Wound care provided to rest home resident (07HDC12520, 29 April 2008)

Rest home ~ Registered nurse ~ Skin tear ~ Convalescent care ~ Documentation ~ Care plan ~ Health and Disability Sector standards ~ Rights 4(1), 4(2)

A complaint was made by family members relating to the care provided to their father while he was a resident of a rest home.

The man was initially admitted for convalescent care following carpal tunnel surgery. Despite regular dressings to his hand and an assessment at an emergency department, no documentation was completed by the home. The man was readmitted to hospital with a severe infection to his hand. Some time after returning to the home, skin tears on his legs became infected, and he was subsequently readmitted to hospital. He was later discharged to another rest home.

It was held that the man was provided with substandard care at the home, particularly during the periods leading to his hospital admissions. The manager, a registered nurse, was found to have breached Right 4(1). By failing to ensure the completion of documentation to an appropriate standard, she also breached Right 4(2).

Health and Disability Sector standards required the home to assess the man's needs and provide him with appropriate and safe services. The home failed to comply with these requirements. There was no evidence that his wounds were thoroughly assessed. Adequate care plans were not put in place. Although the man was admitted to the home on a "short-term" basis, he was there for almost two months, having had surgery, and he required documented assessments and care plans. Even when he was admitted on a more permanent basis, the documentation was of a poor standard and completed haphazardly. The home did not have in place the necessary systems, procedures and policies to ensure that the man received services of an appropriate standard. It breached Rights 4(1) and 4(2).

The registered nurse manager and the rest home were referred to the Director of Proceedings, who laid a charge before the Health Practitioners Disciplinary Tribunal alleging professional misconduct by the nurse. The charge comprised a number of allegations arising out of care provided to three separate rest home residents over a period of two years (see also 08HDC10236 and 08HDC08672).

There were multiple problems relating to the care of residents (including inadequate care by the nurse herself), as well as management issues and a failure to maintain adequate documentation. The nurse also misled HDC by providing an incident form she had re-written.

The Tribunal upheld the charge and the nurse was fined $7,500 and ordered to pay costs to HDC and the Tribunal totalling $18,500. It also imposed conditions that required the nurse to practise under supervision for 12 months, and precluded her from practising in a sole charge or supervisory role for three years. It recommended a competence review prior to re-issue of a practising certificate.

Link to Health Practitioners Disciplinary Tribunal's decision:
http://www.hpdt.org.nz/portals/0/nur09123ddecanon.pdf