Caregiver/Services Provider

Report on Opinion - Case 97HDC5786

Commissioner Initiative

The Commissioner was informed of matters relating to the service the provider, a Caregiver from a Services Provider group, provided to two consumers. The issues of concern were as follows:

The first consumer

One evening in September 1996 the caregiver:

- arrived late to provide her evening care (arrived at 10.00pm rather than 8.30pm)
- had been consuming alcohol prior to arriving to care for the consumer
- brought alcohol into the first consumer's home which she consumed
- smoked a cigarette in the first consumer's bedroom
- behaved in an inappropriate manner in that she stayed on late at the first consumer's residence and attempted to socialise with the consumer's flatmate.

The second consumer

One evening in March 1997 the caregiver:

- did not initially assist the second consumer when she asked the caregiver for assistance after she had slipped onto the floor
- used inappropriate force when she did assist the consumer off the floor and during the process of getting the consumer to bed.

Investigation

An investigation was undertaken on the Commissioner's initiative and information was obtained from:

The Complainant/First consumer
The Provider/Caregiver
The Former Manager, Services Provider group
Manager, Services Provider group
The first consumer's flatmate
A District Nurse
Friend of the second consumer
Caregiver for the second consumer
The second consumer's General Practitioner

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Outcome of Investigation

The First Consumer

The first consumer had multiple sclerosis and required a caregiver for half an hour in the evenings to assist her in going to bed. In late September 1996 the provider, from a Services Provider group, acted as the first consumer's caregiver on two occasions. The first occasion was uneventful and on this occasion, the consumer gave the caregiver permission to smoke in her house.

On the second occasion the caregiver arrived at 10.00pm, one and a half-hours late. The consumer had already got into bed with the assistance of her flatmate, although she had not changed into her nightwear. Prior to arriving, the caregiver had attended a social function and had consumed some alcohol there. The consumer advised the Commissioner that the caregiver had a bottle of wine with her that she opened and consumed at the consumer's home. The consumer also had some wine. The caregiver denied consuming any wine at the consumer's home.

The consumer stated that the caregiver assisted her to change into her nightwear and made some personal comments to her about her (the consumer's) divorce. The consumer reported difficulty in getting into the nightwear with little assistance from the caregiver and stated that she would have felt unsafe being lifted into bed by her. In addition, the caregiver smoked a cigarette in her room, leaving a cigarette burning in an ashtray while she went to the toilet. The consumer found this unpleasant, as her room is small. After the caregiver assisted the consumer to change, she shut her door and stayed on at the house socialising with the flatmate. The caregiver finally left at 11.45pm.

The following morning the consumer told her district nurse about the previous evening's events. The nurse passed on her concerns to the agency that contracts services from the Services Provider group. The agency contacted the Services Provider group who followed up with the caregiver. No one from the Services Provider group visited the consumer about the matter. The manager of the Services Provider group at that time informed the Commissioner that they contacted the first consumer to enquire what had happened and that following instruction from her they arranged that the caregiver no longer provide care for the consumer.

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Outcome of Investigation, *continued*

In explanation of her lateness and of her consumption of alcohol, the caregiver stated that she was unaware that she was supposed to be caring for the first consumer on the evening in question. She had called in to the consumer's home to pick up her sunglasses and had offered to help her upon learning that no other care giver had been in that evening. However, the Manager confirmed that the arrangement for her to become the consumer's permanent caregiver had been made several days previously and that the caregiver was responsible for the consumer's care on the evening in question.

The Services Provider group advised the Commissioner that the consumer died in February 1998.

The Second Consumer

The Services Provider group report that the second consumer was a challenging client who liked caregivers to stay on after the allocated time. The caregiver advised the Commissioner that on the night of the events subject to the investigation she had needed to be very firm with the second consumer and she had had to pick the second consumer up after she had purposely lowered herself onto the floor.

The second consumer reported that she had slipped when using her walker to move to sit in another chair and that the caregiver did not come when she first called for assistance. Further to this the second consumer reported that when the caregiver did pick her up she threw her onto the settee then grabbed her throat when she (the consumer) went to use her personal alarm. Further to this the consumer reported that the caregiver continued to handle her in a physically rough manner until the caregiver "threw" her onto her bed still fully dressed and left.

During these events the consumer became upset, phoned her friend, and asked her to come over as she was having some trouble. The friend advised the Commissioner that she thought *"the caregiver had got [the second consumer's] back up"*. The friend was unable to visit as she had no access to a car.

The caregiver denied physically or verbally abusing the consumer but said she was firmer than usual and needed to verbally encourage her to get herself ready for bed.

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Outcome of Investigation, *continued*

The caregiver would usually stay until the consumer was settled despite instructions from the Co-ordinator for the Services Provider group that she was to leave at 10.00pm. On this night the caregiver was unable to stay beyond the allocated time as she was going to visit her son in hospital.

Another Caregiver reported that she noticed a significant change in the consumer following these events and that the consumer had bruising and abrasions on her legs from the fall off the chair and a sore shoulder. The consumer's GP confirmed the occurrence of ongoing shoulder pain.

The second consumer died shortly after this investigation commenced.

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Code of Health and Disability Services Consumers' Rights

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 10
Right to Complain

1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.
2) Every consumer may make a complaint to -
- *a) The individual or individuals who provided the services complained of; and*
- *b) Any person authorised to receive complaints about that provider; and*
- *c) Any other appropriate person, including -*
  - *i. An independent advocate provided under the Health and Disability Commissioner Act 1994; and*
  - *ii. The Health and Disability Commissioner.*

3) Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.
4) Every provider must inform a consumer about progress on the consumer's complaint at intervals of not more than 1 month.
5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.
6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that –
- *a) The complaint is acknowledged in writing within 5 working days of receipt, unless it has been resolved to the satisfaction of the consumer within that period; and*
- *b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of –*
  - *ii. Independent advocates provided under the Health and Disability Commissioner Act 1994; and*
  - *iii. The Health and Disability Commissioner; and*

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Code of Health and Disability Services Consumers' Rights, *continued*

c) The consumer's complaint and the actions of the provider regarding that complaint are documented; and

d) The consumer receives all information held by the provider that is or may be relevant to the complaint.

7) Within 10 working days of giving written acknowledgement of a complaint, the provider must, -

a) Decide whether the provider -

i. Accepts that the complaint is justified; or

ii. Does not accept that the complaint is justified; or

b) If it decides that more time is needed to investigate the complaint,-

i. Determine how much additional time is needed; and

ii. If that additional time is more than 20 working days, inform the consumer of that determination and of the reasons for it.

8) As soon as practicable after a provider decides whether or not it accepts that a complaint is justified, the provider must inform the consumer of –

i. The reasons for the decision; and

ii. Any actions the provider proposes to take; and

iii. Any appeal procedure the provider has in place.

Opinion: Breach – Caregiver

Right 4(2)

In my opinion there has been a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights. By consuming alcohol before arriving to care for the first consumer the caregiver did not meet the relevant standard of service required by Right 4(2). I note the first consumer's statement that the caregiver had difficulty in getting her into her nightwear and that she would have felt unsafe being lifted into bed by her.

In my opinion there is insufficient evidence available to find a breach of the Code of Rights in regard to the events involving the second consumer.

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Caregiver/Services Provider

Report on Opinion - Case 97HDC5786, continued

Opinion: Breach – Services Provider

Right 4(2)

In my opinion there has been a breach of Right 4(2) of the Code of Health and Disability Services Consumers' Rights by the Services Provider group. By not formally documenting the process undertaken in response to the first consumer's complaint and showing no evidence that they followed up and checked the caregiver's stress levels and clients after the incident with the first consumer, they potentially placed clients at risk. This does not meet the appropriate standard required in these circumstances.

Right 10

In my opinion there has been a breach of Right 10 of the Code of Health and Disability Services Consumers' Rights by the Services Provider group, as there was no formal follow up with the first consumer in regard to her complaint about the caregiver.

Actions

If in the future the caregiver is re-employed by the Services Provider group her work is to be constantly monitored until the Manager believes her performance to be appropriate. I also recommend that the Services Provider group include anger and stress management courses as part of their staff training. In particular, if issues of concern such as those covered in this opinion occur again, the staff member concerned should be required to undergo such a course. This would occur in addition to his or her being appropriately supervised and monitored by the agency manager.

The caregiver must inform any future employer for the next two years of this opinion and a copy of this opinion will be sent to the caregiver's current employer.