Management of dementia resident's behaviour and falls by rest home (09HDC01050, 23 June 2010)

Rest home ~ Registered nurse ~ Manager ~ Standard of care ~ Care planning ~ Management of behaviour ~ Management of falls ~ Documentation ~ Clinical governance and quality systems ~ Rights 4(1), 4(2), 4(4)

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The family of a 73-year-old man complained about the standard of care he received while a dementia care resident at a rest home. The man suffered from Alzheimer's disease and was a resident in the rest home's secure dementia unit for a month. During this time staff struggled to manage the man's behaviour, and his condition deteriorated. He became increasingly drowsy, incontinent, unsteady on his feet, and he suffered five falls. The man was admitted to hospital and a computerised axial tomography (CT scan) of his head confirmed two significant subdural haematomas on his brain. He was treated palliatively and died a short time later.

It was held that the rest home had appointed staff with insufficient experience and skill without providing adequate support and guidance to ensure safe practice, and in accordance with relevant standards. Accordingly, it breached Rights 4(1), 4(2), and 4(4).

The registered nurse's initial care planning for the man was found to have been inadequate, and her response once the man began to deteriorate was also inadequate. Accordingly, she breached Right 4(1) by failing to provide services with reasonable care and skill.

It was also held that the rest home's manager breached Right 4(4) for failing to appropriately oversee the delivery of services and to support staff adequately.

The rest home was referred to the Director of Proceedings. The Director decided to issue proceedings before the Human Rights Review Tribunal. Proceedings are pending.