Rest Home

Report on Opinion - Case 97HDC9132

Complaint

A complaint was received by the Commissioner from two complainants regarding the care provided to their late mother by the licensees and staff at a rest home. The complaint was that:

- *Regular requests from the consumer's family for updates regarding their mother's care were not responded to.*
- *The consumer's family were 'led to believe' that the female licensee was a registered and qualified psychiatric nurse.*
- *The consumer experienced delays of up to three months for the provision of podiatry services.*
- *Medication for agitation was inadvertently left out of the consumer's drug regime.*
- *The consumer escaped from a secure unit of the rest home. The consumer's family was not informed of the escape.*
- *Staff at the rest home were not made aware of all of the consumer's medical conditions.*
- *Following a choking incident, which required abdominal thrusts to clear an obstruction, the consumer was not seen by a doctor for three days. The consumer's family were not informed of the incident.*

Investigation

The complaint was received from Advocacy Network Services Trust on behalf of the complainants on 6 October 1997 and an investigation was commenced. Information was obtained from:

The first Complainant/Consumer's daughter
The second Complainant/Consumer's daughter
The Former Licensee and Manager, Rest Home
The Former Licensee, Rest Home
Two Former Caregivers, Rest Home
Former Acting Principal Nurse, Rest Home

A Former Registered Nurse, Rest Home
A Podiatrist

A visit to the rest home was made on 1 October 1998. Records were obtained and viewed as part of the investigation.

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Background

In early July 1996, the consumer moved into the stage three secure unit of the rest home. The consumer suffered from dementia and was unable to manage her own affairs. Control of the consumer's affairs had been taken over by her daughter, (the first complainant), under a Protection of Personal and Property Rights Order.

The consumer moved out of the rest home in early July 1997 and died in hospital fifteen days later.

The licensees sold the rest home during 1998 and are no longer involved in the rest home industry.

Outcome of Investigation

Information

The consumer was resident at the rest home for 12 months. The consumer's daughters, (the complainants) state that during this time they became increasingly concerned at the lack of information provided by the rest home to their family concerning the care of their mother.

During 1996 the complainants completed a survey supplied by the rest home, undertaken to appraise its service. In this survey, the complainants advised the rest home that they would like regular updates about their mother's care and condition. The complainants state that *"despite further requests by us, this was never arranged."*

A former rest home caregiver informed the Commissioner that members of the consumer's family visited regularly and staff members often had discussions with them about their mother's daily activities. Records obtained from the rest home note 17 discussions between staff members and the consumer's family between October 1996 and July 1997. The licensees' response to the Commissioner dated 28 November 1997 advised that *"given the regularity of contact and close communication with the family it was not considered necessary to hold formal meetings".*

The manager's qualifications

The first complainant informed the Commissioner that family members were "*led to believe*" that the manager was a registered and qualified psychiatric nurse. During an interview with the Commissioner, the first complainant stated that, *"questions were answered* [by the manager] *with a wealth of information"* and that*"*[the manager] *had let the family know that she had had rest homes in* [a large city] *in the past."* The complainant stated that it was this presentation that made the family think that the manager was a registered and qualified psychiatric nurse.

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Outcome of Investigation, *continued*

In their response to the Commissioner, the licensees stated that, *"*[The manager] *has never represented herself as having any nursing experience other than as a consequence of her ownership, management, and licenseeship of rest homes."*

Podiatry cares

The Commissioner received conflicting information concerning podiatry care provided to the consumer while at the rest home. The complainants stated that *"very regular requests were made for this service* (podiatry). *Each time we were advised the podiatrist had been contacted and it was 'due to happen'. In reality, there was a 2-3 month delay in the provision of this service."*

The licensees stated that a podiatrist from a clinic saw the consumer on three separate occasions, in early August 1996, early November 1996 and early May 1997, during her time at the rest home. The licensees advised that the consumer missed some appointments with the podiatrist as *"…he could not reasonably be expected to attend to her during outbursts of restlessness. Routine footcare was provided by our own caregivers in the interim between visits, and there were no medical episodes arising."*

Information obtained from the podiatry clinic indicates that the consumer was attended on two separate occasions, in mid-October 1996 and late April 1997, while she was resident at the rest home. These dates do not correspond with the information provided by the licensees. The care records for the consumer note that in late September 1996, the consumer was seen by a podiatrist and that there were no significant problems. There is no comment in the records stating that podiatry appointments were missed due to restlessness and the records do not contain information indicating that interim foot care was provided by the rest home caregivers.

Agitation medication

The first complainant advised the Commissioner that in late June 1997, during a conversation with the acting principal nurse she was informed that the medication for her mother's agitation had been inadvertently left out of her drug regime *"for some time"*. The former acting principal nurse was unable to recall such a conversation with the complainant.

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Outcome of Investigation, *continued*

Daily progress notes for the consumer obtained from the rest home contain many references to the consumer's episodes of agitation and attempts made by staff to deal with these. It is recorded that rest home staff undertook a number of measures to reduce the consumer's agitation before medicating her, including attempts to distract her by getting her to help around the unit and efforts to have her take part in deep breathing exercises. Where these methods were unsuccessful in reducing the consumer's agitation hemineurin was administered.

Escape from secure unit

In late November 1996, the consumer escaped from the rest home by climbing through a hedged partition between the secure unit and the larger, enclosed area of grounds. The consumer then exited through the main gates of the rest home, crossed the road and bought a meal of fish and chips.

The main gates of the rest home are electronically controlled and opened by the pressure of a car on a sensor pad. The rest home manager stated that it was unfortunate that a car came through the gate, which allowed the consumer to get to the street.

On discovering the consumer was absent, a caregiver commenced a search, located her and returned her to the unit. On returning to the unit, the consumer was assessed by the caregiver as being *"no worse for wear"*. Given that family members visited on a regular basis, and that the consumer had suffered no serious injury, a decision was made to inform the family during their next visit. The licensees advised the Commissioner that *"the hedge partition, which had until this incident been considered secure, was sealed with fencing the same evening."* The securing of this area was confirmed during a visit to the rest home on 1 October 1998.

The care records for the consumer contain many references to her attempts to leave the rest home and the methods employed by staff to manage this behaviour. During an interview with the manager, the Commissioner was advised that the consumer regularly gathered her belongings, thinking that she was going to play golf or go shopping. The rest home managed this behaviour by attempting to divert the consumer's attention to other activities around the home and by employing a therapist to assist staff in managing her behaviour.

Awareness of the consumer's conditions

The Complainants stated that they were concerned at the lack of information possessed by the staff members concerning their mother's various conditions, including her back pain.

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Outcome of Investigation, *continued*

The consumer suffered from long standing back and chest pain as the result of a spinal fracture that had occurred some years prior to her admission to the rest home.

Staff employed by the rest home at the time the consumer was resident indicated that they had extensive knowledge of her various conditions. The consumer's care notes discuss methods used to manage these. Staff interviewed advised that on commencement of employment, they were provided with a full brief concerning all residents by the manager and that they made a thorough examination of the care plans.

Information obtained from the rest home indicates that the licensees and rest home staff were well aware of the consumer's back condition. Care notes contain many comments from staff that the consumer was seen rubbing her back and complaining of pain.

Choking incident

One day in mid-June 1997, the consumer began to choke while eating a piece of toast. A staff member applied abdominal thrusts and the matter was cleared. The licensees advised the Commissioner that the consumer was assessed after that incident and no harm was detected.

The next day the consumer attended a regular day group. The complainants stated that staff members there, who were not informed of the previous evening's choking incident, noticed that the consumer was experiencing some discomfort and returned her to the rest home earlier than usual.

The licensees stated that "*there would have been no reason to notify* [staff members at the day care centre] *of the choking incident, given that no change in status had been observed at that point".* According to the licensees, the consumer's history of complaining about back pain made it difficult to realise that she was suffering from additional pain and her dementia presented her from being able to effectively communicate the same.

On the day preceding the choking incident, the consumer had been prescribed painkillers for her back pain. According to the licensees, as soon as it became apparent that the consumer's pain was not diminishing, a consultation with a general practitioner was arranged. Subsequently, it was discovered that cartilage in the consumer's ribcage had torn, probably as a consequence of the abdominal thrusts applied during the choking incident.

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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.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
- *a) An explanation of his or her condition; and*
- *b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and*
- *c) Advice of the estimated time within which the services will be provided; and*
- *d) Notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and*
- *e) Any other information required by legal, professional, ethical, and other relevant standards; and*
- *f) The results of tests; and*
- *g) The results of procedures.*

3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about –
- *a) The identity and qualifications of the provider; and*
- *b) The recommendation of the provider; and*
- *c) How to obtain an opinion from another provider; and*
- *d) The results of research.*

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Opinion: Breach

Right 4(2)

In my opinion the licensees of the rest home breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Podiatry care

The licensees advised the Commissioner that the consumer received podiatry care from a clinic on three separate occasions. Information obtained from the podiatrist does not correspond with this. The rest home records do not contain reference to the consumer being provided with foot care by caregivers or to podiatry appointments being missed due to periods of restlessness. The licensees' failure to keep adequate records regarding podiatry are a breach of Right 4(2) of Code.

Opinion: No Breach

In my opinion the licensees did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights with respect to the following matters:

Escape from secure unit

The consumer made repeated, determined efforts to leave the rest home. These attempts were unsuccessful on all but one occasion, when the consumer escaped through a hedge that was thought to be secure. The consumer was then aided by the entry of a car which caused the main gate to open.

In my opinion, it was reasonable for the licensees to consider that the hedge was secure. The erecting of a fence on the day of the escape to prevent a recurrence further demonstrates they took reasonable action.

Awareness of the consumer's conditions

Staff members from the rest home assert that there was widespread knowledge of the consumer's conditions and records confirm this.

Choking incident

The consumer's condition was assessed after the abdominal thrusts were applied and it was thought that she had not suffered an injury. The consumer often complained of back pain and had been given medication for this on the day before the choking incident. It was reasonable for the rest home staff to consider that the pain being complained of was due to the condition that she had been suffering from for some time.

A doctor was contacted when it became apparent that there was no diminution in the pain that the consumer was experiencing.

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Opinion: No Breach, *continued*

Right 4(3)

Agitation medicine

Hemineurin was prescribed to the consumer for agitation, to be administered as required. The staff members undertook numerous measures to reduce the consumer's agitation before resorting to the use of Hemineurin. Treatment of the consumer's agitation was appropriate in the circumstances.

Right 6(1)

Communication

Visits to the rest home by the consumer's family were numerous and frequent. During these visits considerable communication occurred concerning the consumer's care between her family and caregivers at the rest home. Considering the frequency of these visits, it was reasonable for the licensees to wait for one of these visits before informing family members of incidents such as the consumer's escape in which no harm occurred.

Right 6(3)

The manager's qualifications

I received no evidence that the manager claimed to be a registered nurse in her discussions with the consumer's family. The manager's knowledge was gained as the result of a long association with rest homes and their management.

Actions

I recommend that the licensees:

Provide a written apology to the complainants for the standard of record keeping. This apology should be sent to this office and the Commissioner will forward it on to the complainant and the second complainant. A copy of this apology will be retained on the investigation file.