

**Failure to address deteriorating
condition of rest home resident
(03HDC14664, 23 February 2005)**

Rest home ~ Registered nurse ~ Caregiver ~ Diabetes ~ Blood sugar levels ~ Monitoring ~ Management plan ~ Staff training ~ Staff oversight ~ Guidelines ~ Responsibility ~ Standard of care ~ Professional standards ~ Vicarious liability ~ Rights 4(1), 4(2)

A woman complained that rest home staff failed to respond appropriately to her 68-year-old diabetic father's deteriorating condition. The rest home employed a registered nurse manager to work office hours and to be on call at all other times. Hands-on care of the residents was undertaken by caregivers who were neither registered nor enrolled nurses. While the caregivers were responsible for administering the man's insulin and monitoring his blood sugar levels, the registered nurse was responsible for training, monitoring and supervising the care.

During the week before the man was admitted to hospital, his blood glucose levels had been falling consistently. The evening before the admission, the man was observed experiencing "some sort of fit". The senior caregiver on duty telephoned the nurse for advice, and was told to put cot sides on the bed to prevent a fall. His blood glucose levels were low, so she gave him a sweet drink. No further blood glucose readings were taken that night, but a temperature reading indicated severe body heat loss.

The caregiver on the morning shift was surprised to find the man snoring, when normally he would be awake. When his blood glucose level measured low for three readings, the caregiver telephoned the nurse, who told her to call an ambulance. The man was admitted to hospital and transferred to intensive care. He died three days later.

It was held that the registered nurse should have noted the falling levels and reviewed the patient's diabetes management plan, and that in failing to provide services with reasonable care and skill, she breached Right 4(1). By failing to evaluate the effectiveness of the man's response to prescribed treatments and interventions, and to take remedial action and/or refer accordingly, she breached Right 4(2). It was also held that the advice she offered the caregivers was inadequate. They should have been given precise guidance on how to monitor and evaluate the man's condition. In giving advice, the nurse accepts responsibility for guidance given and therefore assumes a duty of care. This failure also amounted to a breach of Right 4(2). A registered nurse in a rest home is responsible for monitoring the clinical observations taken by caregivers and for providing appropriate guidance on action. The nurse should take positive steps to acquire results of observations, and not simply rely on untrained staff.

The rest home was held vicariously responsible for failing to ensure that the nurse fulfilled her role as manager, and carried out appropriate training and supervision.

The nurse was referred to the Director of Proceedings, who issued proceedings before the Health Practitioners Disciplinary Tribunal. A charge of professional misconduct was upheld. The nurse was ordered to practise only under the supervision of a registered nurse approved by the Nursing Council of New Zealand, and was ordered to contribute towards the costs of the hearing and prosecution.

Link to Health Practitioners Disciplinary Tribunal decision:
<http://www.hpdt.org.nz/portals/0/Nur0509clfindings.pdf>