Management of elderly man in dementia unit
16HDC01380, 14 August 2018

Rest home ~ Secure dementia unit ~ Physical assault ~ Wandering ~ Dementia ~ Behaviour management ~ Clinical responsibility ~ Right 4(1)

An elderly man was residing in the dementia unit of a rest home. The man's nursing notes indicated that he presented with behavioural and wandering issues. The rest home told HDC that challenging behaviours were identified in the nursing notes. However, a behaviour management plan was not completed, which would have identified strategies to manage the behaviours, therefore minimising potential risks to the man.

The man was physically assaulted by another resident in the dementia unit at approximately 4am. The rest home told HDC that following the assault, the man's overall clinical management was not facilitated by a designated senior nurse or clinical manager. The rest home acknowledged that with no one person taking responsibility for the man's care, it created a situation where no management plan was initiated to evaluate his ongoing clinical needs. During the morning, evening and night shift of this day, the man was checked a number of times by staff, but was not referred to a general practitioner (GP).

On the day following the assault, the man was checked twice. On the second check, the registered nurse requested that the team leader in the dementia unit seek medical advice. In the late morning, the man was reviewed by the duty doctor, who arranged for him to go to the public hospital for X-rays.

The man returned from hospital having been diagnosed with rib fractures (8^{th} and 9^{th} ribs) and fluid in his right chest. The man's next of kin did not want him to be given a chest drain or intubation, so he received comfort cares following his discharge from hospital. The man passed away a short time later.

Following these events, the rest home was purchased by another company.

Findings
The failure to manage the man's wandering behaviour appropriately over a number of months leading up to the assault, and the overall deficiencies in nursing care after the assault, demonstrated a pattern of suboptimal care and a lack of critical thinking from numerous staff members. The deficiencies occurred in an environment where lines of clinical responsibility were unclear. The above shortcomings were considered service delivery failures that were directly attributable to the rest home. The rest home failed to provide services to the man with reasonable care and skill, and was found in breach of Right 4(1).

Recommendations
In response to the provisional opinion, the rest home provided a formal written letter of apology to the man's family.

It was recommended that the rest home consider whether any of the learning from this investigation can be translated into improvements throughout its other aged care services.

The new owners of the rest home have been asked to:

a) Share this report with its staff who were employed by the previous owners, and consider whether any learning can be taken from this case and translated into improvements to its own policies and procedures.

b) Provide HDC with a report on its consideration of this investigation.