Monitoring of respite rest home patient

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Rest Home ~ Registered nurse ~ Nursing team leader ~ Respite care ~ Norovirus outbreak ~ Dehydration ~ Monitoring ~ Care and skill ~ Right 4(1)

This case highlights the need for rest homes to have adequate systems in place to recognise when a patient is deteriorating so they are able to respond promptly and appropriately. Safety measures need to be in place to ensure the patient receives adequate care and monitoring. Monitoring supported by clear, regular documentation can provide important clues about a patient's changing status. It is especially important when there are several people providing care to the same patient.

The daughter of an elderly lady complained about the care her mother received when she was admitted to a rest home for two weeks' respite care. Prior to this admission the patient was able to mobilise short distances with a walking frame, but required full assistance with all her cares.

Shortly after her admission the rest home experienced an outbreak of Norovirus and went into "lock down". As a result, infected residents were placed into isolation. Additional bureau nurses were brought in to assist and were involved in nursing all uninfected residents, including this elderly lady.

Throughout her admission the patient refused, or ate only small amounts of many of her meals. She spent most days in either a reclining chair or bed.

When the daughter arrived to pick her mother up she was shocked by her appearance. She reported that her mother had lost a considerable amount of weight and appeared very dehydrated. The day following her discharge she lost consciousness at home and was admitted to hospital. She died later that day.

It was held that the rest home was under a lot of pressure managing the Norovirus outbreak. However, it did not have adequate safety measures in place to ensure the patient received adequate care and monitoring throughout her stay, and breached Right 4(1).

It was also held that the nursing team leader failed to implement adequate monitoring when the patient repeatedly refused food and fluids. While this failure did not warrant a finding of a breach of the Code, the team leader was reminded of the importance of initiating closer monitoring and providing adequate clinical leadership.

While not the subject of this complaint, there was also a concern that the rest home did not have a clear medication administration policy and a review of this was recommended. Comment was made on the poor communication with the patient's daughter at the time of discharge but it was noted that steps were taken to address this issue.