Diagnosis and treatment of elderly woman's UTI (11HDC00528, 17 January 2014)

Rest home ~ Registered nurse ~ UTI ~ Falls ~ Policies and procedures ~ Communication with family ~ Diagnosis ~ Rights 4(1), 4(2), 4(5)

A woman complained about the standard of care provided to her elderly mother at a rest home.

The woman had developed a stomach bug and experienced vomiting and diarrhoea. A dipstick urinalysis test indicated that the woman was suffering from a urinary tract infection (UTI), but a urine sample was not obtained to confirm this. The woman was started on a course of antibiotics, however, not all relevant health providers were made aware of this diagnosis or treatment, and the prescription was inaccurately documented, resulting in the woman not receiving the full course of medication.

In the days that followed, the woman had falls and continued to deteriorate. Steps were not taken to investigate the cause of her continuing deterioration. Importantly, no further urine test was obtained. Incident forms were filled out in relation to these falls, however these contained incorrect information, were not appropriately signed-off, and were not acted on. The woman's family were not contacted during this period.

Five days after the dipstick urinalysis test, staff advised one another that the woman was for palliative care. No decision regarding palliative care had been made or discussed with the woman, the necessary health providers, or her family. At the request of her daughters the woman was eventually admitted to hospital, where she was diagnosed with urosepsis caused by her UTI and passed away a short time later.

It was held that the rest home failed to ensure that appropriate policies and procedures were implemented and followed by staff, which resulted in failures by staff to communicate the woman's condition to one another and to her family. This meant that the woman's UTI was not appropriately diagnosed or treated, and her admission to hospital was unduly delayed, in breach of Rights 4(1) and 4(5).

The clinical leader of the rest home failed to ensure that staff were providing appropriate care and failed to assess the woman personally at a time when it would have been appropriate, in breach of Right 4(1). The clinical leader also breached professional standards by failing to accurately document the care provided to the woman, in breach of Right 4(2). The clinical leader also failed to communicate effectively with other healthcare staff to coordinate the woman's care, in breach of Right 4(5).

The facility manager failed to organise for the woman to be admitted to hospital when it would have been appropriate, and failed to ensure that staff were complying with policies and procedures, in breach of Right 4(1). The facility manager also failed to communicate effectively with other staff to coordinate the woman's care when this would have been appropriate, in breach of Right 4(5).

An RN at the rest home failed to ensure that a clean urine sample was obtained after she diagnosed the woman's UTI, and failed to ensure that the correct course of

antibiotics was administered. The RN failed to attend the rest home to assess the woman or advise that she be admitted to hospital when she was on call, in breach of Right 4(1). The RN failed to adequately document the need for the woman to have a repeat urine test, and the antibiotics prescribed, in breach of professional standards and Right 4(2). Finally, the RN failed to communicate effectively with other healthcare staff to coordinate the woman's care, in breach of Right 4(5).