Care of elderly rest home resident with history of falls (06HDC16671, 27 November 2007)

Rest home ~ Clinical nurse leader ~ Documentation ~ Assessment tools ~ Falls ~ Early stage dementia ~ Clinical review ~ Standard of care ~ Rights 4(1), 4(2)

A family complained about the inadequate care received by their late father during his ten-day stay at a rest home. The elderly man's admission to rest home care followed his GP's advice that it was no longer safe for him to continue to live on his own. His family believed this was for respite care. However, the initial assessment by the rest home identified a history of falls, possible incontinence and behaviour that could indicate an early onset of dementia. These issues were noted but assessment tools were not initiated to monitor the severity of the problems or how best these could be managed during his residence. The rest home was experiencing difficulty in accessing GP cover for residents and, although the man's GP did reluctantly agree to provide some medical support, this was not sufficient for his needs.

The man required three admissions to hospital during his stay at the rest home. The last admission followed a fall that left him immobile and with bruising to his face and head. It was established that his falls and other problems were being adequately documented and reported by nursing staff to the clinical nurse leader, but she was not taking the appropriate steps to assess, monitor and refer him on for specialist review.

It was held that the clinical nurse leader did not take sufficient action to manage the resident's sudden deterioration of health. She did not adequately complete the appropriate documentation, initiate the relevant assessment tools or seek a timely medical review to have the resident assessed for more appropriate care. She did not exercise reasonable care that complied with professional standards and breached Rights 4(1) and 4(2).