Response to deteriorating rest home resident (12HDC01091, 13 June 2014)

Rest home ~ Registered nurse ~ Nursing care ~ Aspiration ~ Documentation ~ Communication ~ Right 4(1)

An 86-year-old man was admitted to a rest home after being assessed as requiring 24-hour hospital level care. A registered nurse (RN) completed the man's admission assessments and initial care plan, and noted that he was diabetic and required mildly thickened fluids to prevent aspiration pneumonia.

Five days after his admission, following the man's evening meal, a healthcare assistant (HCA) noted that the man was finding it hard to communicate and breathe. The HCA reported the man's condition to the RN, who immediately assessed the man and noted that his breathing was "chesty and gurgly". The RN considered that the man was experiencing his "usual respiratory distress" and commenced him on oxygen at a rate of three litres per minute. He advised that the man's condition improved on oxygen, but did not record that in the clinical records.

At approximately 11pm that evening, the RN handed over the man's care to a second RN. The second RN assessed the man as not warranting hospital admission or medical intervention. At 2.30am the following morning, the man complained of not being able to breathe, and the RN increased the man's oxygen to four litres per minute without checking whether oxygen therapy had been prescribed. She did not record the man's response to the oxygen. At 7:45am the same day, the RN recorded that the man remained "dyspnoeic and gurgly", and he was transferred to hospital.

It was held that while the first RN's initial assessments and care plan for the man were appropriate, he failed to respond appropriately to signs and symptoms of the man's deteriorating health, and to escalate his concerns to the man's general practitioner (GP) or refer him to hospital. Accordingly, he breached Right 4(1).

It was held that the second RN also failed to respond appropriately to the man's signs and symptoms, by failing to escalate her concerns to the man's GP for advice, or refer him to hospital. Accordingly, she breached Right 4(1).

The company which owned and operated the rest home was held to have breached Right 4(1) for failing to have appropriate senior staffing in place, failing to provide sufficient clarity in its Incident Report Policy on the types of events that should be reported, and for failing to ensure its staff met the required standards for documentation.

Adverse comment was also made about the company's communication with the man's wife regarding his deteriorating health.