Wound care, documentation and consultation with family (09HDC01035, 29 June 2010)

Rest home ~ Registered nurse ~ District health board ~ Dementia ~ Assessment ~ Monitoring ~ Wound management ~ Pressure sores ~ Documentation ~ Care plan ~ Consultation with family ~ Standard of care ~ Rights 4(1), 4(2)

A woman complained about the care provided to her elderly mother while she was a resident at a rest home. After she was assessed for hospital level care and transferred to a private hospital, the private hospital found pressure sores on her heels and a rash in her groin.

The woman was initially admitted for short periods of respite care for a year and then became a permanent resident of the rest home. A year later she was assessed for dementia care and transferred to the dementia unit within the rest home. Approximately two years later, her health deteriorated and she was assessed as requiring hospital level care by a visiting psychogeriatric nurse practitioner.

Two nurses, one working as a registered nurse and the other as nurse manager, who had been working at the rest home over the preceding six months, failed to review the woman's care plan and appropriately document their assessments of her general health and develop a wound care plan for her recurring groin rash. The communication book for the dementia unit for the period under investigation went missing. No one at the rest home consulted with the woman's family about her care, despite this being a requirement of the rest home's contract with the district health board.

It was held that the registered nurse lacked insight into the level of care required, did not fulfil her responsibilities to manage and provide the care appropriately, and did not adequately consult with the woman's family, in breach of Rights 4(1) and 4(2). The nurse manager did not provide sufficient oversight and guidance to her staff on the care the woman needed, consult adequately with the woman's family, or respond appropriately to the woman's deterioration, in breach of Rights 4(1) and 4(2). The rest home failed to provide care to the woman with reasonable care and skill, which complied with all the relevant standards and contractual obligations, including review of her care plan, communication with her family, and the need for timely reassessment by Needs Assessment and Service Co-ordination Services, in breach of Rights 4(1) and 4(2).

This case highlights the importance of rest homes having adequate systems in place to ensure that dementia patients receive appropriate care. It also highlights the importance of communicating with family members and involving them in the care of their loved ones.