Care of rest home resident after unwitnessed fall
17HDC01304, 25 June 2019

Rest home ~ Clinical manager ~ Registered nurse ~ Fall ~ Policies ~ Right 4(1)

A rest home resident had five falls over a period of a few weeks. Her Tinnetti Risk Assessment falls risk rating was not reviewed, and no multi-disciplinary review (MDR) was organised following any of the falls, which was inconsistent with the rest home's policy. The falls risk assessment and care plan categorised the woman as a low risk for falls. Meanwhile, a new interRAI assessment categorised her as a high risk for falls.

The woman had an unwitnessed fall, and received pain relief and nursing care for three days. When she was no longer able to bear weight she was taken to hospital, and a left pubic ramus fracture was identified.

Findings

It was held that the rest home failed to provide services with reasonable care and skill in the following areas:

a) Staff failed to adhere to its policy and procedure relating to residents' falls;
b) There was a lack of cohesion in assessments and care planning;
c) Administration of pain relief following the unwitnessed fall was delayed and sporadic; and
d) The delay in GP assessment following the unwitnessed fall was too long.

Accordingly, the rest home breached Right 4(1).

The clinical manager was criticised for failing to ensure that the woman's care planning and assessments were cohesive and coordinated. She was also criticised for not being more closely involved in the assessments, documentation, and follow-up care.

A registered nurse was criticised for failing to undertake more thorough assessments on the day after the unwitnessed fall, and for not acting on the suggestion of the woman's GP and practice nurse to send the woman for an X-ray. The nurse did not adhere to the moving and handling policy when he decided to assist the woman to stand without a hoist. However, it was considered that this was not unreasonable, as the woman declined the use of a hoist and was insistent on standing.

Recommendations

It was recommended that the rest home develop an assessment tool for follow-up reassessment of a resident who has had a fall; amend its falls policy to clarify who is responsible for assessing a resident after a fall; review its moving and handling policy and consider amending it to cover situations when a resident declines the use of a hoist; provide evidence to HDC that it has implemented the changes to policy that the rest home had already identified; and provide HDC with evidence of further training and education for staff on falls prevention and post-falls care.

It was also recommended that the rest home provide the woman and her family with a written apology.

The new owner of the rest home was asked to share this case with staff and consider whether any learning could be taken, and report back to HDC.