

**Care, co-operation, and communication in a rest home
(09HDC01641, 21 June 2012)**

Rest home ~ Private hospital ~ Assessment and management of deteriorating condition ~ Communication ~ Co-operation ~ Standard of care ~ Rights 4(1), 4(5)

The family of a 93-year-old woman complained about the care provided at a residential care facility during the last weeks of her life.

The woman was a long-term resident in the facility's private hospital. She had a number of chronic health issues. Over a period of 3–4 months, the woman's condition deteriorated. On several occasions it was noted that she was not eating well, she was weak and tired, and she was not mobilising well. She was losing weight and she had a fall. During this time, there were no changes to the woman's care plan and no increase in the monitoring of her condition.

At one point, the hospital's contracted doctors suspected that the woman may have had a stroke. Over the next four days, her condition continued to deteriorate. She was having difficulty swallowing and was frequently noted to be restless, agitated and in pain. Few interventions were implemented or evaluated.

The woman's son was concerned about her deterioration and asked nursing staff several times if he could speak with the doctor. The nursing staff did not communicate these requests to the doctors. The family was then wrongly advised that the facility did not have after-hours medical cover and that the woman would need to go to a public hospital. A family member, who was also a GP, personally arranged for another doctor to visit and assess the woman. That doctor noted that the woman was agitated and dehydrated, and considered that she had had a mild stroke. The following day, the woman's condition was considered to be terminal and all medications were stopped, except morphine. The woman died later that night.

It was held that there was a lack of care and skill in the service provided to the woman by the private hospital. There were repeated failures by multiple staff to provide appropriate care. In the last weeks of the woman's life, nursing staff failed to adequately assess, monitor and respond to her deteriorating condition. There were deficiencies in communication between nursing staff and medical staff, which were compounded by inadequate documentation. Accordingly, the facility breached Rights 4(1) and 4(5).

Aspects of the service provided by the nurse responsible for overseeing the nursing care provided to the woman could have been better. However, the extent to which that nurse's workload and available support impacted on her ability to provide services of an appropriate standard was unclear. Accordingly, she was not found to have breached the Code.