Rest Home

Report on Opinion - Case 98HDC11040

Complaint

The Commissioner received a complaint from the complainant about the standard of care provided to her aunt, the consumer, while a resident in respite care at the rest home in December 1997. The complaint is that:

- *While a resident at the rest home, the consumer sustained a fractured neck of femur, extensive bruising and a black eye, which resulted in a general deterioration in her condition.*
- *The consumer's family were not given adequate information regarding the cause of these injuries.*

Investigation

The Commissioner received the complaint on 14 January 1998, and an investigation was undertaken. Information was obtained from the following people:

The Complainant/Consumer's Niece
The Current Nurse Manager at the Rest Rome
Risk Management Quality Assurance Consultant and Registered Nurse at the Rest Home
A Caregiver at the Rest Home
A Registered Nurse at the Rest Home

The daily communication notes and nursing notes for the consumer's stay at the rest home were obtained and reviewed by the Commissioner.

Information Gathered During Investigation

Background

The licensee of the rest home is a company. The manager at the time of the consumer's fall has left. The then assistant manager is the current manager of the rest home.

The consumer suffers from Alzheimer's which had been diagnosed in August 1997. In October 1997 the consumer's family decided that a short period of respite care would be beneficial to everyone, particularly the consumer's elderly and increasingly frail sister who was her primary caregiver. The complainant advised the Commissioner that this was an extremely difficult decision for the family because they felt it was their responsibility to ensure the consumer's safety and welfare.

Continued on next page

Rest Home

Report on Opinion - Case 98HDC11040, continued

Information Gathered During Investigation, *continued*

The consumer was examined by a support service prior to admission, and was assessed as being a level 4 on the support needs level recommendation scale. The following description of a person assessed at level 4 appears in the Crown Health Enterprise's Support Needs Level Recommendation Assessment:

> *"A level 4 client is unable to manage and needs some supervision/assistance from one person during an entire activity to offer guidance or actual hands on care. Without the constant presence of another person the activity will not be completed. This level of support includes an older person who has an age related psychiatric disability which requires constant supervision or care to ensure the person's safety."*

Admission to the Rest Home

The consumer was admitted to the rest home in early December 1997. The current nurse manager at the rest home advised the Commissioner that the consumer went through the usual admission procedures with a nursing assessment and lifestyle plan being completed. The nursing assessment was completed with information provided by the complainant. The nursing assessment identified a risk of falling. The information provided by the complainant on admission indicated that the consumer's family wished her to maintain independence with her mobility.

The communication notes and the nursing notes for the day following the day on which the consumer arrived at the rest home stated that the consumer was content and settling into the ward well.

Continued on next page

Rest Home

Report on Opinion - Case 98HDC11040, continued

Information Gathered During Investigation, *continued*

Initial Fall

Two days after the consumer arrived at the rest home the following was recorded in the nursing notes:

> "*E Wing* – [the consumer] = *had an unobserved fall. No injuries apparent. Incident form completed. Please observe as slightly unsteady on her feet*".

The communication notes of the same day stated:

> "*Unobserved fall in lounge. ...*[Registered Nurse] *contacted. Check for injuries. None apparent. Incident form filled out. Very unsteady on her feet*".

The communication notes were signed by a caregiver at the rest home.

Actions Taken Following Fall

After the consumer's fall she was examined by the risk management quality assurance consultant (who was also a registered nurse), and also by the registered nurse. In her response to the Commissioner, the registered nurse stated that after examining the consumer, she found:

> *"No obvious injuries or bruising and she appeared to be mobilising well the following day".*

The registered nurse also stated that there was some difficulty in contacting the consumer's family that day. The risk management consultant's observations after examining the consumer were recorded in the incident report as follows:

> *"No obvious injuries observed. No shortening or external rotation of either leg. No bruising evident at this time - please observe over next 24 hours.* [The consumer] *was able to stand and sit independently following fall. No skin tears and bleeding, pulse satisfactory at 86/min. Please continue to observe* [the consumer] *when mobilising".*

Continued on next page

Rest Home

Report on Opinion - Case 98HDC11040, continued

Information Gathered During Investigation, *continued*

The caregiver who worked with the consumer on the day of her fall, told the Commissioner that the consumer was fine for the rest of the day after the fall, but seemed a bit slower the next day. The caregiver stated that the consumer told her that she was not in any pain after the fall. The following day the caregiver recalled checking the consumer again and asking about the pain. Again, the caregiver said that the consumer gave her no indication she was in any pain.

Two days after the consumer's fall, the communication notes entered by the caregiver stated:

> *"Found large bruise on* [the consumer's] *left arm, not aware of how it got there".*

In her response to the Commissioner, the caregiver stated that on that day she was off duty. The registered nurse contacted her to check how the consumer had been the day before, as she was now having trouble moving. These two records contradict each other as the caregiver told the Commissioner she was not on duty, and yet the notes indicated she was. Despite this, it is clear from the nursing notes that bruising did appear on this date. The nursing notes stated:

> "[The consumer] = *new bruising noted to upper (L) arm. ? cause. Also bump and graze on forehead. ?cause.*
>
> *Bruising observed previous night CH/A* […] *but assumed result from fall* [two days before]*; bruising noted in notes from previous fall too. No problems otherwise*".

The communication notes on the third day after the consumer's fall indicated that bruising had also appeared on the consumer's right eye. This was reported to the registered nurse. Further entries in the communication notes on that day indicate that the consumer's bruising became more noticeable as the day progressed. In addition, the nursing notes and the communication notes on that date indicated that the consumer was in pain, which was coming from her right thigh. The communication notes stated:

> *"*[The consumer] *hasn't moved all night again – right leg hurting her when moved – slept OK*".

Continued on next page

Rest Home

Report on Opinion - Case 98HDC11040, continued

Information Gathered During Investigation, *continued*

The nursing notes stated:

> *"*[The consumer]*: appeared to be in pain when being changed in bed. Pain coming from r) thigh. Please observe. ?#NOF(fractured neck of femur)/bruising from previous falls."*

The registered nurse was on day shift four days after the consumer had her fall. After establishing that the consumer was still in pain she called in a general practitioner who examined the consumer and made arrangements for her to be transferred to a public hospital with a suspected fractured femur. The communication notes, nursing notes and doctor's progress notes stated that the consumer was transferred at 1.45pm.

The Commissioner was advised that at approximately 10.00am on the date the consumer was transferred to hospital a family member visited the consumer, before the general practitioner arrived. The family member then phoned other family members who also visited. The registered nurse told the Commissioner that on the day the consumer was admitted to hospital she attempted to contact the consumer's designated next of kin, the complainant, but was unable to get any answer. She finally contacted the complainant in the late afternoon and informed her that the consumer had a suspected fractured femur and had been transferred to the hospital.

Second Incident

The risk management consultant advised the Commissioner that he believed there may have been a second incident after the fall, two days after the consumer arrived at the rest home, that the staff at the rest home were not aware of. He believed this would account for the bruises that appeared two days after the fall and the fractured femur. With regard to this, the registered nurse stated that she questioned staff at the time, and:

> *"No-one saw another fall or anything that could have caused the bruises or the fracture".*

The complainant advised the Commissioner that the consumer's family had major concerns about the lack of communication from the rest home. The family had approached the rest home on a number of occasions to ask for an explanation and further information. She told the Commissioner that the family had made it quite clear that they were not happy and wished to be provided with more information, but to no avail.

Continued on next page

Rest Home

Report on Opinion - Case 98HDC11040, continued

Information Gathered During Investigation, *continued*

The complainant told the Commissioner that the injuries have resulted in the further deterioration of the consumer's dementia and her support needs assessment level has now increased to level 5. The following description of a person assessed at level 5 appears in the Crown Health Enterprise's Support Needs Level Recommendation Assessment:

> *"At level 5, a person requires supervision or assistance from two persons during the entire activity or it will not be completed. This level of support recognises a person who requires professional nursing supervision and continuing nursing supervision, and/or may have severe behavioural problems."*

The consumer has since been discharged from hospital and now resides at another rest home.

Rest Home

Report on Opinion - Case 98HDC11040, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

…

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

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

...

Relevant Standards

The following policy statements in the rest home's Information Booklet are applicable to the complaint:

> *"The staffing ratio enables residents to be monitored constantly throughout the day and night."* (page 2)
>
> *"Our facility provides a secure environment ensuring that residents in our care are unable to wander away unaccompanied."* (page 3)

The following statements in the rest home's House Management of Resident Falls Policy are applicable to this complaint:

> *"**Standard:** To minimise the risk of each resident falling and to enable efficient management of falls in residents who fall frequently.*
>
> ***4.1:*** *Ensure appropriate mobility aids are used i.e. walkers, sticks, or supervision from staff.*
>
> ***4.2:*** *Monitor the environment to reduce the number of obstacles, danger spots such as loose carpets, uneven surfaces etc.*
>
> ***4.3:*** *Orientate the resident to the environment when first admitted."*

Rest Home

Report on Opinion - Case 98HDC11040, continued

Opinion: No Breach

Initial Fall

In my opinion the rest home did not breach the Code of Rights in respect of the consumer's initial fall two days after she arrived at the rest home.

I am satisfied on the basis of the incident forms and evidence presented to me that the consumer's fall was accidental. The notes with respect to this fall are very thorough and I am satisfied that when she fell, all proper steps were taken to ensure that she was not suffering from any injuries. The consumer was examined by the registered nurse and actions were taken to continue to observe her thereafter. I am also satisfied that the completion of the incident form in relation to this fall and immediate follow-up procedures (including repeated attempts to contact the complainant to notify her of the consumer's first fall) were appropriately observed. There is insufficient evidence to support a claim that actions of the staff at the rest home contributed to the consumer's deteriorating condition.

Opinion: Breach

In my opinion the rest home breached Rights 4(2) and 4(3) of the Code as follows:

Right 4(2)

Second Incident

From the information contained in the various notes and the information obtained from staff, it appears that as well as the first recorded unobserved fall, there was another unobserved incident in relation to the consumer. I am satisfied that the injuries which occurred two days after the first fall were not a result of the first fall, as the consumer was examined quite carefully by the risk management consultant/registered nurse at the time.

In my opinion there was a second unobserved fall. Given that the consumer was suffering from Alzheimer's disease and had been there for less than a week, I would have expected her to be kept under relatively close supervision. This is suggested by the policy statements set out above in the rest home's Information Booklet, and House Management of Resident Falls Policy.

Continued on next page

Rest Home

Report on Opinion – Case 98HDC11040, continued

Opinion: Breach, *continued*

The statements in the Information Booklet suggest that people with Alzheimer's disease, like the consumer, be monitored closely. In addition, the guidelines in the House Management of Resident Falls Policy indicate that actions will be taken to minimise possible falls in at risk patients. In my opinion, there is no doubt that the consumer was an at risk patient, especially given her previous fall and the identification of a risk of falling in her admission application.

In my opinion the system of monitoring was inadequate. The consumer broke her femur having had two unobserved falls within three days of each other. Such an event indicates that services were not being provided with in compliance with professional standards.

In my opinion actions taken after the detection of the consumer's pain were also inappropriate. The nursing and communication notes indicate that staff became aware of the consumer's pain on the evening of the day after the second fall. The nurse on duty at that time wrote in the nursing notes that there was a possible fracture of the consumer's neck of femur. The communication notes from that evening stated that the consumer had not moved at all, and when she did her right leg was hurting her.

In my opinion, as soon as staff became aware of the consumer's pain and the possibility of her having fractured her leg, a doctor should have been called in to confirm or refute the diagnosis. The consumer was not admitted to hospital until 1.45pm the following day.

Right 4(3)
In my opinion, the rest home also breached Right 4(3) of the Code.

In a situation where a patient has diminished competence, efforts should be made to ensure the next of kin are kept fully informed at all times. The consumer was in respite care and was to return to her primary caregivers, her family, within a number of weeks. The failure to fully inform the family about the incidents that occurred during her short stay at the rest home did not meet the consumer's right to have services provided in a manner consistent with her needs.

Continued on next page

Rest Home

Report on Opinion – Case 98HDC11040, continued

Opinion: Breach, *continued*

Although efforts were made to contact the consumer's next of kin, the complainant, communications broke down after this. There was an initial telephone call to the complainant in which an explanation and an apology were given. However, following this the family was not provided with any further information regarding the cause of the consumer's injuries. In my opinion, the communication could have been more detailed and clear, even if it was only to say, *"this is what we know, and this is what we don't know*". There should have been better contact and discussion with the family after the event, especially given that the family approached the rest home and informed them that they were not happy and wanted more information.

Actions

I recommend that the licensee of the rest home provides the consumer's family with a letter setting out all relevant information held by the rest home in relation to the consumer's injuries and apologising for the rest home's breach of the Code of Rights. This letter is to be sent to the Commissioner's office and it will be forwarded to the family.

The rest home has now instituted new procedures to ensure a decreased risk of unobserved falls. The current manager of the rest home is to confirm in writing details of the actions that have been taken.