Failure to report fall of rest home resident or to follow correct lifting procedures (06HDC16618, 31 October 2007)

Rest home ~ Health care assistant ~ Fall ~ Incident reports ~ Lifting procedures ~ Standard of care ~ Orientation and support for caregivers ~ Rights 4(1),4(2),4(5)

During the course of carrying out a bed-wash, a health care assistant briefly left an elderly and highly dependent resident unattended, and she fell from her bed to the floor. On her return, the health care assistant picked up the woman and placed her back on her bed. The health care assistant did not, as required by rest home policy, inform anyone of what had occurred or complete an incident report.

Later that morning, after bruising appeared on the resident's head, the nurse manager asked the health care assistant to explain what had occurred. The health care assistant filled in an incident report stating that the resident had bumped her head on a bedside cabinet. On the basis of this information, a medical review was initiated by the rest home. Later that day, a registered nurse found skin tears and other bruising on the body of the resident, which indicated to her that a more serious event had occurred. A more thorough medical review was initiated.

Two days later, the health care assistant provided her employer with a correct description of the resident falling from her bed, and the assistant's actions in picking up the resident and moving her unaided. The assistant had received training in lifting procedures and knew she was required to complete an incident report on an event such as a fall. She said she did not do so out of fear that she would lose her job.

It was held that the health care assistant failed to report or record the fall and, when asked to explain the appearance of bruising, she failed to report accurately what had occurred. This resulted in other providers being unaware of the full extent of the resident's injuries, and compromised the care she received.

When the health care assistant did complete a full incident report on the fall she acknowledged that, contrary to procedure, she had twice lifted the elderly resident on her own, further placing the resident at risk of increased injury.

The health care assistant was held to have breached Rights 4(1), 4(2) and 4(5). The fact that she had failed to promptly and accurately report the fall and attempted to cover up what happened was viewed with great concern. The health care assistant was referred to the Director of Proceedings, who subsequently decided not to issue proceedings.

The rest home was found not to have breached the Code because it had provided the health care assistant with appropriate care instructions and support. Another caregiver was available to assist with lifting, and appropriate steps were taken to manage the resident's injuries.

The nursing bureau that employed the health care assistant was not found to be liable for her breach of the Code. It had provided appropriate induction training to ensure its caregivers familiarised themselves with and followed client policies and procedures.