Care of elderly man prone to falls
16HDC01148, 8 March 2018

Healthcare assistant ~ Rest home ~ Falls prevention ~ Care planning ~ Incident management ~ Communication ~ Rights 4(1), 4(2)

Following a hospital admission, an elderly man was discharged and admitted to hospital-level care at a rest home. The man was noted in the Patient Care Plan and progress notes to have had multiple falls and to be at a high risk of further falls. The progress notes also stated that the man required assistance with all cares. Staff developed the man's long-term care plan, which stated that two staff members should be involved for all cares. The care plan was not updated during his stay.

Over the next few months, the man suffered several falls, some of which were unwitnessed by staff members, including one fall when a healthcare assistant left the man unattended on the toilet to look for his clothes. Following these falls, incident reporting documentation was completed and "actions to prevent recurrence" were recorded. The progress notes stated that a recliner chair would be trialled over the weekend; however, there is no record of an evaluation of the trial. No multidisciplinary meeting was called in accordance with policy.

On the occasions when the man fell, it is recorded that a member of the man's family was informed of his falls. The man's family stated that they were unaware that the man had hit his head when he fell on one occasion, and became concerned when they saw damage to the wall. There is no record that the family were informed that the man had hit his head. Members of the family also found medication on or around the man on a number of occasions and raised concerns about this with staff.

The man's family installed a video camera in his room owing to concerns about the care he was receiving. Video footage recorded by this camera shows a healthcare assistant removing the man's bedclothes and throwing them on the floor, calling his name, slapping his hip once, and giving him five quick slaps or taps on the head. It also shows the healthcare assistant dragging the man across the bed roughly.

Findings

It was held that the healthcare assistant's actions towards the man — an elderly and vulnerable individual — amounted to a very serious departure from fundamental ethical and legal standards. Accordingly, the healthcare assistant breached Right 4(2). She was referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken. The Director decided to take a restorative approach in this case.

It was held that the rest home failed to provide services to the man with reasonable care and skill in the following areas: care planning, falls prevention, monitoring, incident management, and communication with family. Accordingly, the rest home breached Right 4(1).

Recommendations

In response to recommendations made, the rest home reviewed the effectiveness of its medication management policy; developed a training schedule for staff on challenging behaviour, de-escalation skills, abuse and neglect; and included in its ongoing refresher training: techniques to identify personal stress and coping mechanisms, a process for staff to report such stress, fatigue, and pressures at work, and instruction that reporting of concerns is expected and accepted from all staff. The rest home also reviewed its incident policy in relation to multiple falls, and reviewed the process by which information in incident reporting forms is analysed for trends.

It was also recommended that the rest home review the effectiveness of its processes for assessments of care planning; review the involvement of clinical nurse managers in residents' care; set in place a procedure to ensure that regular family meetings are held; and complete education for all staff on comprehensive documentation. In addition, it was recommended that the rest home conduct an audit of six months' documentation, for a random selection of 10 residents, to ensure that all documentation complies with accepted standards; and that the rest home establish a procedure to ensure that all residents who are serial fallers are referred to an external gerontology nurse specialist.

The healthcare assistant and the rest home each provided a letter of apology to the man's family.