

Inadequate care of elderly rest home resident (12HDC00571, 30 June 2014)

Rest home ~ Nurse manager ~ Registered nurse ~ dementia ~ care planning ~ Falls ~ Wound care ~ Handover ~ Assessment ~ Hip fracture ~ Rights 4(1), 4(2), 4(5)

An elderly woman who was a long-term resident at the rest home, had osteoporosis, some cognitive impairment, and a progressive dementia. The woman was experiencing low back pain and was receiving ongoing opiate pain relief. She required full assistance for personal cares, and walked with a mobility frame.

When a reddened area on the woman's back was identified, the Nurse Manager (NM) considered that the redness was pressure related. No short-term care plan was instigated that day or a few days later when a urinary tract infection was suspected.

A short time later the registered nurse (RN) on weekend duty reviewed the woman. The woman was transferred to hospital because of her increased back pain. The hospital assessment resulted in a prescription for continued opiates and three days of diazepam. The RN transcribed the hospital prescriptions onto medication administration charts. The RN applied a Duoderm dressing to the wound but did not start a short-term care plan, record the size of the wound, or describe the grade of the wound.

The woman had two falls within a few days. The NM completed an incident form after the first fall, and follow-up was scheduled for when a general practitioner was due to visit. After the second fall, the NM examined the woman and instigated short-term and pain management care plans, but documented few instructions for staff to follow. The GP reviewed the woman, but the NM did not advise the GP of the woman's falls.

Handover of residents' care and communication with care staff usually took place via a staff communication book, resident progress notes, and a handover sheet. The NM and the weekend RN did not usually see each other in person. Handover between the NM and RN roles was not formalised or governed by a facility policy. Communication between NM and the weekend RN was usually performed by use of an RN communication book. The NM did not communicate to the RN in the RN communication book or in person that the woman had fallen.

The NM went on leave for 10 days. The RN did not review or familiarise herself with the woman's incident reports or handover sheets prior to providing nurse manager cover. During the NM's leave, the RN reviewed the woman. The RN noted that the woman had new bruising and her left leg was "dragging" but the RN could not identify a cause. The RN did not consider a fracture as the cause of the woman's pain. The RN did not seek advice from the GP or the hospital, and did not advise the family of the woman's bruising.

A visiting physiotherapist assessed the woman and observed that the woman's left leg was laterally rotated and shortened, and considered that the woman had a recent hip fracture. The woman was transferred to hospital by ambulance. A fracture of the neck of femur was diagnosed. The hospital noted and treated the pressure area wound on the woman's back.

The NM did not utilise short-term care plans for pressure management of the woman's back or suspected urinary tract infection. No pain chart was used in conjunction with the Pain Management Plan formulated after the woman's second fall. Limited guidance was given to staff regarding the woman's reduced mobility, why her urine should be checked, and management of the woman's constipation. Appropriately skilled assessments of treatment efficacy were not consistently carried out. The NM did not provide services with reasonable care and skill and, accordingly, breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

It was found that the NM did not advise the GP about the woman's falls. In addition, the informal and indirect nature of handover communications between the NM and the RN, in tandem with infrequent use of short-term care plans, meant that important clinical information was not adequately provided to the registered nurse. This contributed to a lack of continuity in care and the NM breached Right 4(5).

The RN failed to review and appropriately familiarise herself with the woman's clinical situation. The RN's assessment, evaluation and response to the woman's bruising and dragging of her leg were not adequate. The RN failed to provide services to the woman with reasonable care and skill and, therefore, breached Right 4(1). The RN did not complete an accurate wound description, wound chart and short-term wound care plan. These actions did not comply with professional standards and, accordingly, the RN breached Right 4(2).

The owner/operator of the facility did not take sufficient steps to ensure that appropriate systems, policies and guidelines were in place to provide services to the woman with reasonable care and skill. Therefore, it breached Right 4(1).