Care of a diabetic rest home resident
(11HDC00686, 14 February 2014)

Rest home ~ Registered nurse ~ Pressure areas ~ Monitoring and coordination ~ Right 4(1)

A woman complained about the care provided to her 89-year-old father, who was admitted to a rest home for hospital-level care. He was resident at the rest home for just over five months, and during that time, several aspects of his care fell below an appropriate standard.

The man's weight was not monitored for a period of three months following his admission during which time he lost 17.5% of his body weight. Staff were not instructed to monitor his fluid and food. He was assessed as a high risk for falls, and fell multiple times but no plan to manage his falls was developed. The man was also assessed as being a very high risk of developing pressure sores. He developed multiple pressure areas. While the wounds were treated, they were not recorded, monitored or evaluated in accordance with the rest home's own policy.

The man had to be admitted to hospital on several occasions for dehydration and elevated blood sugar levels, recurrent urinary tract infections and sepsis. One particular hypoglycaemic episode at the rest home was poorly handled by the duty RN, who tried to feed the patient while he was unresponsive, causing him to choke.

There was no evidence that staff discussed the patient's weight loss, frequency of falls, or wounds with medical staff, until a severe wound was noted shortly before he died.

It was held that the patient's weight and hydration levels were not adequately monitored, and his wound care was poorly coordinated. Inadequate steps were taken to manage his falls, and there was poor communication between nursing/care staff and medical staff. Care planning and documentation also fell below the requisite standard. The rest home did not ensure there was adequate clinical oversight or orientation for its staff, or that staff complied with its policies. The rest home therefore failed to provide services with reasonable care and skill and breached Right 4(1).

It was also held that the senior registered nurse responsible for the patient failed to ensure the patient was provided with adequate care and support. However, taking into account the nurse's workload, and the lack of continuity and fragmentation of the clinical management systems in place at the rest home, the deficiencies in her care did not amount to a breach of the Code.

Similarly, it was held that the nurse manager failed in her responsibility for supporting and managing the clinical team to ensure that a quality service was delivered to patients. However, taking into account the limitations of her scope of practice, that her workload was excessive, and she was operating in an environment that did not have adequate systems in place to ensure that she was able to fulfil her role, the deficiencies in her care did not amount to a breach of the Code.

There was adverse comment about the registered nurse's decision to feed the patient jelly beans while he was unresponsive during a hypoglycaemic episode.