Caregiver, Ms A

Rest Home/Hospital

A Report by the

Deputy Health and Disability Commissioner

(Case 07HDC16959)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Provider/caregiver
Mrs B	Complainant/consumer's daughter
Mrs C	Consumer
Ms D	Rest Home/Hospital facility manager
Ms E	Unit Co-ordinator
Ms F	Registered nurse
Ms G	Registered nurse
Ms H	Registered nurse
Ms I	Registered nurse
Mr J	Caregiver
Ms K	Caregiver
Ms L	Caregiver
Ms M	Caregiver
Ms N	Caregiver
Ms O	Caregiver
Dr P	General practitioner

Complaint

On 24 September 2007 the Commissioner received a complaint from Mrs B about the services provided to her mother, Mrs C, by a Rest Home/Hospital and caregiver Ms A. The following issues were identified for investigation:

- *The appropriateness of the services provided to Mrs C by caregiver Ms A in August 2007.*

- *The appropriateness of the services provided to Mrs C by the Rest Home/Hospital in August 2007.*

An investigation was commenced on 17 January 2008.

Information reviewed

Information was received from:

- Mrs B
- Ms D
- Ms A

- Ms K
- Mr J
- Quality Assurance Co-ordinator, Rest Home/Hospital

Mrs C's clinical records and relevant Rest Home/Hospital policies and procedures were obtained and reviewed.

Overview

Mrs C
In August 2004, Mrs C, aged 81, was admitted to a Rest Home/Hospital, from another aged care facility, after being assessed as requiring hospital level care. Her medical history included a dense cerebral vascular accident (CVA — stroke) with left-sided weakness, high blood pressure, seizures and dementia. Mrs C was only occasionally able to respond verbally.

On Friday 10 August 2007, a caregiver noticed that Mrs C had severe bruising and swelling to her left arm. However, no action was taken in relation to this injury until Monday 13 August when another caregiver noticed and reported the bruising to senior nursing staff. General practitioner Dr P was asked to visit to examine Mrs C.

Dr P saw Mrs C that afternoon. She considered that Mrs C's arm was fractured and arranged for her to be transferred to a private hospital for an X-ray. The X-ray confirmed that Mrs C had a fracture to the top end of her left humerus.

The Rest Home/Hospital's Facility Manager, Ms D, immediately commenced an investigation into the circumstances of Mrs C's fracture. It was not until 17 August that caregiver Ms A admitted that she dropped Mrs C from a lifting hoist on 9 August.

Information gathered during investigation

Ms A
Ms A is a nurse registered with an overseas board of nursing. She is not currently registered with the New Zealand Nursing Council. Ms A commenced part-time employment at the Rest Home/Hospital in August 2006. She was assessed and certified as competent in the theory and use of the hoists used to transfer dependent patients. She had initial training in the facility's restraint policy on 25 August. Ms A was appointed to a full-time position on 12 September 2006. She completed the Aged Care Education New Zealand Core Programme in October 2006 and participated in the Rest Home/Hospital staff training programme between August 2006 and June

2007. On 22 August 2007, Ms A's position with the Rest Home/Hospital was terminated and she was subsequently employed as a caregiver at another aged care facility.

The Rest Home/Hospital
The Rest Home/Hospital is owned and managed by a rest home company. References to the Rest Home/Hospital in this report include the company.

The facility is contracted by a District Health Board to provide 41 medical and geriatric hospital beds, 53 rest home beds and 18 dementia rest home beds. The hospital is divided into two blocks.

The manager, Ms D, is a registered nurse with overall responsibility for the services provided to the residents and patients at the facility. The Rest Home/Hospital provides staff with policies and procedures relating to transfer plans, manual handling, neglect and abuse and accident/incident reporting. The Rest Home/Hospital underwent a full certification audit in April 2007 and was certified for three years by the Ministry of Health.

9 August 2007
On the morning of Thursday 9 August 2007, Ms A was assigned to work in B block of the hospital. One of her patients that day was Mrs C. At about 11am Ms A prepared Mrs C for a shower. Caregiver Ms K was working in the same part of the hospital and Ms A asked her to help transfer Mrs C from the bed to the shower chair. Mrs C could not stand or move herself. Her care plan specified that she was to be transferred in a sling hoist by two staff.

When Ms K went into Mrs C's room to assist Ms A, she noticed that there was no hoist in the room. This was not unusual because the hoists were in high demand in the morning when the patients were being showered and dressed. Ms A and Ms K lowered the bed, manoeuvred Mrs C to the side of the bed and lifted her across to the shower chair. Ms K then went back to attend to her own patients.

Mr J was also working in the same area of the facility as Ms A on that morning. He said that he was with one of his patients when he heard Ms A calling out. He didn't know whether she was calling his name or calling for help. He left his patient and went across to Mrs C's room. He saw Mrs C lying on her bed fully dressed, with her legs sticking out over the side of the bed. Ms A asked Mr J to help her transfer Mrs C from the bed to the lazy-boy chair which was beside the bed. Mr J helped Ms A lift Mrs C from the bed to the chair and went back to care for his patients. He does not recall a hoist being in Mrs C's room at that time.

Ms A did not report any problems or incidents involving Mrs C on 9 August. She recorded that Mrs C had been showered, "cares done" and that her food and fluid intake was "good".

On the afternoon shift, an unidentified caregiver recorded that the soft splint Mrs C wore on her left hand during the day to prevent contractures was removed at bed-time. There was no record of any injuries or bruising being seen at this time.

Caregiver Ms N worked the night shift that day. She turned Mrs C at 1am and 5am and changed her incontinence pad. Ms N said that Mrs C slept throughout the night and did not appear to be in pain when they turned her onto her side and back.

Friday 10 August
On the morning of Friday 10 August, caregiver Ms L was assigned to care for Mrs C. She stated that she noticed a red bruise on Mrs C's left upper arm when she changed her, and when Mrs C was moved onto her right side she moaned in pain. Ms L noted in the clinical records that she sponged and changed Mrs C, who was eating and drinking well. Ms L noted that Mrs C's bowels had moved and she had been turned from side to side. There is no mention of any bruising or pain. Ms L said that she made a "big mistake" by not notifying the registered nurse on duty about Mrs C's condition. She said, "I was so busy, I still had [three] residents to do."

Ms A was on the afternoon shift on 10 August and was again assigned Mrs C. She said she noticed the bruising on Mrs C's left shoulder that day and thought that Mrs C was "not good", but did not report her observations. Ms A later stated that she "forgot" to report the fall and Mrs C's bruising to the duty registered nurse because she was busy caring for residents.

Saturday 11 August
Ms L cared for Mrs C during the morning on 11 August. Again there is no report of any pain or bruising.

At 3pm on 11 August 2007, when caregiver Ms M attempted to change Mrs C's clothing, she noted that Mrs C was in considerable pain when her left arm was moved. Ms M recorded:

> "[Mrs C] was moaning when took off her tops; it seems like she wants to say something; found a big bruise on her (L) arm and was swollen; [Ms I], [Ms G] and [Ms F] informed; found 2 small bruise also on (L) forehead and eyebrow."

Registered nurse assessments
Registered nurse Ms I worked the morning shift of 11 August on A block. She was completing her clinical records at the end of her shift (at about 3.45pm) when Ms M asked her to look at bruising on Mrs C's arm. Ms I told Ms M that registered nurse Ms G was responsible for the residents in B Block and she should ask her to check Mrs C.

Registered nurse Ms H worked the afternoon shift on A block on 11 August. Ms M asked her to look at the bruising on Mrs C's face while registered nurse Ms F, who had just started her shift, was on the telephone organising staff for the next day. According to the transcripts of the interviews Ms D conducted in August 2007 with

the staff about these events, Ms H told Ms M that the bruising might have been the result of an accident when staff were transferring Mrs C the previous day.

In response to the provisional opinion, Ms H emphasised that she was asked to look at Mrs C's face, not her arm. She said that the comment above, regarding her opinion on the cause of the bruising, is not quite correct. Ms H said that she made this comment as a speculative response to a question put to her by Ms D during the internal investigation. Ms H said that she did not look at Mrs C's arm because she was told that it had been attended to earlier. She told Ms M to complete the incident form.

Ms G was about to finish her shift when Ms M asked her to look at Mrs C. Ms G went to see Mrs C, accompanied by Ms F. Ms G said that she advised Ms F to apply some arnica to the bruising. She thought that the bruising to Mrs C's arm might have been the result of "illegal lifting", but thought that she looked "brighter". Mrs C was, at the time, on antibiotics for a chest infection. In her response to the provisional opinion, Ms G stated that she accompanied Ms F only because she "wanted to look at the bruise too". She said she "asked Ms M to fill out an incident form".

Ms F stated that she thought the bruise "looked old". She did not notice any swelling and considered that Ms G's advice to apply arnica was appropriate. She also noted the bruising to Mrs C's forehead and eyebrow. Ms F said she thought the bruises might have been caused by "rough handling". She said that when she rubbed on the arnica, Mrs C showed signs that she was in pain. Ms F said she realised later that she should have provided Mrs C with pain relief. She also intended to document her observations but she "got too busy and forgot".

Ms I said that she was not directly involved in Mrs C's care from 9 to 13 August and it was her general concern for Mrs C's well-being that prompted her to call by her room as she was leaving work on 11 August. She saw about 4cm of bruising on Mrs C's left upper arm when she undid the top couple of buttons of her nightdress, but could not see any bruising or swelling to her neck or upper shoulder. Mrs C was positioned comfortably and did not appear to be in pain. Ms I said she went back to talk to Ms M about how it might have happened. Ms M mentioned the bruising to Mrs C's forehead. Ms I had not noticed those bruises. She and Ms M discussed the possible causes for the bruising — that Mrs C might have been injured by the bedrails or by knocking against the wall while in the shower-chair. Ms I told Ms M that Mrs C's family should be contacted. She then went home.

In response to my provisional opinion, Ms I stated that she had confidence in Ms F and Ms G, who had completed an assessment of Mrs C's arm. Ms I stated that if either Ms F or Ms G had asked her for a second opinion or a follow-up assessment she would have completed a full clinical assessment. She said that her reason for calling into Mrs C's room on her way home was to satisfy herself that Mrs C was comfortable and, as the restraint co-ordinator for the Rest Home/Hospital, she was concerned about how this injury had occurred. As she was neither the nurse on duty nor the

supervisor for B block, she thought it inappropriate to disturb Mrs C and do a clinical assessment of her bruising.

Accident/Incident report
Ms M completed an Accident/Incident form, recording that she found Mrs C had a bruise on her left arm, which was very swollen, and also two small bruises on the left side of her forehead and left eyebrow. Ms M noted that she informed Ms I, Ms G, Ms F and Ms H, and that these staff members had checked Mrs C. The report includes the note, "Arnica cream applied on the bruise" in different handwriting. This note was unsigned.

Sunday 12 August
On Sunday morning 12 August, Ms L was again caring for Mrs C. Ms L recorded that Mrs C was eating and drinking well and that she "still" had bruising to her left arm.

A note from Ms G stated, "[Mrs C's] L) arm bruise had been noticed on Friday am but forgotten to be reported. Added to fish [Accident/Incident] form". Ms G said that this was "an extremely busy day". She added that the coordinator was off sick, so she (Ms G) was in charge of the whole facility, in addition to having three patients allocated to her, and administering the drugs for her end of the facility. She stated:

> "My workload made it extremely difficult for me to remember to notify [Mrs C's] family about the bruise or to remember to go back and have a look at [Mrs C's] arm again."

She noted that during that day no caregiver reported that Mrs C was expressing any pain or difficulties with her arm.

Monday 13 August
On the morning of 13 August caregiver Ms O reported to the Rest Home/Hospital Unit Co-ordinator Ms E that Mrs C had "bad" bruising to her left arm and asked her to review Mrs C.

Ms E noted that Mrs C had obvious bruising from her elbow to her shoulder, with swelling along her collar-bone towards her neck, and that she flinched when moved slightly. Ms E asked a registered nurse to give Mrs C some Pamol syrup for pain. She contacted Dr P's medical practice to request that Dr P assess Mrs C. Ms E recorded in the notes that Mrs C "needs to be immobilised until further notice. Do not put clothing on that arm to prevent further damage/injury".

Management of injury
Dr P assessed Mrs C at 11.15am and arranged for her to be admitted to a private hospital for an X-ray. Ms E advised Mrs B about her mother's condition. Mrs C was transported to hospital by ambulance accompanied by Ms O.

The X-ray performed at the hospital confirmed that Mrs C had sustained a displaced fracture to her left humerus (bone in upper arm). The orthopaedic registrar assessed Mrs C and reported that she had no obvious functional movement in her left hand. He found that she "seems quite comfortable" and the bruising was "slowly resolving". The orthopaedic registrar noted that the X-ray showed that the fracture was 100% displaced, that he had "talked to [Mrs C's] daughter about the possibility of a fibrous rather than bony union", and that there was no plan to treat the fracture more aggressively. He advised that Mrs C would need analgesia as required, and that the orthopaedic team would review her again in one month.

Mrs C returned to the Rest Home/Hospital at 6pm on 13 August. Her left arm was elevated on a pillow for comfort and she was commenced on codeine phosphate 30mg for pain. Her Mobility Advice Sheet was amended to reflect the care required to manage her arm sling.

Ms E amended the Accident/Incident form adding in the actions taken on 13 and 14 August in relation to the injury to Mrs C's left arm.

Response to the incident
On 13 August 2007, Ms D commenced an investigation into the circumstances of Mrs C's injury. She spoke to Ms A and other members of staff who were involved in Mrs C's care between 9 and 13 August 2007.

Ms A gave three accounts of the events of 9 August which resulted in a fracture of Mrs C's left arm. She provided Ms D with a verbal statement on 13 August, and a written statement on 15 August, and was interviewed on 17 August. There were discrepancies in the information she provided about how Mrs C sustained the injury.

First account
On 13 August, Ms A advised Ms D and the Unit Co-ordinator Ms E that she had not done anything wrong. Ms A said that she had asked caregiver Mr J to help her transfer Mrs C from the bed onto the shower-chair. She admitted that she manually handled Mrs C from her bed to a chair and when doing so heard a crack. Ms A gave no explanation for not using a hoist and told Ms D that she had forgotten to report the incident.

Mr J was spoken to about the incident and advised that he had seen Ms A take the standing hoist into Mrs C's room. He does not recall the hoist being in the room later when Ms A called for help and he assisted her to transfer Mrs C (who was fully dressed) from her bed onto a lazy-boy chair. Mr J did not observe Mrs C's face during the transfer; however, he is sure that she did not groan at that time. He said that it was unusual for her to make a sound and he would have remembered if she had.

On 14 August, Ms D and Ms E met with Mrs B. Ms D apologised to her and explained that they had identified the cause of her mother's injury. They discussed possible actions to take, which included moving Mrs C closer to the office.

Ms A's second account
On 15 August, Ms A provided Ms D with a written statement. In this document, Ms A stated that she had asked an unnamed caregiver (this was later found to be Ms K) to assist her to transfer Mrs C from her bed to the shower-chair. After the shower, Ms A recalled that she pushed Mrs C, who was on the shower-chair, across to her bedroom to be dressed in her day clothes. She attempted to dress Mrs C while she remained seated on the shower-chair. Ms A stated:

> "I want to ask somebody's help but I don't want to leave [her] unattended on the shower chair because she intend to lean forward so I just did it myself after that I put the cot side up and look for someone that can help to transfer her again from the bed to the comfy chair, before the transfer I grabbed again her left arm and that time I [reckon] this in pain because I kinda heard a click in her left arm, which she also presented a grimaced face and an 'ohh' when I started lifting her up and put her on her comfy chair.
>
> I forgot to report it to the RN because all the residents on the B side had been pushed to the dining room to have their lunch except her so it slipped my mind."

When Ms A gave Ms D her written report on 15 August, she was asked why she had not admitted the events earlier. Ms A stated that she was scared that she would be deported.

Ms A's third account
On 17 August, Ms D again interviewed Ms A, who was supported by a union delegate about her knowledge of Mrs C's injuries. Also present at the interview was the Operations Manager and the Facility Manager who recorded the discussions. Ms D told Ms A that this meeting was to give her the opportunity to explain why her written report of 15 August differed from her verbal report of 13 August.

Ms A said that at morning tea on 9 August she had asked caregivers Ms K and Mr J to shower Mrs C as she was under pressure to complete her tasks that morning. She said that Ms K had helped her transfer Mrs C onto the shower-chair. Ms A said that after she showered Mrs C and transferred her back to the bedroom, Mrs C's bowels moved. Ms A stated:

> "Then because its lunchtime, I need to finish her so I used the standing hoist. Stand her up to clean her bottom properly. Whilst standing she was slipping and her left arm moved backwards. It's the arm twisted back may cause the fracture and the sling caused the bruising. Then I bring down the hoist, I supported her body, I was in a panic at that time. …
>
> When [she] nearly slip when she was still in the hoist. I lowered the hoist then supported her and we landed together. I took of the sling. I hold her arm, she

> already in pain. I lowered down the bed. Hug her and move her to the bed. I was so afraid and I'm sorry for what happened."

Ms A admitted that the report she gave on 13 August was to "cover herself" and her written report of 15 August was "partially true".

Action taken
On 17 August, the Rest Home/Hospital Quality Assurance Co-ordinator provided the Ministry of Health HealthCERT Manager with details of these events as a "reportable event".

On 21 August, there was a further meeting with Ms A. Minutes were kept of this meeting. Ms D informed her that it was her chance to provide any additional information. Ms A said she was sorry, it was an accident and she wanted a second chance. Ms D advised her that the matter had been investigated and that disciplinary action was to be taken against her. She would be informed of the decision on 24 August.

On 23 August, Ms D wrote to Ms A to advise her that she accepted her letter of resignation which was effective from Monday 27 August 2007.

On 28 August, Ms D wrote to Mrs B to inform her of the outcome of the internal investigation conducted to identify the cause of her mother's injury and the corrective actions taken as a result. Ms D concluded:

> "This incident has caused us all to reflect on what we can do to prevent a recurrence. An organisation can have the most refined and well documented policies, procedures and systems but there is still one area beyond our control — the individual actions of a staff member at a chosen time. Certainly the message that we are trying to instil in all our staff is that there may well be occasions where human error occurs, but the biggest failure of all is the failure to report — to enable the wrong to be corrected, and to assist in making right the mistake.
>
> An additional action has been taken by [the rest home/hosptial] organisationally via a memo to all direct care staff throughout our [facilities].
>
> I am really sorry that this incident regrettably occurred to your Mum and caused the stress and anger that you and your family have felt. I do hope you will accept my apology, and feel comfortable with the action we have taken."

In August 2007, Ms G wrote an (undated) apology letter to Mrs B which she co-signed with Ms F, stating:

> "I know that you won't accept this apology from [Ms F] and I but we both want to express our sincere apologies to [Mrs C] and your family for our part in this dreadful situation. Our part was not to assess [Mrs C's] bruising

thoroughly, we failed to assess her injury properly and then give adequate pain relief.

We have been both severely reprimanded and at [Mrs C's] expense we have both learnt from this experience, which will help other residents but didn't help [Mrs C] at the time.

We have learnt that regardless how frantically busy we are, when someone is found to have an injury we stop everything we are doing and give a complete full assessment and don't hesitate to ring the doctor. Also to assess thoroughly for pain and give adequate pain relief when required.

Our deepest apologies again."

Issues identified

Every morning during the week starting 13 August 2007, Ms D met with the care staff to discuss these events. As a result of those meetings Ms D learnt that, contrary to the policy, all staff manually handled residents at times. Staff advised that this was because they could not always locate a hoist when they needed one. Ms D was also informed that the registered nurses were not encouraging the team — working with and supporting the team by managing case loads. The registered nurses who saw Mrs C during the weekend of 11/12 August 2007 were advised that their performance in relation to this event (their clinical assessments and documentation) were sub-standard. This has been addressed through a disciplinary process and they were required to write a reflective practice paper on the event.

Ms D said that in August 2007 there were four hoists, two sling hoists and two standing hoists for 41 residents. Fifty percent of those residents would need to be moved in a hoist. Staff told Ms D that there were insufficient hoists and they could not find a hoist when one was needed. She said that part of the problem was that staff hid the hoists in rooms for future use. The organisation has since bought a further two hoists.

Ms D implemented changes to address the problems. These are:

- Registered nurses are not allocated a case load, and help care staff as required to support their allocated team.

- Staffing was reviewed and an additional staff member has been provided from 7am to 1pm and 3pm to 10pm.

- Four extra staff were employed to avoid reliance on bureau staff.

- In August and September 2007 additional training was provided for staff on accident/incident reporting, duty note reporting and a new care hand-over report was implemented.

Additional information

Rest Home/Hospital policies
The Rest Home/Hospital provided a number of policies to ensure resident safety which are relevant to these events. The policies included the following information:

Transfer Plans
The policy, "Transfer Plans — Residents", dated September 2005 stated:

"1. Every resident will have a transfer plan.

2. This document will be readily available to the staff who are expected to use it."

The policy detailed how the plan would be formulated, who was to contribute to the plan, the time frames for routine review of the plan, and the factors to be taken into consideration when a plan was being drawn up.

The policy stated:

"**Use of Montreal Sling**

- Used for residents with a flaccid arm (particularly for stroke residents) to prevent skin tears or dislocation of the shoulder joint during transfer.
- Position carefully after each transfer.

Hoists

- A variety of hoists are used throughout the group,
- Not every hoist is the same and some are to be designed for residents who are **unable** to weight bear at all. Others are suitable for residents who have **some** ability to weight bear.
- Each resident has a manual handling plan which will clearly state **which** hoist is to be used for which resident, and you must adhere to this."

Manual Handling
In September 2005, the Rest Home/Hospital provided its staff with the policy "Manual Handling", which was headed, "No residents shall be lifted by a single staff member (This includes lifts and turns in bed)."

Incident Reporting Standards
The policy "Incident Reporting Standards" specified that incident forms are legal documents, should be an accurate account of events and must be completed as soon as possible after the event. A separate document, "Accident/Incident Forms — Use of", lists the specific events to be documented on Accident/Incident forms, which include:

"**Falls**

- In the event that a resident suffers a fall (witnessed or not), or when a resident, for whatever reason ends up on the floor. …

Bruising

- Any discolouration or contusion."

Competence assessments
The Rest Home/Hospital expected all staff to complete Competency Assessments as part of their orientation and there was a policy that outlined this requirement. The Facility Manager was responsible for ensuring that there was a system in place to ensure staff completed their competencies within the required time frames. One of those competencies was "Hoist use". The objective of that competency was that "staff will complete the following in order to evidence knowledge and demonstrate safe practice".

The complete policies are attached as Appendices 1 to 4.

Responses to provisional opinion

Ms A
Ms A stated that at the time of these events, she wanted to apologise to Mrs B in person but had been advised against this. She said that since leaving the Rest Home/Hospital she has continued to enquire about Mrs C's well-being. She said that she is genuinely remorseful about her behaviour. She has provided a written apology for Mrs C and her family.

Ms I
Ms I stated that she was very distressed that Mrs C had suffered an arm fracture and that it was not promptly assessed and treated. She said:

> "I am truly sorry for any part I may have inadvertently played in that omission in care. I am passionate about caring for the elderly. I am very concerned that my actions of calling in to see [Mrs C] on my way home have been seen as showing a lack of competence as an RN in the clinical assessment of a patient's condition."

Ms G
Ms G said that she accepted that she "made a mistake". She stated that she has reflected on her practice in response to this incident, and she outlined changes she has

made in the way she responds to bruising and any injury. Ms G said that she understands the need to take action on an injury, and not assume that other staff will do so.

Ms F and Ms H
Ms F and Ms H responded jointly and stated that they "deeply regret" their failure to adequately assess Mrs C's injuries or give her pain relief.

Ms F is not now working at the Rest Home/Hospital. She stated that the workload was an issue for carers and nurses. Ms F indicated that she is not using this as an excuse but she is clear that the working conditions at the Rest Home/Hospital impacted on her ability to provide optimal care. Ms F noted that conditions have since improved.

The Rest Home/Hospital
The quality assurance co-ordinator responded for the Rest Home/Hospital. She advised that following the receipt of the provisional opinion, Ms D arranged education for the qualified staff regarding their professional responsibilities. This session was facilitated on 5 May 2008 a senior nurse who is currently employed in the role of Education and Clinical Support for the Rest Home/Hospital. The topics covered were, accountability and responsibility — decision-making and judgement in nursing, reflective practice, and New Zealand Nursing Council competencies for practice.

On 28 April 2008, the General Manager for Care Services issued a memo to all the group's facilities highlighting the comments in the provisional opinion about non-compliance with transfer and lifting policies. She reiterated the expectation that all facilities follow up on any issues of non-compliance identified. Facility managers will be required to give staff notice that ongoing non-compliance will not be tolerated. This was also mentioned in the weekly newsletter, dated April 2008, circulated by the General Manager of Health Operations.

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.
(2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards. …

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Opinion

This is the opinion of Deputy Commissioner Rae Lamb, and is made in accordance with the power delegated to her by the Commissioner.

Opinion: Breach — Ms A

Under Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code), Mrs C was entitled to have care provided by Ms A with reasonable care and skill, and in compliance with the relevant standards. On the morning of 9 August 2007, as on every other day, Ms A had an obligation to ensure Mrs C's safety. She had received instruction on the use of the hoists and knew the Rest Home/Hospital's policy that no resident was to be lifted by a single staff member. Furthermore, when Mrs C fell, Ms A should have acted appropriately by calling for assistance, and subsequently reporting the fall.

Safe positioning and transfer
Ms A was assigned to care for Mrs C on the morning of 9 August. At 11am she was running late when she prepared to shower Mrs C, who had a left-sided paralysis from her stroke and was unable to stand.

Mrs C's care plan specified that she was to be transferred in a sling hoist by two people, and another caregiver saw Ms A take a standing hoist into Mrs C's room. However, Ms A asked Ms K to assist her to manually transfer Mrs C from the bed to

the shower-chair. Ms A then took Mrs C to the shower on the shower-chair and returned her to her bedroom the same way.

Ms A has given three accounts of what happened next, and she has admitted that her first two explanations were incomplete. After initially denying any involvement in Mrs C's injury, she has explained that Mrs C's bowels moved while she was attempting to dress her after the shower. Ms A found that she could not clean her up while she was seated in the shower-chair. While Ms A was supporting Mrs C in a standing position and attempting to clean her, Mrs C slipped and her left arm twisted backwards in the standing hoist's sling. Ms A admitted she had heard a crack from Mrs C's left arm as she fell. Ms A tried to extricate Mrs C from the hoist sling while she was standing, with the result that they both fell to the floor. She removed the sling from Mrs C's arm and knew that Mrs C had been injured and was in pain. Ms A lowered the bed and lifted Mrs C onto it.

Although the two caregivers who helped Ms A with Mrs C did not recall seeing a hoist in the room, she was seen taking the standing hoist into the room. In light of this and the injury sustained by Mrs C, it is my view that the account Ms A gave about Mrs C slipping out of the standing hoist is the most likely scenario. At that time there were insufficient hoists available, particularly during the mornings when there was a high demand for the hoists. This problem was accentuated because staff would hide hoists in rooms for future use. Ms A knew that she should not use a standing hoist for Mrs C, and she should not move her alone. She needed a sling hoist and the assistance of another carer. However, she was in a hurry to complete her work as she was running late, and she needed to dress Mrs C, who could not help herself in any way. It is likely that Ms A used the hoist that was available, not the one she should have used, and in attempting to stand Mrs C, who was paralysed down the left side and therefore unable to take her own weight, the accident occurred.

After the accident Ms A called Mr J to help her to transfer Mrs C, who was dressed, from the bed onto a lazy-boy chair. Ms A knew that Mrs C had been injured. She did not report the incident to Mr J and he did not see the hoist. It is unclear whether it had been taken from the room before he was called, or he simply did not notice it.

Ms A failed to ensure Mrs C's safety when caring for her on 9 August 2007. She moved Mrs C without the assistance of another person, as required by Mrs C's mobility plan, and the Rest Home/Hospital policy. Additionally, she failed to obtain assistance to move Mrs C immediately after the fall. This is particularly concerning given that Ms A knew Mrs C had been injured and she risked compounding the injury by moving her, unaided, onto the bed.

In failing to use the correct hoist Ms A did not provide a service with reasonable care and skill. In trying unsuccessfully to stand Mrs C alone to dress her, Ms A failed to follow her employer's policy that such transfers are to be conducted by two staff. She did not comply with the relevant standards. Ms A's actions amount to breaches of Rights 4(1) and 4(2) of the Code of Rights.

Reporting the incident
Although Ms A was employed as a caregiver at the facility, she is registered as a general trained nurse in her home country and wishes to be registered to practise in New Zealand. Her failure to follow transfer and lifting policy and procedure was serious, but even more serious was her attempt to conceal her mistake.

The Rest Home/Hospital provided staff with a policy and instruction on reporting accidents and incidents. The policy states that all falls and any bruising, discolouration or contusion must be reported.

Ms A did not report the incident on 9 August 2007. Furthermore, when she was again assigned to care for Mrs C the following afternoon, she again failed to report the incident or any change in Mrs C's condition. She later recalled that she had observed the bruising to Mrs C's shoulder and thought she appeared to be "not good".

Mrs C's injuries were finally reported on 11 August but it was not until 13 August that the significance of her injuries was realised and appropriate action taken.

When Ms A was spoken to on 13 August, she initially denied any involvement. Later that day she admitted to transferring Mrs C from the bed onto a shower-chair and at that time hearing a "crack". She said she had "forgotten" to report the incident.

Two days later Ms A provided a very different explanation, stating that she transferred Mrs C twice by herself on 9 August, from the shower-chair to the bed and then from the bed to a "comfy" chair. Ms A said that on both occasions she had "grabbed" Mrs C's left arm. The second time, she heard a click and saw Mrs C grimace.

On 17 August, Ms A provided a third explanation and admitted that she had caused the injury to Mrs C's arm when she attempted to change Mrs C by using the standing hoist unaided. As previously discussed, I believe this to be the more credible explanation for Mrs C's injury.

In a recent opinion about a caregiver who failed to report an accident, I stated:[1]

> "Ms C was more concerned about what was likely to happen to her than whether Mrs A required medical attention following her fall. … Ms C was too scared and embarrassed to admit her knowledge of events. This is no excuse. Ms C had a professional responsibility to report the incident to nursing staff and provide an honest answer to Mrs A's family. Ms C then chose to continue her deception, rather than admit to full knowledge of the incident."

This appears to be a very similar case. Ms A's reason for not reporting this matter was to protect herself from possible deportation. She put her own interests ahead of Mrs C,

[1] Opinion 06HDC16618, 31 October 2007, page 10.

a vulnerable patient who could not readily communicate what had happened, or her pain. Ms A had a duty to put Mrs C first.

When Ms A failed to report the accident, she not only contravened the policy of her employer relating to accident/incident reporting, but she deprived Mrs C of the chance to have her injuries attended to in a timely manner. As a result, Mrs C suffered the pain of a fractured arm for four days. In my view, Ms A had sufficient time and opportunity to advise senior staff of the incident, and her failure to do so was unprofessional, unacceptable, and of considerable concern. These actions amount to a breach of Right 4(2) and 4(5) of the Code.

In light of Ms A's deceit, I am of the view that she should be referred to the Director of Proceedings to consider whether further action should be initiated.

Opinion: Breach — Rest Home/Hospital

The Rest Home/Hospital had numerous policies and procedures in place to guide staff in a variety of care issues applicable to these events. The organisation also addressed quality issues by having in place an organisational quality framework.

Ms A had been provided with instruction concerning the care of Mrs C, and other staff were available to assist her to lift and transfer Mrs C. Ms A had also been trained in the use of the hoist. There were clear policies and procedures about how to lift and move residents, and staff responsibilities in reporting any accidents or incidents.

The facility management also acted promptly and appropriately when the incident was brought to their attention and when Ms A's actions were determined. Additional resources and training were introduced to address the issues highlighted by the internal inquiry into these events.

I endorse Ms D's comment to Mrs C's family that the biggest failure was Ms A's failure to promptly and truthfully report the incident.

However, despite all this, I am not satisfied that the Rest Home/Hospital took sufficient action to ensure that Mrs C was provided with a reasonable standard of care at the time of these events.

In particular, I note that Ms A was not the only staff member who did not follow the organisation's policies and procedures. A number of other staff also failed to do so. On two occasions, other carers (Ms K and Mr J) assisted Ms A to move Mrs C manually, when her care plan specified that she was to be transferred in a sling hoist by two staff. Another carer, Ms N, turned Mrs C during the night of 9 August apparently without assistance.

When the manager, Ms D, talked to carers following these events, they told her that, contrary to the policy, all staff manually handled residents at times. Staff explained that this was because they could not always locate a hoist when it was needed.

Ms D advised that in August 2007 about half of the 41 residents needed to be moved using a hoist, and there were only two standing hoists and two sling hoists available for this. As a result of the staff comments, two additional hoists were purchased.

It is also apparent that Ms A was not the only staff member who failed to report the bruising that appeared the day after the fall. Another carer, Ms L, said she did not report it to the nursing staff because she was so busy with three other residents.

For three days, staff cared for Mrs C, washing and dressing her, and no one reported or followed up her injuries until the afternoon of the third day (11 August) when Ms M drew the matter to the nurses' attention.

Even then, the response was inadequate. One of the most striking aspects of this matter relates to the response of the four different registered nurses who viewed Mrs C when they were told about the bruising on 11 August. Not one of those nurses performed an adequate assessment of Mrs C's injuries or gave her pain relief. One of the nurses, who had observed that Mrs C was in pain, said she realised later she should have given her some pain relief, and she failed to document her observations because she became too busy and forgot.

Certainly, workload appears to have been a significant issue for both carers and nurses. I note that Ms D has instituted changes to the way the work is organised following comment from carers that the nurses were not working with, and supporting, the team by managing case loads. Additional staff have also been hired. Extra training has also been given on accident/incident reporting.

In my view, the inaction and failure to follow policies and procedures by so many staff in August 2007 demonstrates a culture of non-compliance, and an environment that did not sufficiently support and assist staff to do what was required of them. The Rest Home/Hospital must take some responsibility for this.

Even more disturbing than the inaction on the bruising is the fact that "rough handling" and "illegal lifting" were considered by the nurses as possible causes of the bruising, yet this was not followed up. No inquiry was initiated until concerns were raised by another carer on 13 August. At best, this reflects an unfortunate oversight due to pressures of work; at worst it reflects a casual acceptance of suboptimal care and non-compliance with internal policies. Whatever the reason, it was unacceptable.

There was a series of unfortunate lapses, failures and omissions, involving a number of different staff involved in the care provided to Mrs C, who could not articulate her distress and suffered unrelieved pain for four days. In my view, the Rest

Home/Hospital failed to provide services with reasonable care and skill to Mrs C and therefore breached Right 4(1) of the Code.

Other comment

The Rest Home/Hospital was dependent on its registered nurses complying with its systems and using their professional skills to provide a reasonable standard of care. However, it is clear that the nurses involved in Mrs C's care over the weekend of 11 to 13 August, Ms I, Ms G, Ms F and Ms H, did not provide that level of care.

Ms D has advised that the performance issues with the nurses have been addressed through the disciplinary process. They were told that their care was sub-standard and required to write a reflective paper on the event.

Two of the nurses, Ms G and Ms F, promptly accepted responsibility for their part in these events, apologised to Mrs C's family, and reviewed their practice and made necessary changes. Both Ms I and Ms H have now expressed their regret for their part in this incident. However, given the serious nature of these events, I intend to refer registered nurses Ms I, Ms G, Ms F and Ms H to the Nursing Council of New Zealand for consideration of whether a review of their competence is warranted.

Follow-up actions

- Ms A 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 proceedings should be taken.

- A copy of this report will be sent to the Nursing Council of New Zealand with a recommendation that Ms A's competence be reviewed should she seek nursing registration in New Zealand.

- The Council will also be asked to consider whether a review of Ms I, Ms G, Ms F and Ms H's competence is warranted.

- A copy of this report, with details identifying the parties removed except for Ms A, will be sent to HealthCare Providers New Zealand and the Association of Residential Care Homes.

- A copy of this report with details identifying the parties removed except for Ms A and the Rest Home/Hospital will be sent to the Ministry of Health and the District Health Board.

- 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.

Addendum

The Director of Proceedings considered the matter and issued proceedings before the Human Rights Review Tribunal. The matter proceeded by way of an agreed summary of facts in which Ms A admitted a number of key failings on her part. Contrary to the aggrieved person's care plan, she transferred the consumer without the assistance of another caregiver and used an incorrect hoist. Following the patient falling to the ground, and contrary to policies in place at the rest home, she then failed to report or document the incident which led to the injury sustained by the consumer. When questioned by management at the rest home she provided three different versions of the event in question.

The Tribunal made a declaration that Ms A's actions were in breach of Rights 4(1), 4(2), and 4(5).

Appendix 1 — Transfer Plans

Implemented: 09/05
Latest Review:
Approved: . *Care Services Manager*

Subject: Transfer plans – residents
Reviewing Body:

TRANSFER PLANS – Residents

Objective: Risk of injury to staff and residents will be minimised by clearly documented and accessible transfer plans.

1. Every resident will have a transfer plan.
2. This document will be readily available to the staff who are expected to use it.
3. It will be formulated with contribution from nursing and physiotherapy staff, and be completed within 7 days of the resident's admission.
4. It will be reviewed 6 monthly or more frequently should a resident's condition alter. (see back of transfer plan)
5. When formulating the plan, consideration will be given to the following:
   - The degree of resident mobility.
   - The number of staff required to carry out the lift.
   - Equipment/mechanical assistance required/available.
   - The resident's ability to understand and co-operate with instructions.
   - The likelihood that the resident will become resistive.
   - The likelihood that the resident will suddenly go limp or make uncontrolled movements.
   - The resident's weight.
   - Who should be involved in the formulation of the plan.

Page 1 of 3 294 Trs Pla

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

STICKY LABEL

TRANSFER PLAN

Transfer plan completed by :

TURNING IN BED

Instructions

TRANSFERS

Instructions

MOBILITY

Instructions

COPY

Implemented: 09/05

Page 2 of 3

294 Tra Pla

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Appendix 2 — Manual Handling

Implemented: 09/05
Latest Review:
Approved: *Care Services Manager*

Subject: Manual Handling
Reviewing Body:

MANUAL HANDLING

Objective: Staff will adhere to the following in order to minimise risk and injury to residents and staff

NO RESIDENTS SHALL BE LIFTED BY A SINGLE STAFF MEMBER
(This includes lifts and turns in bed)

The facility will:

- Provide staff with education at orientation, where they will cover back care, body mechanics, equipment and safe transferring techniques.
- Issue a Manual handling booklet to all new staff
- Provide sufficient mechanical handling aids which will be well maintained.
- Provide staff with training in the correct use of the equipment and ensure managers monitor appropriate use of the equipment.
- Provide staff with manual handling plans for each resident.
- Provide ongoing education on manual handling.
- Use the disciplinary process for staff who fail to use resident manual handling plans or who transfer a resident alone.

Staff will:

- Ensure that ALL transfers are done according to individual transfer plans by two staff members unless the resident is able to walk unaided.
- Turn and move all residents in bed with two staff
- Expect senior nursing staff to demonstrate leadership in safe manual handling and ensure that all staff under their supervision adhere to safe work practices and use equipment correctly.
- Use mechanical aids where possible, the use of hoists is strongly recommended and is mandatory if stated in individual transfer plans
- Wear a low-heeled shoe with a non-slip sole that provides support and a good base for manual handling.

Page 1 of 3 149 Man Han Bklt

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MANUAL HANDLING EQUIPMENT

- Equipment will be available to assist staff with the transfer of residents in order to maintain resident and staff safety.
- Individual resident needs (including equipment requirements) will be assessed by the health team and documented on the resident transfer plan.

Transfer belts

- These are fitted by the physiotherapist and labelled with the resident's name
- It is important that the belt stays with the resident for easy access. Senior staff are responsible for ensuring this occurs on their shift.
- A correctly fitted belt is placed around the resident's waist and needs to be firm but not tight. Check that it does not encompass the breasts of a female resident and use the handles on the belt for transferring.
- When the transfer is complete the belt is unclasped whilst the resident is seated or removed if the resident is in bed

Slide sheets

- These are used for cares to residents in bed, whether moving up and down or changing sides.
- No shared use between residents

Blue transfer pads

- These may be supplied to individual residents or placed in strategic areas for general use.
- They must be sprayed with disinfectant between use and washed daily in soapy water.

Turntables/Swivel boards

- These are available at some facilities and are used for residents who require assistance in swivelling during transfer.

Hoists

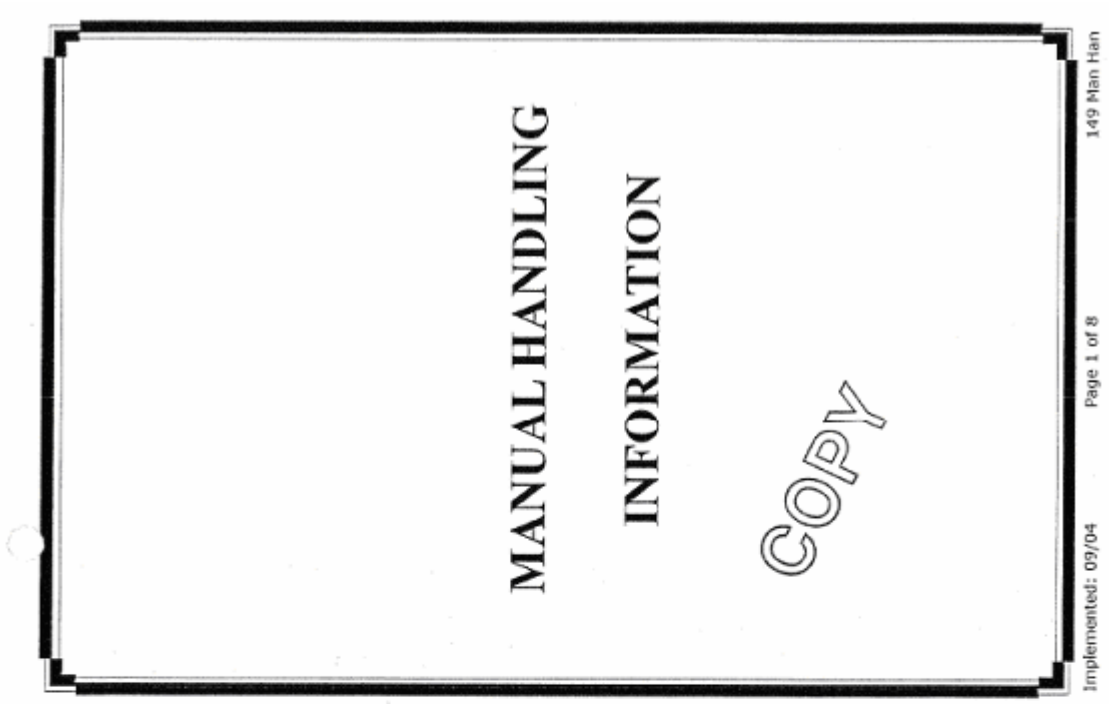
- The use of hoists is actively encouraged in the transfer of residents, including those who are unreliable during transfers.
  NB Each hoist has a maximum weight bearing capacity. Staff must ensure this limit is not exceeded
- ALL non weight bearing residents over 35 kg will be transferred by hoist .
- There are 2 types of hoists available and both have distinctly different uses.

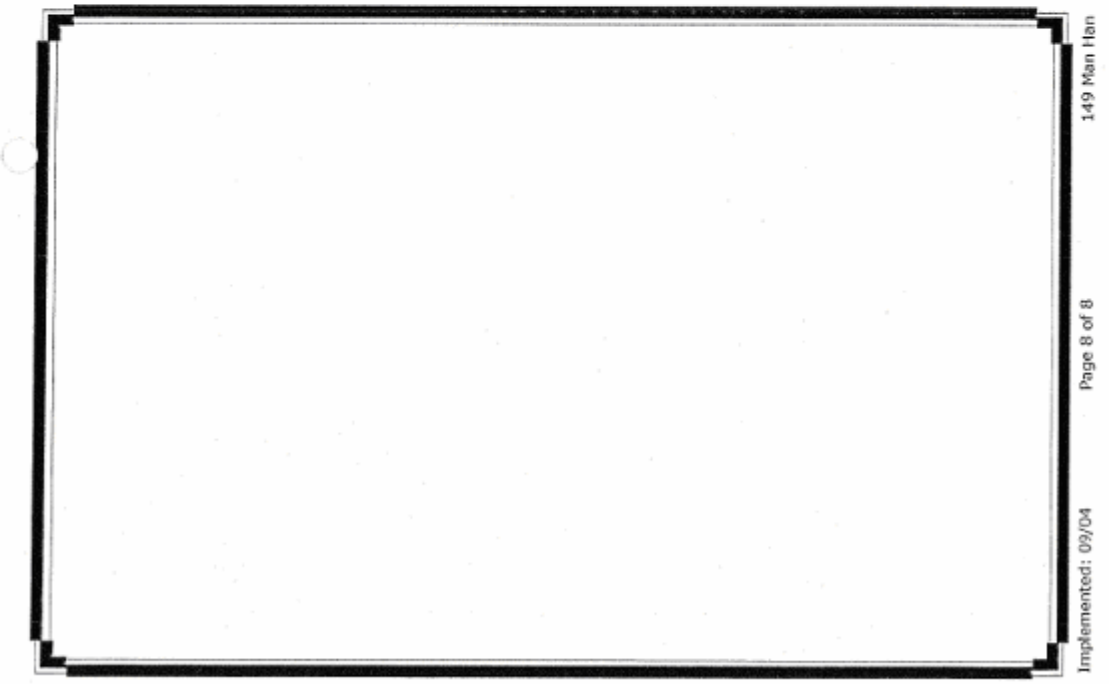
Transfer Hoists - These totally transfer a resident with no active participation from the residents. Ideally each resident has their own sling, if this is not possible then staff must place something between the sling and the resident's skin to minimize IFC risks

Stand-aid hoists - These hoists are used for residents who have an ability to partially weight bear and have the use of at least one arm as it assists them to a standing position.

Incoming goods and deliveries

- Heads of Department should make every effort to ensure that hospital deliveries are made as close as possible to the storage location
- In the event that inwards goods and boxes have to be moved around the hospital staff must use trolleys or hand truck
- If boxes exceed 20kgs then two staff are required to handle or transfer them
- The kitchen manager should assess the weight of goods ordered (eg 20kg bags flour and sugar etc) and minimise the movement required by staff





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Welcome to our Facility

Many of the residents that you will be caring for are frail and elderly. They are limited in the amount of assistance that they can give during cares, and as a result you will be doing a great deal of manual handling.

You will have received plenty of information during your session with the hospital physio and this handout goes over many of those aspects.

If, after a while, you feel that you are still having trouble mastering the manual handling technique **please do not hesitate to ask for more education.** You could approach the hospital physio or any senior member of the nursing staff.

Basic Rules for manual handling

Many residents have little or no power to help themselves. Residents should be encouraged to do whatever they can, **however little.**

*****THINK AND PLAN *****

Always arrange the room before transferring

- Is there enough space?
- Are the brakes on the bed and chair?
- Is the bed height adjusted to suit the shortest nurse mid thigh?
- Position furniture at right angles as this allows for minimal turning and carrying.
- Ensure that the resident has footwear on if assisting with weight bearing.

Use of Montreal Sling

- Used for residents with a flaccid arm (particularly for stroke residents) to prevent skin tears or dislocation of the shoulder joint during transfer.
- Position carefully after each transfer.

Hoists

- A variety of hoists are used throughout the group.
- Not every hoist is the same as some are designed to be used for residents who are **unable** to weight bear at all. Others are suitable for residents who have **some** ability to weight bear.
- Each resident has a manual handling plan which will clearly state **which** hoist is to be used for what resident, and you must adhere to this.

Enjoy your work within the group and keep your back safe. Make the most of any education opportunities and always remember that the manual handling policy requires that **no** staff member transfer alone. We think it's safer for you and it's definitely safer for the resident.

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Use of blue transfer pads/blue boards/Medislings

- These are readily available throughout the hospital and can be used in a variety of ways.
- They **must** be placed at the **base** of the resident's spine if used to assist with transferring or standing.
- They can be used to support the legs in a chair transfer.
- They are used in conjunction with a draw sheet to raise residents up the bed or to turn them over.
- Any signs of wear on these pads **must** be reported to a senior member of the nursing staff or brought to the attention of the physios.

Use of transfer table/turning disc

- Used when the resident is unable to move sideways for transferring.
- The resident must be able to weight bear correctly or at least stand on one leg.
- Useful for people with minimal hip movement.
- Make sure the turntable is placed centrally, under the resident's feet and ensure the resident is standing erect, not leaning over.
- Knees should be at right angles before standing.
- Gently turn resident once standing.

Implemented: 09/04 Page 6 of 8 149 Man Han

5

Read the resident Transfer plan

This will tell you the correct way to transfer the resident. Consideration will have been made with regard to:-

- The resident's disability i.e. stroke, fracture, arthritic joints, dementia etc.
- The size and weight of the resident and their ability to weight bear.
- The number of nurses required and what equipment is needed.

*****ALWAYS CHECK THE PLAN*****

Traffic Light System

Red, Orange and Green dots alert staff to transfer needs of residents.

RED—STOP!	Hoist transfer only
ORANGE—WARNING!	Two staff and transfer equipment required
GREEN - GO!	Mobile resident. One staff member to transfer

Use of Slide Sheets

These eliminate the need to lift Residents. They are placed in half under a resident. One surface slides against another. Training will be given in appropriate use.

2

Implemented: 09/04 Page 3 of 8 149 Man Han

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Use of transfer belts

- Adjust the belt firmly around the waist of the resident, position with the hand grips to the back.
- If the belt is not adjusted firmly it may slip and you may lose control of the transfer.
- The bet should be released after use and if the resident is transferred by wheelchair, care needs to be taken that the belt does not become tangled in the wheels by fastening at back of chair.
- When using the transfer belt, grasp the hand grip rather than the belt itself.
- Take time, if the resident is able, to encourage a standing position before transferring. This way you are assisting your resident and allowing them as much independence as possible.

Position for transfer

- Move the resident as close to the edge of the bed or the chair as possible, with their feet firmly on the ground.
- Stand as close to the resident as possible.
- Stand with feet slightly apart to provide good balance. This also gives you a good base should the transfer not proceed as well as it should (i.e. resident suddenly ceases to weight bear)
- Your front foot should point in the direction of the move, the back foot will vary to give stability.
- Your back should be straight, your chin tucked in, your tummy tight and the knees bent.
- Use your strong hip and thigh muscles to raise the resident, use one smooth motion, do not jerk. One of the pair must call the move - Ready, set, go

3

Implemented: 09/04 Page 4 of 8 149 Man Han

Important DO's in manual handling

- Make sure you have enough space.
- Take your time with preparation.
- Make sure you adhere to the resident manual handling plan.
- You must have good footwear on.
- Talk to the resident and tell them what is happening.
- Never move a resident from under their arms as this can cause both damage and pain.
- Protect the affected arm of the resident who has had a stroke. Never move them by pulling on their paralysed side, be aware that it is supported when transferring.
- Position the chair or the wheelchair that you are transferring **into,** on the **unaffected** side of the stroke victim as this is their strongest side and they may be able to help a little.
- Concentrate on your body position, chin in, back straight, tummy taut, knees bent.

*****USE EQUIPMENT CORRECTLY*****

Important Points

- No 'one nurse' transfers.
- No handling of residents by hands or upper arms. Transfer belts make this unnecessary.
- Do not twist your bocy during a transfer. If you need to change direction, move your feet.
- Don't take short cuts, you risk harming yourself or the resident

4

Implemented: 09/04 Page 5 of 8 149 Man Han

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Appendix 3 — Competency Assessments

Implemented: 07/05
Latest Review:
Approved: *Care Services Manager*

Subject: Competency Assessment
Reviewing Body:

COMPETENCY ASSESSMENTS

Objective: Competency assessments will be used in order to ensure staff have appropriate skills and knowledge

- All staff are required to complete Competency Assessments as part of their orientation. Information below outlines what competencies need to be completed by whom
- Competency assessments are available on the : Intranet
- The Facility Manager is responsible for ensuring a system is in place to ensure competencies are completed within required time frames

Competency Register

- Each staff member will have a competency register maintained during their employment which will provide documented evidence that competency has been achieved and is current

Qualified nurses

- As part of orientation and annually thereafter
  - i) Restraint
  - ii) Drug administration
  - iii) Controlled drug administration
  - iv) Nebuliser
  - v) Blood sugar levels and Insulin Administration
  - vi) Hoist Use
- Within 3 months of employment and annually thereafter
  - i) Oxygen administration
  - ii) Wound management
  - iii) Nursing Assessment tools
- As and when required and annually thereafter
  - i) PEG feeding and Management
  - ii) Naso gastric tube care
  - iii) Sub cutaneous fluids
  - iv) Graseby Syringe Driver
  - v) Ear syringing

Caregivers

- As part of orientation and annually thereafter
  - i) Restraint
  - ii) Hoist Use

Page 1 of 4 094 Com.Ass

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

- For Caregivers / Senior Caregivers who will administer medications include at orientatic and annually thereafter
  - iii) Drug administration
  - iv) Controlled drug administration
  - v) Nebuliser

- As and when required and annually thereafter
  - i) PEG feeding
  - ii) Clinical assistant / Senior Caregiver
  - iii) Blood sugar levels and Insulin Administration
  - iv) Oxygen Administration
  - v) Wound Management

Activities Staff

- As part of orientation and annually thereafter
  - i) Restraint
  - ii) Hoist Use
  - iii) Van Driving and/or Loading

Van Drivers (employee or volunteer)

- As part of orientation and annually thereafter
  - i) Van Driving and/or Loading

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COMPETENCY ASSESSMENT REGISTER

NB Record the date the assessment was successfully achieved

STAFF MEMBER'S NAME :-

DESIGNATION :-

Restraint	Drug Admin	Controlled Drug Admin	Checking Controlled Drugs	Nebuliser	BSLs / Insulin Admin	Wound Management	Oxygen Admin	Assessment Tools	Hoist Use	PEG feeds

Implemented : 07/05

Page 3 of 4

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COMPETENCY ASSESSMENT REGISTER

STAFF MEMBERS NAME :- **DESIGNATION :-**

Sub Cutaneous Fluids	Graseby Syringe Driver	Naso gastric tube care	Ear Syringing	Clinical Assistant	Van Driving and or Loading	Other	Other	Other	Other	Other

Implemented : 07/05

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Implemented: 08/05
Latest Review:
Approved: *Care Services Manager*

Subject: Competency Assessment – Hoist Use
Reviewing Body:

COMPETENCY ASSESSMENT - HOIST USE

Objective: Staff will complete the following in order to evidence knowledge and demonstrate safe practice

- Staff are **not** permitted to use any hoist until they have demonstrated competency.
- Staff who are required to use a hoist during their employment are required to complete this assessment **during their orientation period and annually thereafter**
- Competency will be assessed by a Registered Nurse who has achieved Competency
- All elements of the assessment have to be met in order to achieve competency
- If competency is not achieved the Manager / Clinical Manager will determine a Plan of Action with the staff member and set a reassessment date **within a week**
- Completed Competency assessments will be kept in the staff member's Personnel File and entered in the staff member's Competency Record

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COMPETENCY ASSESSMENT HOIST USE	FACILITY:
	Staff Member's Name
	Designation
	Date Competency achieved
	ASSESSED BY :-

	STAFF MEMBER IS ABLE TO DEMONSTRATE	**Competent Yes**	**No**	**COMMENTS**
TRANSFER HOIST				
1	Checked resident's Transfer Plan			
2	Explained procedure to resident			
3	Cleared transfer area of any obstructions			
4	Has appropriate equipment ready e.g. shower chair, wheelchair, lazyboy chair			
5	Two staff members present			
6	Sling correctly positioned on resident in bed and / or in chair			
7	Hoist positioned in correct alignment to equipment when transferring from bed and / or chair			
8	Hoist straps correctly positioned and checks that they are secure			
9	Instructs assisting staff member on what he/she is to do and where they are moving resident to			
10	- One staff member maintains safety of resident's body, head and limbs during hoist - Second staff member operates hoist			
11.	Hoist is moved clear of bed / chair before transferring			
12.	Hoist is placed in correct alignment with equipment resident is to be transferred to			
13.	Lowers resident with care and guidance			
14.	Removal of sling from resident			
15.	Resident is left comfortable / well positioned			
16.	Hoist and sling are returned to storage			

Implemented : 08/05

E10 Com.Hoi

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17.	a) removing battery for recharging b) placing battery on charger c) removing battery from charger and fitting on hoist			
STAND – AID HOIST				
1.	Checked resident's Transfer Plan			
2.	Explained procedure to resident			
3.	Cleared transfer area of any obstruction			
4.	Has appropriate equipment ready e.g. shower chair, wheelchair, lazyboy chair			
5.	Two staff members present			
6.	Feet and legs positioned correctly			
7.	Sling secured around legs firmly / comfortably			
8.	Body sling secured firmly			
9.	Instructs resident to hold bars and ensures they are doing so			
10.	Instructs assisting staff member on what he/she is to do and where they are moving resident to			
11.	- One staff member maintains safety of resident throughout transfer - Second staff member operates hoist			
12.	Hoist does not come in contact with anything during transfer			
13.	Lowers resident with care and guidance			
14.	Both slings removed			
15.	Resident is left comfortable / well positioned			
16.	Hoist and sling are returned to storage			
17.	a) removing battery for recharging b) placing battery on charger c) removing battery from charger and fitting on hoist			

Implemented : 08/05

E10 Com.Hoi

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It is my professional opinion that .....

is competent ☐
is not yet competent ☐

to use a Transfer and Stand- Aid Hoist

Assessor : _____ Designation _____ Date_____

If **NOT YET COMPETENT** please state reasons why.

REASON

Assessor : _____ Designation_____ Date _____

Plan of action

Reassessment Date: _____

Manager / Clinical Manager _____Designation _____ Date_____

Staff Member_____ Designation _____ Date _____

Follow up and evaluation

is competent ☐
is not yet competent ☐

Manager / Clinical Manager _____ Designation _____ Date _____

Staff Member _____Designation _____ Date _____

Implemented : 08/05

E10 Com.Hoi

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Appendix 4 — Incident Reporting

Implemented: 11/05
Latest Review:
Approval: *, Care Services Manager*

Subject: Incident reporting standards
Reviewing Body:

INCIDENT REPORTING STANDARDS

Objective: Staff will adhere to the following in order that incidents or events are appropriately recorded

- Incident forms must be completed as soon as possible after the event - they are legal documents and should contain an accurate account of an event
- They should outline the event in **the sequence of how things occurred**
- They should be completed in line with accepted documentation standards
- The incident report should include
  - Your name and designation
  - Where the incident occurred
  - Date and time of incident
  - The resident's full name
  - A full description of the event
  - The description of what you observed
  - A list, in chronological order of what you did following the incident
  - All the findings related to your observations
  - The resident's response to any actions you took
  - Record which family member was informed (if no one home- or a message was left on answer phone – record that)
  - If a Doctor was contacted record the time, the name of the Doctor and what the Doctor's recommendations were
  - Document any care or treatment given
  - A list of all those involved in the incident

Page 1 of 2 360 Inc Rep

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- When completing an incident form you need to ensure that:
  - You record only those things you personally witnessed
  - Do not make assumptions – if someone is on the floor next to the bed do not
  - assume they fell off the bed
  - You are not influenced by anyone to write anything you feel uncomfortable with
  - The information is legible and only includes information you know to be true
  - You have not included judgemental statements – eg 'unprofessional conduct by Nurse C"

Source: NZ Nurses Organisation

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Implemented: 07/05
Latest Review: 11/05
Approved: _____ , *Care Services Manager*

Subject: Accident/Incident Forms - Use of
Reviewing Body:

ACCIDENT/INCIDENT FORMS - USE OF

Objective: Staff adhere to the following in order to ensure accurate and comprehensive reporting of all accidents and incidents within the facility

- Specific events will be documented using this form - criteria below indicate what events will be reported.

Category One

- Incidents that are considered to be of a more serious nature are covered in a separate policy - see 'Category One incidents'

Falls

- In the event that a resident suffers a fall (witnessed or not), or when a resident, for whatever reason ends up on the floor

Skin Tears

- Any incident where a skin tear is sustained or found

Bruising

- Any discolouration or contusion

Pressure sore

- Any abrased, reddened or blanched area that has resulted due to pressure and which does not resolve after 20 minutes.

Resident behaviour

- An incident of unacceptable behaviour from a resident
- An altercation between residents, or between a resident and a staff member or visitor - 2 forms will be completed one for the resident displaying the behaviour and one for the person the behaviour is directed at.

Medication incident

- Medication given to wrong resident (also Cat One)
- Wrong medication administered (also Cat One)
- Wrong dosage administered (also Cat One)
- Wrong route
- Beyond expiry date
- Resident received medication they are known to be hypersensitive to

Page 1 of 4 014 Acc For

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- Medication found (on floor, in resident's bed)
- Medication not dispensed
- Controlled drug discrepancy

Environmental

- An event that relates to false fire alarms, fire situations, security incidents, breaches of loc up procedure, significant property damage.

Other

Any event that is considered reportable but does not fall into the above categories.

How to complete the forms

- Forms will be completed as soon after the event as possible (pencil must **not** be used).
- All relevant information must be included and a clear and concise description of events and what actions were taken and by whom.
- All forms must be countersigned by the Duty Leader who checks that an accurate account has been made and that all necessary data has been entered (time and date, witnesses etc) and documents what action was taken in response to the event.
- Witnesses to the event must also sign the form.

NB - Incident forms are legal documents and may be subject to scrutiny if litigation is to occur - they must be precise and accurate.

Notification of the family

- Next of kin must be informed as soon as practical in the event of any accident/incident occurring - unless minor, or family has stated otherwise.
- If a nurse is unsure whether an event warrants the family being contacted, the Duty Leader will make the decision.
- The issue of notification is discussed with the family at the first resident review meeting, and their wishes will be documented. This decision is then reviewed 6 monthly.
- The nurse in charge at the time of the incident is responsible for informing the NOK and will document who was informed and at what time.
- If between the hours of 2000 and 0800 and the incident is not of a serious nature - NOK may be notified the following morning.

Incident / Infection record

- Each resident has a record of all incidents that have occurred (kept at back of clinical file) - this assists in identifying patterns and trends in order that interventions may be put in place.

Accident / Incident analysis

- All resident incidents are entered into a data collection system
- Statistics are analysed monthly and based on the data Key Performance Indicators are calculated.
- These are designed to monitor the performance of the facility in a particular area.
- Quality improvements are actioned in response to these figures and then levels are monitored in order to assess the effectiveness of them.

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ACCIDENT / INCIDENT FORM	Facility:
	Date: Time:
	Name of injured Person :
	Resident ☐ Staff ☐ Visitor ☐
	Location of incident

Person completing the form: **Des:**

Category One		Fall		Medication incident	
Skin tear		Pressure sore		Other	
Resident behaviour		Bruising		Environmental	

Describe the incident and identify the cause :

What injuries occurred

What might have prevented the incident occurring ?

What action was taken as a result of this incident ?

Signature	**Designation**
Name of witnesses if any	

Implemented : 07/05 Latest review: 11/05 Page 3 of 4 014 Acc For

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Duty Leader informed? Y / N	Time:	By whom:
Name of duty leader		
FM/ on call informed ? Y / N	Time:	By whom:
Doctor contacted ? Y / N	Date: Time:	By whom:
Name of Doctor		
Doctors comments if applicable:		
Relatives informed ? Y / N	Date : Time :	By whom:
Name or person informed		
Incident follow up and evaluation of actions taken :		
Date :	**Completed by :**	**Des:**
Additional comments or Quality Improvement suggestion ?		
Date :	**Completed by :**	**Des:**
Incident entered in Resident Incident Record by :		
Facility Manager / Deputy signature:		**Date:**
Comment:		

Implemented: 07/05 Latest review: 11/05 Page 4 of 4 014 Acc For

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