Care of elderly man at risk of falls
16HDC01581, 13 June 2019

Rest home ~ Falls ~ Supervision ~ Right 4(1)

An 86-year-old man was admitted to a rest home. It was identified on admission that he had a high risk of falling. A number of interventions were put in place, but they were not successful at mitigating his risk of falling, and the man sustained 97 documented falls over a period of 11 months. Of these, 55 were reported on an accident/incident form, and it was documented that his next of kin was informed of about 23 of the falls.

On one occasion, staff observed that the man had been trying to get outside, and that even after he was taken for a walk, he wanted to go out "again and again". At approximately 1pm, the man was found on a road near the facility. At approximately 1.10pm, the man was found to have left the facility a second time. He was not seen leaving the premises on either occasion.

Findings

It was held that the rest home did not take sufficient action to reduce the man's falls risk, and did not supervise the man adequately when he left the facility on his own. It was found that the rest home did not provide the man services with reasonable care and skill, and, accordingly, breached Right 4(1).

Criticism was made of poor communication with the man's family.

Recommendations

It was recommended that the rest home (a) provide evidence that its policies and procedures on falls management, incident reporting, client assessment, and care planning are current and reflect best practice, with reference to the reviews and updates that have been undertaken over the past three years; (b) provide evidence of audits that have been undertaken to assess compliance with the policies and procedures referred to above; and (c) apologise to the man's family for the deficiencies outlined in the report.