Report of an investigation into allegations of abuse and neglect at a Disability Services Group Home

EXECUTIVE SUMMARY

The investigation arose from a letter to the Honourable David Llewellyn, Minister for Health and Human Services dated 22 March 2004, where the parents of a disabled young man expressed their concerns as to the standard of care being provided by the Department of Health and Human Services to their son, a resident of a Disability Group Home operated by Disability Services.

The Department decided that it was preferable that the investigation be conducted by the Health Complaints Commissioner and on 4 June 2004, the Secretary of the Department lodged a complaint and the Commissioner then determined that the matter warranted investigation under Part 6 of the *Health Complaints Act* 1995.

The resident who is the subject of the complaint is a young man with a permanent disabling condition as a consequence of suffering an acquired brain injury. He requires continuing rehabilitation and relies on PEG feeds for nourishment. He is entirely dependant on carers for bed mobility; transfers from bed to wheelchair; wheelchair mobility, feeding, dressing, showering, toileting, grooming and domestic functions.

The parents were concerned about aspects of their son's care alleging that: his feeding site had become flyblown; his rehabilitation programme was not being followed; he was being left unattended by Disability Services staff; there was a lack of interaction between their son and his carers; personal items, items of his clothing and linen were being used on the other client living at the unit, and vice versa; a hoist provided for assisting with his transfers was not being used; and no weekend outings were arranged for him and the other resident client. The complainants categorized incidents giving rise to allegations of abuse and neglect.

The parents insisted on the immediate removal of their son from the care of Disability Services to another organization, capable of providing the necessary care required by their son. They expressed their distress at the way their son had been *treated and neglected* and they believed that there had been a decline in his rehabilitation since he had been resident. The focus of this investigation was whether there was any substance to their allegations. Ultimately some allegations were supported, in whole or in part and others were not. In all there was a less than satisfactory standard of care in some aspects of the man's care.

The most significant allegation that maggots had been found on the young man's PEG site was supported. It was apparently an isolated incident and once detected was dealt with promptly, however, it was also indicative of a failure to meet an acceptable standard of hygiene, at least in the day or so preceding the incident. It was also established that the attendances at the Peg Clinic, to keep granulated tissue under control and to prevent bleeding, were not as frequent as recommended by the clinic.

Fortunately, the young man suffered no long-term ill effects. However, the unfortunate occurrence indicated a failure by the carers responsible on that occasion to meet an acceptable standard of care and the parents were understandably distressed by the occurrence. Particular care will need to be taken in the future to ensure that a similar situation is not repeated.

The matters of concern to the parents highlighted the importance of good communications between carers and families; the need to maintain standards of service delivery for clients with complex health requirements and the need for ongoing performance management, assessment and training where necessary. It is imperative that appropriate systems are in place for the reporting of critical incidents within Disability Services. The recommendations were as follows:

1. That an evaluation of current service delivery be undertaken to address any matters of potential risk to clients with complex and exceptional needs (including medical and unstable health needs), to ensure that all appropriate standards are understood by those charged with the care of those clients, and to further ensure that those standards are being adhered to. Specifically, in relation to this level and type of medical/nursing interventions and care required by those clients.

2. That the Department of Health and Human Services appoint a person or persons with high level nursing expertise and experience to undertake a review of the provision of nursing care to complex and exceptional needs clients within Disability Services, in particular:

   2.1. the mechanisms and procedures for determining the level of nursing care required by those clients;
   2.2. the planning, assessment, delivery and evaluation of nursing care requirements of those clients;
   2.3. the skill mix and the competence of those delivering care;
   2.4. the standards of other health care providers and the care they are required to provide to those clients;
   2.5. the policies, procedures and guidelines for the provision of nursing care in disability support; and
   2.6. the links between the services that provide nursing and community care within Community Population and Rural Health.

3. That procedures be developed for ongoing performance management and assessment, including the provision of continuing training and education for staff members – not only in relation to the care of clients, the safe and separate storage of clients' personal belongings, the use of specialist equipment (such as the hoist) and the performance of required procedures (such as PEG feeding and the maintenance of PEG sites), but also in relation to appropriate communications between staff and the families of clients. This recommendation requires that on going learning or refresher training for staff is linked with professional and workplace development, recruitment and retention.

4. That procedures be implemented for the reporting and investigation of critical incidents, in order that specific incidents – such as that involving the client's PEG site – are investigated and dealt with as and when they might occur, and relevant stakeholders are informed of outcomes in a timely manner. That this be in the context of a Quality Management and Safety framework that promotes a culture of open disclosure and quality assurance.

5. That equipment used in the care of clients be routinely checked to ensure its fitness for purpose and an appropriate maintenance schedule in relation to that equipment be kept.

The Department acted appropriately and promptly to respond to the recommendations including engaging KPMG as consultants and establishing a reference group to consider the needs of clients with complex medical conditions or complex challenging behaviour.