

**Health Practitioners Disciplinary Tribunal**  
***The Director of Proceedings v Nurse E — 3–7 July 2006***

During the week of 3–7 July 2006 the Health Practitioners Disciplinary Tribunal heard a charge involving care provided to an elderly patient in a rest home/hospital. The nurse was the clinical nurse leader of the facility and, as such, had overall responsibility for ensuring that residents received appropriate clinical care.

As a result of a severe head injury in 1994, a stroke in 1995, and subsequent epilepsy, daily activities such as feeding had become increasingly difficult for the consumer and he became a permanent resident at the rest home and hospital in 1995.

In February 2000, the resident suffered a respiratory and cardiac arrest and, at that time, was diagnosed with aspiration pneumonia resulting from the intake of food particles in his upper respiratory tract. It was decided that, to avoid a recurrence of this, he would be fitted with a feeding tube into his stomach. Once the procedure was completed he was then entirely dependent on the feeding tube for his dietary intake. The feeding regime consisted of “Jevity” which is a special formula of liquid food which, when given in the correct amount, is nutritionally complete.

The amount given to any patient on such a feeding regime needs to be determined by a dietician who calculates the individual’s requirements based on factors such as body type, height, and age.

When the resident was discharged from hospital in February the dietician had fixed the daily intake at 2000ml of Jevity. This was higher than the daily requirement because the resident was underweight at the time. The dietician’s instructions were that the resident’s weight needed to be monitored weekly and that if there were any changes the dietician should be contacted.

In June 2000 a registered nurse (Nurse E) at the facility reduced the Jevity from 2000ml to 1500ml per day. The reduction was made in response to the resident having gained weight during the time between his discharge from hospital and the date of the reduction. While the content of the conversation is disputed, this nurse did at least contact the dietician in relation to the reduction.

In September 2000, without consulting with a dietician or a GP, Nurse E made a further reduction from 1500ml to 1000ml. The reduction was initially a one-off in order to enable the resident to go out with family. Subsequent reductions were made by Nurse E on days throughout September and October for either similar reasons or in response to abdominal distension experienced by the resident. Eventually the reduction to 1000ml became permanent.

Over the next 18 months the resident, who had been 77kg in September, dropped to 57.3kg in February 2002 — a loss of 19.7kg. The resident was admitted to hospital in March 2002 and passed away a few days after admission. The geriatrician then made a complaint to HDC.

Nurse E was charged with making the reduction in September 2000 without consultation or authorisation from either a dietician or medical practitioner;

administering or directing others to administer the feeding regime at the reduced amount, and also for failing to put in place sufficient systems to monitor and evaluate and/or respond to the resident's care (especially weight loss).

Evidence was given by a dietician that the minimum daily amount required to sustain an adult is approximately 1400mls. The evidence of the geriatrician, the GP, the dietician and the expert nursing advisor was that the dietician has responsibility for fixing the daily amount of Jevity.

The Tribunal found that the nurse had, between 6 September 2000 and 31 March 2002, without consultation with or authorisation from a medical practitioner or a dietician, administered and directed the administration of PEG feeding at the reduced amount of 1000mls per 24-hour period, and that having instituted that change, failed to put in place sufficient systems for reviewing or monitoring that change. The Tribunal observed that Nurse E's failing was not her lack of understanding of enteral feeding, but her failure to appreciate that as she knew nothing about the enteral feeding she should be seeking proper advice before making a significant alteration to the nutrition. A nurse is required to understand that she may need to consult on matters outside her area of expertise, and that a failure to consult has potentially serious consequences.

A copy of the decision can be found at [www.hpdt.org.nz](http://www.hpdt.org.nz).