Care provided to elderly rest home resident (11HDC01197, 20 June 2014)

Rest home ~ Registered nurse ~ Graduate nurse ~ Rest home level care ~ Supervision ~ Care planning ~ Monitoring and evaluation ~ Dehydration ~ Rights 4(1), 4(2), 4(5)

A complaint was received about the care provided to a rest home resident. The woman had multiple co-morbidities and was taking multiple medications.

An inexperienced graduate nurse was employed to provide registered nurse (RN) duties at the rest home the woman lived at, as well as at another facility owned by the company operating the home. The RN was employed under the supervision of a Clinical Services Manager (an experienced RN) for about three months. The Clinical Services Manager resigned, and no subsequent arrangements were made to find a replacement. The RN registered his concerns with management that, for a period of time, he was left to cover RN duties at the two facilities without any clinical supervision.

The woman developed a cough and was losing her voice. Three days later, the woman was not feeling well, and did not want to eat. No short-term care plan was put in place to inform caregivers of any monitoring or interventions required.

Two days later, the RN recorded some basic observations, including that the woman had diarrhoea. The RN contacted a general practitioner (GP) by fax, requesting a prescription for the anti-diarrhoea drug, loperamide. He did not provide the GP with any other information regarding the woman's symptoms, and did not consider that further intervention was required. The RN put an isolation notice on the woman's door as an infection control precaution, but did not send any specimen for testing.

The RN was not working at the facility for the following two days, but was on-call. In the RN's absence, the woman vomited and it was noted that she was barely eating. Despite various caregivers documenting the woman's deterioration, no staff contacted the RN.

Over those two days, a caregiver who had been off duty for 10 days returned and noticed the woman's weight loss, but did not contact the RN. The caregiver said that woman consumed some replacement energy drink. This was not documented. The RN returned to duty that afternoon. During handover, the caregiver told the RN that she felt that the woman needed to see a doctor. The RN assessed that the woman was in danger of dehydration, and encouraged fluids. However, he did not organise a medical review.

At 10pm the woman had an episode of diarrhoea. She was given loperamide, and night care staff were instructed by the RN to encourage fluids and monitor the woman. The RN did not call a doctor or an ambulance. No vital signs or observations were recorded. No food or fluid intake chart was initiated. The RN considered that emergency admission/assessment did not appear to be necessary, and instead planned to call a GP first thing the next day (a Monday).

On the Monday morning the RN checked the woman and made an appointment for the GP to visit later that morning. After breakfast, the woman was very unwell. The

RN called an ambulance. The woman was transferred and admitted to a public hospital before the scheduled GP visit could take place.

At the public hospital bloods and investigations were undertaken. Treating staff formed the clinical impression that the woman had a diarrhoeal illness with acute renal impairment, heart failure, and a respiratory tract infection. The woman passed away in hospital.

It was held that the RN's assessment, monitoring and evaluation of the woman's vital signs and condition, and his management of her symptoms, were inadequate. He did not provide services with reasonable care and skill and breached Right 4(1). His documentation did not comply with professional nursing standards and, accordingly, breached Right 4(2). The RN did not provide information to other staff about changing clinical circumstances, and this contributed to the lack of continuity and quality in the woman's care, breaching Right 4(5).

Adverse comment was made regarding the experienced caregiver who recognised the woman's deterioration but failed to seek assistance.

The decision to assign an inexperienced graduate nurse, without clinical supervision, full responsibility for the direction and delegation of care for rest home residents was inappropriate, and placed both the residents and the nurse at risk. The company operating the facility did not take sufficient steps to ensure that appropriate systems were in place to provide services to the woman with reasonable care and skill. Therefore, it breached Right 4(1). By failing to ensure that staff were complying with policies and procedures, it breached Right 4(2).