A Rest Home

Caregiver, Ms C

A Report by the

Health and Disability Commissioner

(Case 05HDC16647)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer (deceased)
Ms B	Complainant, Mrs A's daughter
A Rest Home	Provider/Rest home
Ms C	Provider/Caregiver
Mr D	Licensee and manager, the rest home
Dr E	General practitioner
Ms F	Mrs A's daughter
Ms G	Registered nurse
Ms H	Registered nurse
Ms I	Registered nurse
Ms J	Representative from Age Concern
Ms K	Representative from Age Concern

Complaint

On 16 November 2005, the Commissioner received a complaint from Ms B about the services provided by a rest home to her mother, Mrs A. The following issues were identified for investigation:

The adequacy and appropriateness of care provided by the rest home to Mrs A in September 2005.

The adequacy and appropriateness of care provided by caregiver Ms C to Mrs A in September 2005.

An investigation was commenced on 11 January 2006, and extended on 10 February 2006 to include the care provided by Ms C.

Information reviewed

- Mrs A's rest home clinical record
- Mrs A's DHB clinical record
- Information from:
  - Age Concern
  - Ms B
  - Ms F
  - Dr E

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

— Ms C
— The rest home
— Mr D
— Ms G
— Ms H
— Ms I

The rest home was visited during the course of the investigation.

Information gathered during investigation

Summary
In September 2005, Mrs A was a 79-year-old resident of a 50-bed rest home owned and managed by Mr D.

On the evening of Saturday, 3 September 2005, while caregiver Ms C was transferring Mrs A from her chair to bed, an incident occurred which resulted in a skin tear to Mrs A's upper left arm. On the morning of Monday, 5 September, the nurse caring for Mrs A noted bruising and a misaligned shoulder, and subsequently a fractured arm was diagnosed.

No accident had been reported that explained the injury, and Mr D, the licensee and manager of the rest home, investigated the matter. Following several meetings with staff, and the involvement of both Age Concern and the Police, Ms C requested a private meeting with Mr D on 22 September, and admitted that during the transfer on the evening of 3 September Mrs A had had a fall, which caused the injuries.

Ms C was suspended from duty, but refused to attend the rest home again, or to be involved in any subsequent disciplinary processes. Ms C was dismissed on 7 October 2005.

Background

Mrs A
Mrs A had been a resident at the rest home since 15 September 2004, requiring hospital-level care on account of her dementia. She required full assistance with all her activities of daily living, and regular toileting. Mrs A's care plan advised that two members of staff were to assist her to transfer. Her family visited regularly, and every weekend.

Due to her dementia, Mrs A was unable to communicate. Ms G, care co-ordinator, stated that Mrs A was very difficult to understand, as she "only communicated with her eyes".

Ms C
Ms C is registered as a nurse overseas, having qualified in September 2000. She moved to New Zealand, and since February 2003 had worked at the rest home as a caregiver. Ms C hoped to gain New Zealand nursing registration. Mr D, licensee and manager of the rest home, had written in the past to the Nursing Council of New Zealand "endorsing [Ms C's] work skills and experience for a future registered nursing course".

As part of her orientation training to the rest home, on 28 February 2003 Ms C had received training in "incident/accident folder location/ form completion … correct and safe lifting techniques", and was also required to read the Lifting Policy which was kept in the Staffing and Nursing Manuals. Ms C signed the orientation form, confirming that she had received this training and had read the Lifting Policy.

On 7 March 2003, Ms C was involved in a one-day training course on lifting techniques. On 7 April 2004, she received further training on "Lifting techniques, sliding sheet … and hoist operation".

Chronology

Saturday, 3 September
On the evening of 3 September, Ms I was the registered nurse on duty, supporting the four caregivers who provided the direct care to the residents of the rest home. One of these caregivers was Ms C. She was on duty in the hospital wing, caring for Mrs A until the end of her shift at 9pm. In an incident form completed at 8.50pm on 3 September, Ms C recorded:

> "I noticed at tea time that [Mrs A] was holding her arm very tightly. When I came to feed her I put her hands down and she held her shoulder again. When I took her in her room [to] start changing her and released her hand from her arm and saw a big bruise (it was bleeding) [Ms I] was busy and I thought I put the [dressing] on it and put [Mrs A] in bed."

Ms C recorded on the incident form that she had informed Ms I at 6.25pm of the incident. Ms C finished work at 9pm; she was next at work on Monday, 5 September, starting work at 3pm.

Ms I confirmed that Ms C had asked for the keys to the dressing cupboard, as Mrs A had a "small skin tear". As Ms I was too busy to attend personally, Ms C put a dressing on the wound. Ms I's shift ended at 7pm.

Sunday, 4 September
There is no record in Mrs A's notes for 4 September that there were any signs of injury. Mr D advised the Commissioner that Sundays are bed-wash days (as opposed to days when residents have showers or baths). Ms I stated that she saw Mrs A a number of times during the day, and her appearance appeared unchanged from normal. She also advised that she checked the skin tear, but did not remove the dressing.

Monday, 5 September
A caregiver attended Mrs A on the morning of 5 September. While undressing Mrs A for a shower, the caregiver noted that Mrs A had bruising around her shoulder and face and a "misaligned shoulder bone". The caregiver immediately called Ms H, who was the registered nurse on duty, and Ms G (another registered nurse). Mr D was also informed.

Mr D advised that, to save time, it was decided to have an X-ray done before a formal referral for an X-ray was obtained from the rest home's contracted general practitioner, Dr E. A mobile X-ray was performed at the rest home.

Ms G advised that she contacted Dr E's clinic, and spoke to the practice nurse, asking about getting an X-ray performed. Although she was slightly unsure of the precise course of events, Ms G was sure that she spoke to the practice nurse prior to confirmation of the fracture by the radiographer.

The X-rays were developed on-site and showed a fracture. Ms G stated that the advice of the radiographer taking the X-ray was accepted, and Mrs A's arm was placed in a sling. Ms G contacted Dr E's surgery. She advised that Dr E's surgery staff "do not allow direct contact with [Dr E]", and she left a message describing what had occurred. The incident form completed at 9am on 5 September stated "[Dr E] called".

Mr D stated that, on confirmation of the fracture, Mrs A's daughter, Ms F, was contacted to inform her about the injury to her mother. Mr D met Ms F and her sister, Ms B, later in the day. At this point, Mr D completed a complaint form on their behalf, and informed them of his intention to investigate the cause of their mother's injury.

The clinical note made by Ms H (a registered nurse) at 2pm stated:

> "Faxed to [Dr E] requesting some strong pain relief for [Mrs A] — no response yet."

The X-ray was reported by a radiologist. The report was faxed to the rest home at 5.30pm. It stated:

> "There is a fracture of the surgical neck of the humerus with prominent medial and anterior displacement of the humeral shaft fragment. No dislocation seen."

The clinical record indicates that paracetamol was given regularly.

Tuesday, 6 September
Dr E stated that he first became aware that an incident had occurred when he received the X-ray report on the morning of 6 September, which stated that Mrs A had suffered a fractured arm. Dr E presumed that the rest home had arranged the X-ray through another doctor, and stated:

> "The basis for this presumption was that no X-ray is ever done without a practitioner request, and certainly this is a requirement of the ACC funding system that all radiology funding is dependent upon a practitioner … requesting the X-ray. I was scheduled to visit the rest home later in the day, hence I did not enquire further."

Dr E did not alter the treatment provided when he attended the rest home, apart from a prescription for morphine 10mg slow release, twice a day, for Mrs A's pain.

Subsequent events
Mrs A received regular pain relief and daily dressings over the next few days, and her arm was kept elevated because of swelling. The clinical record states that she was eating well (10, 11 and 12 September), and that pressure-area care was given because of a broken area of skin on Mrs A's buttocks.

On 13 September, Dr E reviewed Mrs A, and referred her to the orthopaedic team at a public hospital for an opinion. She attended as an outpatient, and no change in treatment was advised by the orthopaedic team.

Two days later, Dr E reviewed Mrs A again. He was concerned about her general condition, as she was less responsive than usual. He arranged for Mrs A's admission to the public hospital under the care of the medical team. A CT scan was performed during her admission to the public hospital, which showed no acute changes, and intravenous fluids were commenced.

After general care in hospital for a number of days, it was decided by Mrs A's family that she should be transferred to another private rest home on discharge. Accordingly, on 23 September, Mrs A was transferred to another rest home where she later died.

Investigation by the rest home

Mr D initially investigated the incident on 5 September, concluding that the injury to Mrs A occurred at some stage between 9am on 3 September and 9am on 5 September. The only incident form completed during this period related to the skin tear reported by Ms C on the evening of 3 September.

Between 5 and 8 September, Mr D interviewed all the members of staff who had cared for Mrs A in the period from 3 to 5 September (including Ms C). No one admitted to being aware of any cause for the injury.

On 12 September, Mr D met with all members of staff, including Ms C, "to discuss [Mrs A's] injury, potential ramifications on [the] facility and advise that [the] matter will be put in the hands of the local police if the culprit did not come forward".

On 13 September, Mr D contacted Ms J and Ms K from Age Concern, and a decision was made to again interview all the staff who had cared for Mrs A during the period from 3 to 5 September. In response to the provisional opinion, Mrs A's daughter, Ms B, advised that the family had been in contact with Age Concern and the Police with their concerns about the care provided to Mrs A at the rest home. Mr D also contacted the Police "and requested [their] future involvement".

Mr D and Ms J interviewed all of the relevant staff. Ms C was interviewed on 19 September and denied any incident had occurred that could have caused Mrs A's injury.

On 21 September, Mr D interviewed Ms C again because the incident form she had completed on 3 September was the only evidence of any adverse event. Again, she denied that any incident had occurred other than the skin tear.

On 22 September, with the Police, Ms K and Ms J present, Mr D held a staff meeting. This was attended by Ms C. Immediately after the meeting, Mr D, Ms K and Ms J met with Ms C and another registered nurse (a staff member who had been involved in Mrs A's care during the period from 3 to 5 September). The registered nurse was allowed to leave the meeting after being "cleared of any involvement". During this meeting, Ms C requested to meet Mr D in private. Mr D stated that Ms C asked whether, if she admitted to involvement in Mrs A's injury, her job would be saved. Mr D said no. According to Mr D, at this private meeting Ms C admitted to being involved in the incident, and described Mrs A's fall. They subsequently returned to the meeting with Ms J and Ms K, and Ms C repeated her admission.

In the report of the Age Concern investigation, Ms J stated:

> "The outcome of this investigation was a staff member admitting to dropping [Mrs A] during a transfer she did on her own from the chair to bed and failing to document the incident."

Mr D suspended Ms C immediately. She did not respond to subsequent requests to be involved in the disciplinary process, and was dismissed on 7 October.

Mr D wrote to Mrs A's daughter, Ms F, on 23 September, describing the events as related to him by Ms C:

> "I can confirm that [Mrs A's] injuries resulted from a fall at 6.15pm on Saturday 3 September 2005 when [she] was being transferred by one caregiver from her lounge chair to her bed. [Mrs A's] shoulder fracture resulted from her falling against the small

> dresser unit in her room. The caregiver was able to break her fall and regain her grip before [Mrs A's] head and shoulders touched the floor. The caregiver treated a skin tear on [Mrs A's] upper left arm and completed an incident/accident [form] relating to the skin tear, but failed to record or reference that the skin tear resulted from a fall against her dresser unit. She also notified the registered nurse of the skin tear, her cleansing and treating the skin tear with a dressing, but failed to advise that the skin tear resulted from a fall. Sadly, the reason given by the staff member for not recording or advising registered nurses of the fall was a result of panic and a fear of possible repercussions. Her non advice and [Mrs A's] communicational restraints meant that staff were unaware of the serious injury until bruising and swelling was observed on Monday morning."

Ms C wrote an apology (undated, but sent by Mr D to Ms F on 23 September 2005), which stated:

> "I, [Ms C], working [at the rest home] as a nurse aide, was aware of scratch to [Mrs A's] skin while shifting her as she told me about it, but I was not aware of the dislocated shoulder … at the time. I would have straight away reported it to the authorities if [I had] known about the dislocated shoulder.
>
> If you think I am responsible for her dislocated shoulder, I sincerely apologise for that.
>
> I am a kind and helping person, I love looking after the elderly people. I feel very sorry for what had happened to [Mrs A].
>
> I once again sincerely apologise for [Mrs A] and the family for what had happened.
>
> I apologise to the Rest Home management for any inconvenience caused and promise that I will be more careful in future.
>
> With kindest regards.
>
> [Ms C]."

As a result of the incident, Mr D ensured that all staff attended further training relating to lifting procedures, "complaints and compliments process", incident reporting, and "elder abuse and neglect prevention awareness".

In summarising the Age Concern report, Ms J stated:

> "I feel [Mr D] conducted this investigation in an honest and transparent manner. He has had staff attend further in-service training with the aim to preventing further incidents of this nature.

In-service training included lifting procedures, Elder Abuse and Neglect Prevention Awareness, and was in the process of reviewing his documentation procedures.

We also felt he actioned the appropriate disciplinary procedures.

In our view we were able to investigate and establish the cause of [Mrs A's] injuries, and identify gaps that were discussed with [Mr D] to follow up."

Response to Commissioner's investigation

Ms C, in response to my investigation, stated:

"There was no fall on the evening of 3 September 2005. While I was transferring [Mrs A] I noticed a skin tear on her upper arm as she might be holding her arm too tightly. …

The skin tear happened on 3 September. I immediately advised RN about it. The fracture was noticed on 5 September … There were 6 shifts in between skin tear and noticing of fracture. [Mr D] forced me to accept that I caused the fracture. I had to accept it because I was on a Work Permit and he said he will fire me and my Work Permit will be revoked and I will be deported [overseas]. He said he helped me and now I should help him otherwise [the rest home] will be shut down. So I had to accept it. He also forced me to write apology letter to [Mrs A's] family."

In response to the provisional opinion, Mr D stated:

"I formally refute [Ms] C's allegations … that I 'forced' her into admitting to dropping [Mrs A] and causing injury. In our private discussion her motives were totally selfish. Her aim throughout our [private] discussion was to negotiate retaining her job at [the rest home] and was in fear of the personal shame this incident would bring on her family, the repercussions this could have on her father's pending deportation and the ramifications this would have on her current NZ citizenship application. … After our private meeting she returned to my office and calmly, albeit tearfully admitted to the offence and described in detail as to how it occurred and what steps she took to break [Mrs A's] fall. She then also calmly answered questions relating to her knowledge and awareness of the incident/accident procedures, the requirement to advise the registered nurses of all details relating to incidents or accidents. She then confirmed that no other person was involved and concluded by apologising to [Ms J, Ms K] and I. She then asked that I convey her apologies to my wife, [Mrs A] and her family, to which I recommended that she write a letter of apology."

Response to provisional opinion — Ms C

Ms C's representative responded for Ms C. He stated:

> "In your report you have blamed [Ms C] only for everything happened with [Mrs A]. You have not realised that [Ms C] was on a Work Permit and her stay in New Zealand was dependent on the sweet will of her employer. She was not allowed to stay even for a day once her employer terminates her services. Her employer was in a position to influence her. He pressurised her to admit the fall that never happened in [Ms C's] presence.
>
> Her employer blamed her for everything because he could not find anyone else to blame. He asked her to admit the fall. He told her he helped in getting Work Permit and now she should help him. He also told her that [the rest home] will be closed if she does not admit and that nothing will happen to her if [she] admits.
>
> You have mentioned that there is no evidence that [Ms C] admitted her fault due to duress. In that way there is no evidence, except her own admission, to suggest that fall happened during her presence. Your conclusion is only based on her own admission. Keeping in view her situation, it is not reasonable to blame her only in the absence of any independent evidence.
>
> You have also blamed her for not informing about the incident to her senior. She informed about the incident to [Ms I] who was her senior and the only senior staff available. You have mentioned that she should have informed to other senior staff member, but there was none.
>
> You yourself have said that [Ms C] was only a caregiver. It is beyond her expertise to diagnose the exact injury. She informed [Ms I], the only senior staff available. [Ms I] is a registered nurse. She could have been able to diagnose the exact injury, but she was too busy to attend [Mrs A]. As a registered nurse she was supposed to attend [Mrs A] but she failed to attend her and you blamed [Ms C] instead of [Ms I]. Why?
>
> You have mentioned that [Mrs A] should have been lifted by two persons and [Ms C] made a mistake if she lifted her [single-handed]. The fact is there was no second person available to help her. She had no other option except to lift her alone. Question is how could she ask second person to help when nobody was available to help her. Still you blame her and not her employer. Why?
>
> It seems that employer and you have found a scapegoat in [Ms C] because she is not a New Zealand resident and she is not capable to fight for her rights. Both of you [seem] to have an agenda to throw her out of this country. In that way she will be blamed for everything and [the] matter will be closed without making proper investigations against the employer. It is so convenient for you as well as for employer.

You have recommended reporting to all Health Providers and Nursing Council. That means she will never be a registered nurse in New Zealand. What more [do] you want to do against her? You want to refer the matter to Director of Proceedings to consider further proceedings against [Ms C]. She is not a New Zealand resident. She is not working and has no means to pay if damages are awarded against her. So I wonder what you want to get out of the initiation of proceedings against her.

In my submission, reporting to Health Providers and to Nursing Council itself is more sufficient punishment for [Ms C]. She will never be able to be a registered nurse and will never be able to work in [the] Health industry. I think that is more than sufficient to serve the public interest."

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 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

...

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 — Ms C

Safe transfer

Under Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs A was entitled to have caregiver services provided by Ms C with reasonable care and skill. In the context of this case, Mrs A was entitled to be transferred safely by Ms C between her chair and bed on the evening of 3 September. When an accident occurred, Ms C should have responded appropriately.

According to her care plan, Mrs A required two members of staff to transfer her to ensure her safety. Mr D advised that during his investigation it became apparent that some members of staff (including Ms C) felt confident transferring Mrs A on their own. However, Ms C should have been aware of the increased risk of an accident while attempting to transfer Mrs A without assistance, and when an accident occurred, Ms C was required to respond appropriately.

In her defence, Ms C stated that she had received no lifting training while at the rest home, yet her recollection is inaccurate. She received training on 28 February 2003, 7 March 2003, and 7 April 2004. I find it implausible that Ms C has forgotten this training.

In her response to the provisional opinion, Ms C stated that no one else was available to assist her with transferring Mrs A. This is incorrect. There were three other caregivers available to assist her, had she asked. There is no evidence that she attempted to obtain assistance.

It is unacceptable for a caregiver to drop a patient when moving her, particularly when attempting to do so without a second staff member to help as required by a care plan. In these circumstances, Ms C failed to exercise reasonable care and skill and breached Right 4(1) of the Code.

Incident report and explanation to family

Under Right 4 of the Code, Mrs A was entitled to have caregiver services of an appropriate standard provided by Ms C, including services provided with reasonable care and skill, in a manner consistent with her needs, and that optimised her quality of life. In the case of a patient with dementia and diminished mental capacity who suffers a fall, the relevant caregiver has a duty to comply with the facility's incident reporting processes *and* to ensure that the family is promptly informed of the patient's injury. As explained below, Ms C failed to comply with these obligations and thus did not provide services of an appropriate standard.

Although she was only a caregiver at the rest home, Ms C was required to comply with the policies in place. On 3 September, she completed an incident form and advised Ms I, the supervising registered nurse, of a skin tear to Mrs A's arm. It is clear that Ms C was aware of the need to report to more senior staff any injuries or incidents, and was aware of the process for recording injuries using an incident form. She had also received training on the processes involved in incident reporting. However, on the evening of 3 September, Ms C did not inform Ms I of the full extent of the incident involving Mrs A. A full report by Ms C would have prompted an examination of Mrs A, and could have led to earlier diagnosis and treatment. Ms C also failed to provide complete information on the incident form.

Having performed an in-depth investigation, Mr D was faced with a serious injury to a resident, but did not know how it had come about. Eventually, some 19 days after the incident, and following a number of meetings and interviews with staff, Ms C admitted that

Mrs A had suffered the injury while being transferred to her bed on the evening of 3 September.

Ms C has subsequently stated that Mr D forced her to make this admission, threatening that if she did not, her work permit would be revoked and she would be deported to her country. This is a serious accusation, but there is no evidence to support her claim and Mr D has refuted this allegation. Immediately following the private meeting, Ms C admitted in the presence of Ms K and Ms J that the injury occurred while she was attempting to transfer Mrs A from a chair to bed.

On the incident form of 3 September, Ms C stated:

> "I noticed at tea time that [Mrs A] was holding her arm very tightly. When I came to feed her I put her hands down and she held her shoulder again. When I took her in her room [to] start changing her and released her hand from her arm and saw a big bruise (it was bleeding) ..."

In her apology letter, written between 21 and 23 September, Ms C wrote:

> "I … was aware of scratch to [Mrs A's] skin while shifting her as she told me about it …"

In her response to the complaint, Ms C advised:

> "While I was transferring [Mrs A] I noticed a skin tear on her upper arm …"

These are three subtly different accounts: that Ms C found the skin tear while changing Mrs A; that Mrs A informed Ms C about the injury; and that she found it when transferring Mrs A. I find none of these accounts credible. In particular, it is clear from Mrs A's clinical record that she was unable to communicate, and therefore unlikely to have "told" Ms C about the skin tear.

It is difficult to understand Ms C's actions. It could be that she honestly did not believe that the incident on the evening of 3 September was serious. When she next came back to work on Monday, 5 September, at 3pm, the fracture had been discovered, Mr D had started his investigation, and she may have been too afraid to admit her knowledge of events. She then chose to adhere to her deception, rather than to admit to not having reported the incident in full at the time it had occurred.

Whatever her motivation, Ms C's failure to report Mrs A's fall resulted in the fracture remaining undiscovered for more than 36 hours. Although I accept that Mrs A did not communicate with her carers, and it is likely that she gave no outward signs of discomfort, it is difficult to believe that she was not in pain during this period.

Ms C's failure to report the fall also resulted in delays in informing Mrs A's family that their mother had suffered an injury. Mrs A suffered from dementia and was unable to communicate. In these circumstances, as a caregiver Ms C had a duty to provide information to Mrs A's family, including an explanation of her condition.

Ms C has acted in a dishonest manner by failing to report an incident, consciously and repeatedly deceiving an investigation process, and making false claims about her lifting training. She also made an unsubstantiated statement that she had admitted her involvement in Mrs A's accident under duress. This is unacceptable behaviour on the part of a caregiver and by anyone who seeks to become a registered nurse in New Zealand. By her actions, Ms C breached Rights 4(1), 4(3) and 4(4) of the Code.

In my view, this case warrants reporting to HealthCare Providers New Zealand, and the Nursing Council of New Zealand. The public interest also requires that Ms C be referred to the Director of Proceedings to consider whether further proceedings should be instituted.

Opinion: No breach — The Rest Home

Management of injury

Mrs A's injury was not discovered until the morning of 5 September, just over 36 hours after the injury had occurred. Although it is difficult to comprehend how a fractured arm could not have been noticed in the intervening period, Mrs A was able to communicate only with great difficulty with her family or carers. Accordingly, staff may have been unable to interpret any change in her condition. Ms I advised that she saw Mrs A a number of times on Sunday, 4 September, and her appearance appeared unchanged.

Once the injury became apparent, on the morning of 5 September, staff appear to have reacted appropriately. Although the decision was made to arrange the X-ray prior to contacting Dr E, which is against accepted protocols, this decision was made with the best of intentions, to speed up Mrs A's treatment. From the contemporaneous records, Dr E's practice was contacted both by telephone, and then by fax, on 5 September. Mrs A's family was also informed of the injury.

Internal investigation

Immediately on discovering Mrs A's injury, the rest home set in motion an investigation. In total, there were at least three staff meetings to try to encourage anyone who knew of Mrs A's injury to come forward. At least three sets of individual interviews were held with staff who were involved in Mrs A's care. I am satisfied that the management of the rest home approached the investigation in an open manner, with both Age Concern and the Police being involved in the investigation and interviews of staff. Staff were required to undergo

extra training as a result of this incident. Ms J of Age Concern stated in her report that Mr D "conducted this investigation in an honest and transparent manner".

Summary
I am satisfied that the rest home responded appropriately when confronted by the injury on 5 September, and in its investigation into the cause of the injury to Mrs A. The rest home instituted additional staff training to prevent a similar event recurring. Accordingly, the rest home did not breach the Code. I do, however, remind the rest home of the requirement to obtain a medical practitioner's referral for an X-ray prior to the X-ray investigation wherever possible.

I note that during the internal investigation, it came to the management's attention that some members of nursing staff chose to transfer Mrs A without assistance. Therefore I also recommend that staff be reminded of the need to comply with lifting policies, so that when a resident is assessed as requiring two members of staff to transfer, this does occur.

Vicarious liability — The Rest Home

Employers are responsible under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code. Under section 72(5), it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee's act or omission that breached the Code.

The records show that Ms C received training on lifting techniques on three occasions. Ms C also received training on the incident-reporting process. She completed a form and informed the registered nurse on 3 September of a skin tear. I am satisfied that she knew of her responsibilities as a caregiver to complete incident forms accurately, and to inform the registered nurse of any incident.

Ms C's employers could not have foreseen or prevented her failure to accurately report the incident on 3 September. In these circumstances, the rest home is not liable for Ms C's breach of the Code.

Recommendation

I recommend that Ms C provide a copy of my final report to her current employer, and confirm to my Office that she has done so.

Follow-up actions

- A copy of this report, with details removed identifying parties other than Ms C, will be sent to the Nursing Council of New Zealand, the Ministry of Health, HealthCare Providers New Zealand, and Age Concern.

- Ms C will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any further proceedings should be initiated.

- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes, upon completion of the Director of Proceedings' processes.

Addendum

The Director of Proceedings decided to issue proceedings before the Human Rights Review Tribunal. The Tribunal found that Ms C breached Right 4(1) in that she failed to comply with the "two person lift" policy of the rest home and failed to transfer Mrs A safely from her chair to her bed. It also found that Ms C breached Right 4(2) in that when Mrs A fell during the transfer from her chair to the bed Ms C failed to complete an adequate Incident Report in accordance with the policy of the rest home. Ms C also breached Right 4(5) in that she failed to notify the nurse on duty that Mrs A had fallen, or advise any caregiver or nurse or the manager that Mrs A had fallen while in her care.

In a subsequent decision on damages the Tribunal awarded Mrs A's daughter damages of $3,500 for injury to feelings. However, this decision was subject to the Court of Appeal decision in *Marks v The Director of Proceedings* [2009] NZCA 151 which concerned the definition of "aggrieved person" under the Act. As a result of the Court of Appeal's decision in *Marks* the award of damages was not enforceable because Mrs A's daughter was not a consumer of health services in this case. The Tribunal's declarations in relation to breaches of the Code stand. The Tribunal's decision is available on:

http://www.nzlii.org/nz/cases/NZHRRT/2007/12.html