Assessment and monitoring of elderly man with dementia (12HDC00630, 4 November 2014)

District health board ~ Registered nurse ~ Falls ~ Dementia ~ Medication ~ Non-compliance ~ Checks ~ Communication ~ Right 4(1)

An 87-year-old man had been suffering from worsening dementia for around two years and had been non-compliant with his prescribed medication regimen. His son held an enduring power of attorney (EPOA) as to his personal care and welfare, which had not been activated.

The man was admitted to a public hospital after it was discovered that he had blood-tinged urine. His prescribed medications were recorded in the notes, but his son advised the hospital pharmacist that the man was non-compliant with his medications. The hospital pharmacist therefore crossed out the medications and wrote in the progress notes that the medication had been stopped. However, the man was administered his prescribed medication during his admission (including aspirin).

During his admission, the man had an un-witnessed fall. Neurological observations were carried out on the day of the fall and then discontinued. The following day, a watch was put in place due to the man's disruptive behaviour and wandering. His son expressed concern to staff about the man's deteriorating state and behaviour, which was unusual for him. The man was placed on constant observation because he was wandering.

The following day, the man was placed on observations every 15 minutes. The registered nurse (RN) on afternoon duty failed to undertake a number of the required checks. The RN then handed over his patients to a second RN before taking his meal break, but did not tell the second RN to check the man at 15-minute intervals, or when the man had last been checked. When the RN returned an hour later, he realised that the man was missing. The RN contacted Security, who understood from that conversation that the man had gone missing in the previous 10 minutes. CCTV footage later confirmed that the man had left the ward approximately two hours earlier.

A member of the public found the man and called an ambulance. He was then taken back to the hospital, where he was found to have a large bilateral subdural haematoma. A registrar discussed the man's poor prognosis and resuscitation status with his son at the bedside, which his son felt was inappropriate. The man later died in hospital. His son is concerned that the administration of aspirin during the man's admission may have contributed to his death.

It was held that the RN breached Right 4(1), in that the RN did not make all the required 15-minute checks, failed to hand over the man's care adequately when he took his meal break, and failed to ascertain the correct information and convey it to Security after he discovered that the man was missing.

It was held that the DHB breached Right 4(1), in that its staff did not undertake the required neurological observations following the man's fall and failed to take action as the man's condition deteriorated. The DHB also had no formal process for meal

break handover of patients by nurses, visual handover was not required, and there was no structure in place to ensure that appropriate staff were present during meal breaks.

Adverse comment was made about the DHB's failure to clarify whether the man's medications or whether the EPOA had been activated, and in relation to the DHB's communication with the man and his son.