Poor wound care and documentation, and financial exploitation of rest home resident (08HDC10236, 28 November 2008)

Rest home ~ Registered nurse ~ Falls ~ Medication management ~ Incident reports ~ Documentation ~ Podiatry ~ Charges ~ Job description ~ Caregiver ~ Pressure sores ~ Financial exploitation ~ Pharmacy costs ~ Rights 2, 4(1), 4(2)

A man complained about the care provided to his elderly mother while she was a resident at a rest home until her admission to a public hospital with severe pressure sores. The woman was initially admitted for respite care. She had dementia and osteoporosis, and required constant supervision. However, other than the admission documents, no further clinical documentation was completed that recorded her care until she was formally admitted as a resident three months later.

The woman sustained a number of falls and skin tears, not all of which were reported on incident forms. The family was notified of only one of these incidents. Several days after a pressure sore was first noted, the woman was admitted to hospital. On admission, she was assessed as malnourished, and having pressure sores requiring surgical treatment.

The fees charged by the home for medication and podiatry treatments were very high. The woman was charged for services she did not receive, and excessively charged for some services that were provided.

It was held that the documentation of the woman's care fell woefully short of an acceptable standard, with large gaps in her progress notes, a care plan that did not address her falls risk, and inadequate incident reporting and recording of medications given. The registered nurse was responsible for these failings, and breached Right 4(2). The woman developed a serious pressure sore which was not identified and treated early enough. On a significant majority of days she did not receive her morning medication. The nurse was personally responsible for administering this, as well as being responsible, as manager, for monitoring the medication administration standards of others and supervising the woman's care. The woman was not provided with care of a reasonable standard, and in accordance with professional standards, and the nurse/manager breached Rights 4(1) and 4(2).

It was also found that there was a systemic problem at the rest home that resulted in the woman receiving a poor standard of care, and resulted in inadequate documentation of care. The home did not provide reasonable care in accordance with Health and Disability Sector standards, and breached Rights 4(1) and 4(2). It was also held that the home financially exploited the woman, in breach of Right 2.

The registered nurse manager and the rest home were referred to the Director of Proceedings, who laid a charge before the Health Practitioners Disciplinary Tribunal alleging professional misconduct by the nurse. The charge comprised a number of allegations arising out of care provided to three separate rest home residents over a period of two years (see also 07HDC12520 and 08HDC08672).

There were multiple problems relating to the care of residents (including inadequate care by the nurse herself), as well as management issues and a failure to maintain adequate documentation. The nurse also misled HDC by providing an incident report she had re-written.

The Tribunal upheld the charge and the nurse was fined $7,500 and ordered to pay costs to HDC and the Tribunal totalling $18,500. It also imposed conditions that required the nurse to practise under supervision for 12 months, and precluded her from practising in a sole charge or supervisory role for three years. It recommended a competence review prior to re-issue of a practising certificate.

Link to Health Practitioners Disciplinary Tribunal's decision:
http://www.hpdt.org.nz/portals/0/nur09123ddecanon.pdf