Physical abuse of elderly dementia resident (13HDC01495, 2 November 2015)

Healthcare assistant ~ Private hospital ~ Dementia care ~ Rest home ~ Abuse ~ Medication management ~ Care planning ~ Incident reporting ~ Rights 4(1), 4(2)

An 82-year-old woman, who suffered from worsening dementia, was admitted to the dementia unit at a private hospital for respite care, and remained there for nine days. During the woman's brief admission she sustained a number of injuries.

The woman's admission assessment, undertaken on the day following admission, contained contradictory information. An initial care plan was also developed the day following admission, and it did not contain certain details about the woman's behaviour and preferences. In addition, there was confusion about her medications.

One night, a healthcare assistant (HCA) on duty in the dementia unit physically abused the woman. The HCA grabbed the woman's upper arms, causing bruising, and slapped the woman's upper thigh, causing bruising. Another HCA observed and overheard the physical abuse of the woman. That HCA did not report the incident overnight, and did not complete an incident form. The following morning, a further HCA reported to a registered nurse (RN) that there was some bruising on the woman's body. While it was noted that the woman had fingermark bruises on her upper arms, the incident report completed did not refer to other details such as the woman's complaints that the bruising was caused by a staff member, or that she had been "bashed on the knee".

After breakfast, the woman was not able to walk, which was not normal for her as usually she mobilised freely. An RN examined the woman's left leg and found it was swollen and shiny, so contacted the woman's GP and advised him of the swelling and enquired about an X-ray. The GP was not informed of the woman's other injuries.

The woman was taken by her family to a public hospital, and was discharged the next day into the care of her family. The woman died around three months later.

The private hospital commenced an internal investigation into the circumstances relating to the woman's injuries, and the HCA was suspended. Following the investigation, the HCA was dismissed for serious misconduct. The matter was referred to the Police.

It was held that the HCA failed to provide services to the woman that complied with professional and ethical standards and, accordingly, she breached Right 4(2).

The initial care plan and incident reports did not contain adequate information, and the initial care plan was not updated to take into account changes in the woman's condition. The medication management was suboptimal, and staff failed to assess the woman's injuries adequately and manage them appropriately. The private hospital is responsible for the multiple shortcomings in the care its staff provided to the woman and, accordingly, breached Right 4(1).

Adverse comment is made that the HCA did not receive additional training on abuse and neglect following an earlier incident where there was an allegation of the HCA physically abusing another resident. Adverse comment is also made about the second HCA's failure to report the incident at the time that the woman was abused.

The HCA was referred to the Director of Proceedings. The Director decided not to issue proceedings.