlling the water temperature in the home was set at 80 degrees.

It is not clear how the consumer got into the bath, although the social worker said she suspected that another resident at the home placed the consumer in the bath. The social worker says she saw that resident running from the bathroom to the balcony yelling, *"hot, hot"*. The consumer was immediately taken out of the bath. The social worker said that there was blood and skin in the bath and the consumer was red from the waist down.

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Information Gathered During Investigation, *continued*

The social worker emptied the bath and filled it with cold water. The consumer was then placed in the cold bath. The social worker asked the other resident present to get assistance from the second staff member, who was working on a shift in an adjoining facility at the home. The second staff member came to assist about five minutes after being called.

The second staff member filled out an incident report with respect to the incident, who states in the report that she "*went over next door, not anticipating an emergency. The staff called out saying* [the consumer] *had scalded herself. I heard* [the consumer] *yelling off and on in the bath area. She was sitting in the bath tub filled with cold water. I saw that it was more than a scald as I saw loose bits and pieces of skin floating around… her legs were raw and reddish up to the knees, her back had scalded quite bad. I told the staff to ring* [the community services manager] *and arrange to have her taken to the doctor."*

The consumer was kept in the cold bath for approximately ten minutes. The second staff member asked if the social worker had contacted the community services manager. The social worker had not done so and while the consumer was in the cold bath the social worker went to contact the community services manager for advice on what to do. The social worker could not contact the community services manager and left a message on her pager at 6.08pm. The social worker stated that she was shocked and didn't think of phoning 111. When the community services manager returned the call, the social worker said that the consumer had suffered some scalding to her foot and she sought permission to take all the residents with her to seek medical assistance as she was reluctant to leave the other residents alone. The community services manager gave the social worker directions to the nearest accident and emergency clinic and arranged to meet her there.

The social worker went to get a dress from the consumer's wardrobe and it was put on the consumer by the social worker and the second staff member. Blood came from the consumer's legs as she was assisted to a van and taken to the clinic.

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Information Gathered During Investigation, *continued*

The van was met at the clinic by the community services manager who, along with a doctor from the clinic, assisted the consumer into the clinic. The social worker says she told the doctor that the consumer had had "*a slight accident*". The doctor examined the consumer and found that she had extensive burns to her lower legs, thighs and buttocks. The doctor immediately referred the consumer to the accident and emergency department at a hospital. The consumer was transferred to a ward of the hospital following treatment in the accident and emergency department. It was discovered at the hospital that the consumer had suffered burns over 27 percent of her body.

The community services manager reported the incident to the residential service managers of the provider organisation. The report states:

> *"At approximately 6.15pm on* [the day of the incident in] *March 1997 I received a pager message to ring* [the social worker] *at the home as soon as possible. I immediately called* [the home] *and spoke to* [the social worker]. *She stated that* [the consumer] *had been scalded. She did not want to leave the home clients to take* [the consumer] *to the doctor… I questioned as to how* [the consumer] *was burnt* – [the provider's staff member on duty] *stated hot bath water. I asked if she had used cold water, she said yes, but* [the consumer] *was upset and in pain. I gave directions to the nearest accident & emergency…".*

On 7 April 1997 the regional service adviser produced a summary of findings of the internal investigation. The recommendations were as follows:

- *All hot water cylinders to be regulated to 57°C.*
- [the consumer] *should have been supervised while running the bath and bathing.*
- *Supervision would have prevented any other resident interfering with the taps (if in* [fact] *this did occur) and* [the consumer] *getting into or being put into the bath prematurely or without testing the water temperature first. It would have also enabled a much faster response had the staff member been in the room when* [the consumer] *got into the bath.*
- *It is not clear how* [the social worker] *emptied the bath of hot water. There would appear to be no chain on the plug for the bath and no evidence suggesting there previously was a chain on the bath plug.*

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Information Gathered During Investigation, *continued*

- *Given the extent of* [the consumer's] *injuries, 111 should have been contacted immediately. Paging* [the community services manager], *waiting for her response, getting* [the consumer] *out of the bath, dressed and into the van and then driven to the* [accident and emergency] *clinic resulted in some 30-45 minutes delay between when* [the provider's staff member on duty] *was alerted to* [the consumer's] *injuries and when she received medical treatment. This is far too long a delay given the circumstances. The extent of* [the consumer's] *injuries* [are] *evidenced by the vivid descriptions provided of her injuries.*
- *While the regulation of temperature of the hot water was not known to* [the social worker], *her lack of supervision and inappropriate delays in seeking medical assistance contributed significantly to the severity and extent of injuries and could impact on* [the consumer's] *recovery."*

I understand the social worker has since tendered her resignation and that she advised that her resignation was not related to the incident under investigation.

It is noted in a memorandum from a services manager to a regional properties manager of the provider organisation that:

> "*After speaking to the maintenance person for* [the home] *it appears he has checked the hot water temperature for approximately a dozen homes to date… The majority of the houses tested over 60+ degrees which is in the category of dangerous*".

Notification of the results of the provider's internal investigation were sent by the services manager to the consumer by facsimile in early June 1997. Following recovery from the injuries she sustained as a result of this incident, the consumer returned to the home and still resides there.

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Information Gathered During Investigation, *continued*

The Chief Executive Officer ("CEO") of the provider organisation has advised the Commissioner that the thermostat at the home has been checked since March 1997, by both staff in the home and the maintenance staff employed within the provider's property division. The provider's CEO advised that staff have checked the water temperature using a hot water temperature card which indicates if the water temperature is over 55 degrees celsius. The maintenance staff have checked the water temperature using the same card and using a hot water probe, as well as checking the hot water cylinder thermostat.

In addition, the provider's CEO advised that a new hot water cylinder fitted with a tempering valve was installed in the home in February 1998. The Master Plumbers Trade Association has also undertaken to carry out an audit of all hot water cylinder temperatures in the provider organisation's residential homes throughout New Zealand.

The provider has recently instituted an annual health and safety audit system whereby all homes will have a thorough annual check by the regional property manager to identify health and safety issues and maintenance needs. The audit form which the manager is to complete asks:

Hot Water Cylinder
Is the water supply enough?
Is the water temperature safe?
Has the tempering valve been installed?
If not, when will this happen?

Response to the Provisional Opinion

An opportunity was given to the social worker to respond directly to the Commissioner regarding the complaint. The provider's staff member on duty did not respond to the Commissioner until 12 April 1999 in response to the Commissioner's provisional opinion.

The social worker's statements quoted in the body of the investigation are taken from the internal investigation notes of the provider.

In response to the Commissioner's provisional opinion, the social worker stated that she had worked a seven day shift plus seven sleepovers without a break. The social worker stated that she was run down.

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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.

Opinion: Breach – Social Worker

In my opinion the social worker breached Rights 4(2), 4(3) and 4(4) of the Code of Health & Disability Services Consumers' Rights.

Right 4(2), Right 4(3)

The consumer was a consumer who needed "*full supervision*". When the social worker went to the lounge to fill out a report, while the consumer was taking a bath, the consumer was not being fully supervised. It would have been appropriate if the social worker waited for the consumer outside the bedroom while the consumer was gathering her clothes.

There were clear indications when the consumer was found in the bath that she was severely injured. The social worker acknowledged that blood and skin was coming off the consumer's body and it would have been appropriate at this stage for the provider's staff member on duty to call for an ambulance. The provider acknowledged a 45 minute gap between the consumer being scalded and treatment at the clinic and also acknowledged that this delay was unacceptable. The provider's internal investigation revealed that the social worker understated the injuries to both the community services manager and to the doctor at the clinic. The social worker, therefore, failed to react appropriately to the extent of the consumer's injuries. In my opinion the descriptions given by the social worker and the second staff member of the consumer's injuries is evidence that the scalding was severe and the social worker ought to have called an ambulance.

In my opinion, the social worker has not complied with her duty to provide services of an appropriate standard.

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Opinion: Breach - Provider Organisation

Right 4(4)

In my opinion the provider breached Right 4(4) by not having an adequate system in place to ensure that thermostats in their residential homes were set at a satisfactory level. The investigation established the temperature of the water at the home was set at a maximum of 80 degrees, which is a dangerous level. In failing to ensure that the temperature of the water at the home was safe, the provider organisation have not complied with their obligation to minimise potential harm to the consumer and other clients at the home and have therefore breached Right 4(4).

Future Actions

Following this incident, the provider implemented an immediate adjustment of the thermostats in all of their residential homes, and have advised that this is being checked on a monthly basis as part of each home's health and safety procedures. They have also sought external assistance for an opinion on safe water temperatures.

The provider's CEO has advised the Commissioner that some of the provider organisation's procedures in relation to emergencies have been altered since the time of the consumer's injuries. The introduction of a procedures manual and home handbook into every residential home in the northern region has made the expectations of staff clearer and has standardised practises across the region. The procedures manual is a guide for all staff working in residential homes in the northern region and serves as an introduction to the provider organisation, to staff roles and responsibilities and is designed to be a reference tool. The home handbook accompanies this and contains specific information about each home.

The provider's CEO has advised the Commissioner that following this incident, a note was placed on the staff-room notice-board emphasising that the consumer requires supervision at all times and especially at bath time.

Actions

I recommend that the provider and the social worker apologise to the complainants.

In addition, I recommend that the provider undertake a review of staffing levels and current rostering systems.

A copy of this opinion will be sent to the complainant.