

## **Falls management of rest home resident (11HDC00940, 28 November 2013)**

*Rest home ~ Registered nurse ~ Enrolled nurse ~ Care plan ~ Falls management ~ Documentation ~ Hip fracture ~ Enduring power of attorney ~ Health and Disability Sector Standards ~ Rights 4(1), 4(2)*

This case concerns an 81-year-old woman with advanced dementia who entered the secure dementia unit in a rest home for respite care.

There was no evidence in the woman's records of either a care plan or adequate assessments on admission. There was also no copy on file of the woman's enduring power of attorney (EPOA), or evidence that it had been appropriately activated.

Three days after her arrival at the rest home, the woman had an unwitnessed fall, sustained bruising to the right of her forehead, and became unresponsive. Although an incident report form was completed and signed by the clinical manager (a registered nurse), no follow up action was recorded. The woman was transported to hospital by ambulance and discharged four days later, having been assessed as requiring full-time care.

The woman sustained other falls over the next month, but her family and attorney were not always informed. After a third fall, the woman reported a painful left leg and was unable to stand, but there was no record of the woman being reassessed, and care staff were given no directions for managing the woman's mobility, pain, or falls risk. Although the rest home manager, an enrolled nurse, reviewed the woman, no changes were made to the management of the woman's care.

Several days later, the clinical manager reviewed the woman and found that she was in severe pain and unable to walk. The clinical manager ordered X-rays, revealing a fractured left hip. The woman was transferred to hospital for surgery, and did not return to the rest home.

It was held that the clinical manager failed to obtain a detailed history, fully complete the admission documentation, or prepare a care plan for the woman on admission. She also failed to complete a falls risk assessment, and did not ensure that the woman's ability to make decisions was assessed and her EPOA sighted and retained on file. Additionally, the clinical manager failed to inform the woman's family or attorney of her falls. After the woman's third fall, when the clinical manager was aware of the woman's pain and inability to walk, she failed to arrange a general practitioner (GP) assessment. The clinical manager did not provide services with reasonable care and skill and breached Right 4(1).

The rest home manager failed to ensure that care planning and falls risk assessments were completed and documented. She also failed to obtain a GP or registered nurse assessment of the woman, and failed to ensure that the woman's family or attorney were informed of her falls. The rest home manager did not provide services with reasonable care and skill and, accordingly, also breached Right 4(1).

By failing to provide safe care and ensure its staff were complying with its policies and procedures, the owner and operator of the rest home failed to comply with the

Health and Disability Sector Standards and breached Right 4(2). The rest home also failed to ensure that a detailed history was recorded, a care plan and falls risk assessment were completed, and a plan was implemented to address the issue of falls. The rest home failed to ascertain the woman's legal status or respond appropriately following her falls. It did not provide services with reasonable care and skill and breached Right 4(1).

The rest home, the RN, and the EN were referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

The Director of Proceedings brought a successful prosecution against the enrolled nurse before the Health Practitioners Disciplinary Tribunal. The enrolled nurse is no longer practising as a nurse but, should she seek to resume practice, she must undergo a competency review before being reissued with an annual practising certificate. She will also be subject to supervision conditions for a period of six months upon resumption of practice, and she will not be able to engage in sole practice or a management role in the aged care sector for 12 months. Costs were also ordered against her.

The charge against the registered nurse was withdrawn.

The Human Rights Review Tribunal made a declaration that the rest home breached Rights 4(1) and 4(2). Issues relating to damages and costs were resolved between the parties by negotiated agreement.