Use of hoist when transferring rest home resident (08HDC00469, 18 December 2008)

Caregiver ~ Rest home ~ Registered nurse ~ Patient transfer ~ Hoist ~ Fall ~ Fracture ~ Right 4(1)

A woman complained about the care provided to her elderly mother in a rest home. The patient had a history of fainting episodes. Following a previous fainting episode which occurred while she was being transferred using a standing hoist, her transfer plan was changed from standing hoist to sling hoist transfers. This change was documented in the woman's records and her transfer plan was updated. It was also communicated to all caregiving staff during morning handovers.

However, one caregiver continued to use the standing hoist, and was reminded of the changed to the transfer plan by the unit manager, a registered nurse. While the caregiver was transferring the patient using a standing hoist the woman fainted and either fell, or was lowered to the ground. As a result of this incident the woman suffered bilateral fractures to her femurs. She died a few days later in hospital.

It was held that the caregiver breached Right 4(1) for disregarding the transfer plan. The registered nurse took appropriate steps to ensure the transfer plan change was communicated to all staff, and did not breach the Code. It was held that as soon as the rest home was aware of the incident, appropriate action was taken. It had adequate staffing and equipment for the number of residents, and did not breach the Code.