Care of elderly rest home resident
17HDC02219, 16 October 2019

Rest home ~ Catheter care ~ Wound care ~Hoist and transfer training ~ Communication ~ Right 4(1)

A woman in her nineties was discharged from a public hospital and admitted to hospital-level care at a rest home. The woman had a long-term indwelling catheter (IDC) in place, and was unable to weight bear to mobilise. She required two-person assistance and a full sling hoist for all transfers. On admission to the rest home, the woman was assessed as being at high risk of developing pressure sores, and her perineal and sacral areas were evaluated by nursing staff regularly.

During the woman's time at the rest home, there were a number of documented issues with her catheter, including dislodgement of the catheter, the catheter and catheter bag leaking, and urinary tract infections. It was found that the skin on the woman's sacrum had broken down, and a GP arranged for her to be transferred to hospital for review. Sadly, the woman died after a period of ill health.

The woman's son held an activated Enduring Power of Attorney (EPOA) for his mother's health and well-being. On multiple occasions he raised concerns with rest home staff about the care provided to the woman, including management of the woman's IDC, the manner in which staff were using the hoist to transfer the woman, care of the woman's wounds, and the high temperature in the woman's room.

Findings

It was considered that the rest home had the ultimate responsibility to ensure that the woman received care that was of an appropriate standard and complied with the Code.

A good relationship between staff and family is important to deliver good care in residential settings. The son was very involved in the care of his mother, and he had multiple concerns about that care. It was considered that the rest home should have been more proactive, and should have requested external support to guide staff and support the woman's son.

The following deficiencies were apparent in the care the woman received:

- Following the woman's admission, multiple individual incidents occurred that showed a lack of knowledge and skill regarding IDC cares by its staff, including poor placement of the catheter bag, poor placement of the catheter tubing, incorrect positioning of the IDC tubing while in the hoist, and the catheter not being secured, resulting in it becoming dislodged.
- Multiple staff did not adhere to the care summary plan and the catheterisation and catheter care policy.
- The rest home did not provide adequate further education to its staff on IDC management several months into the woman's admission, despite being aware of ongoing issues with staff skill in relation to the woman's IDC early in her time at the rest home.
- Hoist and transfer training did not occur more promptly.
- Multiple nurses reviewed the woman's sacral wound, but did not make a referral to a wound care specialist in a timely manner.

- In the summer months, the temperatures recorded at the rest home did not comply with its policy, and exceeded its comfortable temperature range.

For these reasons, it was held that the rest home did not provide services with reasonable care and skill, and breached Right 4(1).

Recommendations

It was recommended that the rest home company:

(a) provide a written apology to the woman's son;
(b) provide evidence that all registered nurses and caregivers at the rest home have been trained in IDC cares and management, and safe moving and handling;
(c) audit its compliance with its policy regarding temperature monitoring;
(d) consider whether staff training on effective communication with family members is required;
(e) use this report as a basis for its staff training; and
(f) use the learnings and insights gained from the woman's experience, and disseminate this opinion more widely among its other care homes.