Rest Home

Report on Opinion - Case 98HDC17105

Complaint

The Commissioner received a written complaint about the treatment of a consumer at a Rest Home. The complaint is that:

- *In mid-August 1998 at approximately 11.05pm, the consumer, a resident of the Rest Home, was found very wet and cold lying on wet grass with his legs hanging over the kerb on a street.*
- *The consumer was confused and whilst he knew his name, he could not identify his place of residence and he had no identity details on him.*
- *The Rest Home was contacted at 11.40pm and confirmed that a resident had been missing from the home since 9pm.*
- *The consumer was finally picked up at 11.45pm.*

Investigation

The complaint was received on 25 August 1998, an investigation was commenced and information was obtained from:

The Complainant
The Manager, Rest Home
A Gerontology Nurse Practitioner
The Psychiatric District Nurse
The Consumer's next of kin
The Community Constable

Relevant clinical documents were obtained and viewed.

The Rest Home was visited by the Commissioner's investigation staff on 31 March 1999 and the Ministry of Health audit report of September 1997 was obtained as part of the investigation.

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Outcome of Investigation

The two licensees for the Rest Home were identified. The Home is licensed for 27 residents and is managed by a third party. In late March 1999 there were 24 residents accommodated in the home.

The Rest Home is an older style home, being a weatherboard house, situated about 20 feet from the public footpath. Access to the house is via a crescent shaped, cobbled driveway. There are no gates or front fence to ensure security. There is an old garage situated in the centre front of the property that would prevent staff from effectively observing anyone leaving the home.

At 11.00pm one night in mid-August 1998, the complainant was travelling home from her place of work, which is a private hospital. As she was travelling down a main street, she noticed something beside the road, and told her husband to stop the car. The complainant got out of the car and found the consumer lying in the grass, wet and cold, with his legs over the kerb of the road. The complainant helped him into the car. He appeared confused and was unable to recall his correct address, but was able to supply his name. The complainant assumed that he was a resident of a rest home, although he had no form of identification other than a piece of paper with his phone number.

The complainant returned to her place of work to notify the police. She then rang a number of rest homes in the area, and on contacting the Rest Home under investigation was informed by a staff member that they had a male resident missing. The Manager later confirmed by telephone to the Commissioner the identity of the staff member on duty that night.

The complainant offered to drop the consumer off at the Rest Home, but the offer was refused. The on-duty staff member informed the complainant that she would wake her husband to uplift the consumer from the private hospital. The consumer was picked up at 11.45pm.

The complainant contacted Age Concern about this matter. They advised her to make a complaint to the Health and Disability Commissioner.

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Outcome of Investigation, ***continued***

In response to a report from the Age Concern Elder Abuse Team about the above incident, a Gerontology Nurse Practitioner visited the Rest Home. She also spoke to a Psychiatric District Nurse whom the consumer sees on a weekly basis.

The Psychiatric Registrar for mental health services in the area, in his letter the Medical Officer of the Rest Home (early June 1998) reports that the consumer "has had a schizophrenic illness for many years and now has a dementing process". The consumer attends a mental health services clinic every Thursday, where he is seen by the Psychiatric Nurse, who has known him for many years. In early June 1998 the consumer had been seen by the psychiatric registrar at the clinic mainly because of his problem of wandering. The Registrar recommended that if the consumer's wandering continued to be a problem, he would need to be placed in a Stage 3 secure unit.

The Gerontology Nurse visited the Rest Home on 5 October 1998. In her report she stated that the consumer was content and comfortable, but that he was not wearing an identifying wristband. The Rest Home Manager told the Gerontology Nurse that there was a written protocol in place regarding the consumer's wandering and that she would update it. The Manager said that the staff are instructed that they are to be aware of the consumer's location at all times. If he does go missing, they are to look for him, notify the police within two hours and notify the consumer's brother, (his next of kin). The Manager is to be notified if the incident takes place after hours.

The Gerontology Nurse further noted in her report her concerns about the lack of security for the home, especially the lack of security gates. The Manager was reported as stating that the owners of the premises were going to install security gates after the front garage had been removed. No date was given for the work, but it was reported that quotes had been obtained and it was expected that work would commence in the near future. The Gerontology Nurse concluded her report by stating that she supported the concept of the consumer staying at the Home dependent on continuing staff awareness of the consumer's need for supervision and the installation of security gates.

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Outcome of Investigation, ***continued***

On 31 March 1999, the Commissioner's investigation staff visited the Rest Home. It was noted that there were no fences or security gates at the front of the property. The Manager informed the Commissioner that she had received quotes for the gates, and that work had been due to start during the last week of March 1999. The Manager stated that the gates to be installed would be 1.5m high wooden gates. She was unable to say what type of closing mechanism would be installed. The Manager did not have a definite date for when the work would commence.

The Manager informed the Commissioner that the consumer had wandered from the rest home twice in early March 1999. Both incidents were noted in the daily progress notes relating to the consumer. The Manager was unable to produce the incident reports detailing these events. The Manager stated that the consumer continues to be visited weekly by the Psychiatric Nurse. The Psychiatric Nurse, when interviewed on 6 April 1999, stated that she had not been made aware that the consumer's wandering continued to be a problem and recognised the risk to his safety if his wandering persisted.

The Gerontology Nurse was interviewed on 6 April 1999 as part of the investigation. She stated that she visited the Home on another matter in early March 1999 and was concerned that the fence and gates had not been installed at that date. She discussed the consumer with the Manager, but was not made aware that he had left the rest home on two occasions in March. The Gerontology Nurse stated that she is aware that the decision for the reassessment of the consumer is being left to the Manager's professional judgement. It was the Gerontology Nurse's opinion that the matter now needs to be referred to the Care Team for their intervention, as the consumer's safety continues to be threatened.

In the first week of April 1999 the Manager faxed copies of quotes for installation of gates and fencing, dated late March 1999, to the Commissioner. The Manager stated that the gates would initially be installed as well as part of the fencing. The Manager advised the Commissioner that the remaining fencing would be completed when the garage at the front of the property, which houses the fire sprinkler valve set, had been demolished and the sprinkler valve set relocated. There is no date for when this work will be done. The Community Constable gave details of her personal involvement in escorting residents back to the Rest Home. The Constable was unable to provide specific details about who the residents were, or dates of incidents.

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Outcome of Investigation, *continued*

In the second week of April 1999 the Manager faxed through the incident reports relating to the consumer wandering from the rest home twice in early March 1999. It appears that on each occasion, documented by the staff, he was missing for about an hour before the staff located him. On the second occasion he was located by a staff member in a street. There was no documented evidence that staff had contacted Police when the consumer went missing, either in March 1999 or in August 1998, when the matter was first brought to the Commissioner's attention.

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: Breach, Rest Home Manager

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

Right 4(2)
The incident of the consumer's absence from the Rest Home was reported by Age Concern to the Gerontology Nurse. The Nurse spoke to the Manager about the complaint in October 1998 and noted at that time that policies and procedures to instruct staff in measures to ensure the consumer's safety had not been updated. She also noted that the consumer was not wearing an identifying wristband. The Gerontology Nurse also found that the Accident/Incident forms recording the consumer's absences from the Rest Home had not been completed satisfactorily. These forms are used to record unusual behaviour, to identify patterns and plan intervention to prevent the reoccurrence of incidents such as the consumer's wandering.

The Manager's failure to provide staff with information and guidance in preventing the consumer's wandering breached the consumer's right to have services provided that comply with relevant standards.

Right 4(3)
The fact that the consumer continues to wander from the Home is not being fully documented, and the staff at the mental health services centre are not being made aware that the problem continues. The Psychiatrist, in his report of June 1998, stipulated that the consumer would need to be reassessed for placement in secure care if his wandering continued to be a problem. The consumer has continued to wander from the Home for considerable periods of time, but has not been referred for reassessment. There appear to be unrealistic expectations placed on staff to supervise the consumer at all times. The Rest Home presently has 24 residents, a number of whom have mental health problems. There are 2 caregivers per shift to care for this number of residents.

In not having the consumer reassessed regarding his suitability for continuing placement at the Rest Home, the Manager has breached the consumer's right to have services provided in a manner consistent with his needs.

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Opinion: Breach, Rest Home Licensees

Right 4(4)

The Manager gave the Gerontology Nurse assurances in early November 1998 that finance had been approved by the owners of the Rest Home for the security gates to be erected "in the near future". These gates have not been installed. This omission poses a very real risk to residents wandering from the confines of the rest home out into the busy thoroughfare surrounding the Home. When the Investigation Officers visited at 1pm on 31 March 1999, it was raining. They noted that the street is a busy through-road, and the Home is situated on an inclining part of the road. A resident stepping out into traffic would be at severe risk, particularly in bad weather, as due to the incline and camber of the road, vehicles would have difficulty in stopping in time to avoid an accident. The Rest Home did not provide a safe environment for the consumer.

The consumer is an active man who enjoys walking and socialising. In the present environment at the Rest Home, he is unable to enjoy these activities, as the environment is unsafe. By not providing a security gate and fence, the Rest Home failed to provide a service that minimised potential harm to the consumer, and optimised his quality of life.

In my opinion, for every breach of the Code by the Manager, the Licensees as the Manager's employers are vicariously liable.

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Actions Taken

The Manager advised that:

1) The gate and security fence were erected on 21 April 1999.
2) The consumer has been reassessed by the Gerontology Nurse.
3) On 29 April 1999 at a meeting with the consumer's next of kin, the Psychiatric Visiting Nurse and the Manager decided that the consumer should stay at the Rest Home.

Future Actions

I recommend that:

- The Licensees as the owners of the property erect security gates, with appropriate mechanical closures to ensure the safety of residents, immediately.
- The consumer is referred to the Psychiatrist, mental health services, for reassessment of his suitability for continued placement at the Home.
- The Licensees, as the owners of the Rest Home, apologise in writing to the consumer's family for breaching the Code.
- The Manager instructs staff at the Home in the correct method of completing incident report forms and ensures incident reports are completed.
- The Manager formulates a method of collating completed incident report forms to identify patterns and plan intervention to prevent incidents such as the consumer's wandering.

Other Actions

A copy of my opinion will be forwarded to the complainant and the Health Funding Authority, and the consumer's brother.