Rest home admission assessment and care
(10HDC00308, 29 June 2012)

Aged care facility ~ Clinical services manager ~ Registered nurse ~ Admission assessment ~ Hospital-level care ~ Documentation ~ Rights 4(1), 4(2)

The family of a 93-year-old man complained about the care provided to their father when he was transferred from public hospital care to an aged care facility.

The family contacted the facility's Clinical Services Manager (CSM), a registered nurse, to discuss room availability and arrange a viewing of a studio unit. The CSM formed the impression from discussions with the family that their father had a reasonable degree of independence.

The man underwent a geriatrician review and a support needs assessment which identified that he required hospital-level care. The assessment was faxed to the aged care facility. The studio unit previously selected was not suitable, as hospital level-care could not be delivered in that part of the facility. The CSM contacted the family to arrange for their father to use a rest home room until a hospital-level bed was available, but did not discuss the arrangement with the hospital.

The man was transferred to the aged care facility. The admission documentation and assessment completed by the admitting registered nurse (RN) lacked sufficient detail and did not reflect the man's care needs in relation to suprapubic catheter management, ulcer care and urinalysis.

The room provided was in an out-of-the-way location and not readily accessible by staff. The care provided by facility staff over the next week was substandard. The concerns raised by family members were not fully documented or acted upon. The GP was not called. The man became very unwell and was transferred back to the public hospital. Sadly, he died that evening. The cause of his death was suspected to be sepsis. Subsequent complaints about their father's care while resident in the facility which were made by the family were poorly handled by the facility.

It was held that the CSM exercised poor skill and judgement in admitting the man to a rest home bed in the knowledge that he required hospital-level care, without making adequate arrangements to ensure he received the level of care he required. She failed to adequately oversee the provision of care delivered by other staff. By failing to ensure the man received services of an appropriate standard, she breached Right 4(1) and, by failing to maintain adequate documentation, breached Right 4(2).

The admitting RN failed to adequately document the admission. Admission records did not give clear information and direction to other staff regarding the man's care needs and this affected the continuity and quality of his subsequent care. She failed to comply with the relevant standards and breached Right 4(2). The admitting RN also failed to adequately assess the man or evaluate his condition. She failed to provide services with reasonable care and skill and breached Right 4(1).

It was also held that the facility's owners did not sufficiently support or provide oversight of senior staff and did not ensure that the man was provided with services with reasonable care and skill, and therefore breached Right 4(1).