Respite care services provided to a woman with a history of respiratory illness 15HDC01543, 27 June 2018

District health board ~ Rest home ~Registered nurse ~Respite care ~ Short-stay policy ~ NASC ~ Baseline observations ~ Oxygen saturation ~Right 4(1)

A man complained about the care provided to his wife while in respite care. She suffered from incomplete paraplegia and relied on her wheelchair to move around, and she required a hoist and sling for care. Her husband was her primary full-time carer, and arranged for the woman to stay at a rest home for respite care while he took a break.

The rest home's short-stay policy at the time required potential respite-care residents to have a Needs Assessment Service Coordination (NASC) assessment less than 12 months old and/or a GP review within the three months prior to admission. When the woman was admitted, her most recent NASC assessment had occurred over two years earlier. Accordingly, it did not note that approximately six weeks prior to admission, the woman had been hospitalised for bilateral pneumonia and type 2 respiratory failure, and that subsequently she had been referred to a respiratory clinic to assess her breathing and to investigate sleep apnoea.

The rest home reported that when the clinical manager contacted the NASC assessor regarding the age of the assessment prior to the woman's admission, the assessor acknowledged that it was not current but said that "they had nothing further". The woman's husband did not communicate the respiratory issues that the woman had suffered prior to her admission. The rest home also reported that the rest home manager requested that the woman visit her doctor prior to admission, but this did not happen.

The woman was admitted to the rest home by a registered nurse, who noted that the woman's medications were not blister packed, and that a copy of her medication chart had not been provided by the woman or her husband. At around 3pm, another nurse started the afternoon shift as the senior registered nurse on duty. The admitting nurse verbally delegated the woman's care to the senior nurse, and said that she asked her to follow up with the admission paperwork and to complete baseline observations. The rest home said that its expectation was for baseline observations (vital signs) to be completed by the admitting nurse, and for any assessments not completed by the admitting nurse to be handed over to the oncoming nurse for completion. The rest home said that the baseline observations were handed over to the senior registered nurse to complete. However, no baseline observations were completed and recorded on admission.

Early in the hours of the following day another registered nurse documented having found the woman sitting on the floor after a fall from her bed. The woman was assessed and her vital signs were taken. Her progress notes record that she had oxygen saturations of 80% (normal range is 95–98%). The nurse completed an incident form outlining the events, and documented the 80% oxygen saturation level on the form. The nurse did not instigate oxygen therapy and initiate ongoing monitoring or timely escalation of the result to the GP, or ensure that this was handed over to the morning staff to carry out.

Three days later, the clinical manager reviewed the incident form for the fall. She noticed that no baseline observations had been taken on admission. The clinical manager therefore added into the short-stay admission record the observations that had been taken after the fall (including the oxygen saturation of 80%). She did not investigate the low oxygen saturation level further, although it could not be explained by the fall.

Three days later, another registered nurse documented in the progress notes that the woman had appeared to be short of breath after her evening meal. She was observed sitting

asleep in her wheelchair with her chin on her chest. The nurse believed that because the woman was obese, her position could be blocking her airway. On assessment, the nurse noted a blue tint to the woman's lips, and her oxygen saturation was found to be 67%. In response to this, the nurse administered oxygen until the woman's saturation increased to 95%, and sent a fax to her GP regarding the need for a review. No further observations were recorded for the remainder of the night. Sadly, the woman passed away.

Findings

It was held that the rest home had the ultimate responsibility to ensure that the woman received care of an appropriate standard and complied with the Code. The rest home was found to have failed in that responsibility and to have breached Right 4(1) for the following reasons:

- The short-stay policy required potential respite-care residents to have a NASC assessment that was less than 12 months old, and/or a GP review within three months prior to admission. The woman was accepted for respite care without a recent NASC assessment or GP review.
- The woman's baseline observations were not taken on admission.
- Staff failed to act on low oxygen saturations on multiple occasions. Staff needed to think critically and respond appropriately to the resident's condition.
- The inaction and failure of multiple staff to adhere to policies and procedures pointed to an environment that did not support and assist staff sufficiently to do what was required of them.

It was found that the registered nurse who found the woman after a fall failed to provide services with reasonable care and skill and was in breach of Right 4(1). She documented low oxygen saturations yet failed to instigate the appropriate intervention (oxygen therapy) and initiate ongoing monitoring and timely escalation of the result to the GP, or ensure that this was handed over to the morning staff to carry out.

It was found that the registered nurse who later documented the woman's shortness of breath over an evening meal failed to provide services with reasonable care and skill and was in breach of Right 4(1). She responded to an oxygen saturation level of 67% by administering oxygen until saturation increased to 95%, and by sending a fax to the GP regarding the need for review. However, the appropriate action would have been to call 111 or arrange an urgent review by a GP.

The clinical manager was also found in breach of Right 4(1). As clinical manager, she was ultimately the person with primary responsibility for the care provided to the woman. In relation to the fall, when the clinical manager reviewed the incident form she did not investigate the low oxygen saturation further, although it could not be explained by the fall. Accordingly, she failed to provide services with reasonable care and skill.

Adverse comment was made that following the handover of the woman on the day of her admission, the senior registered nurse did not review the notes, including the short-stay admission record, and ensure that all of the admission requirements had been completed.

The admitting nurse was criticised for not ensuring that clear direction was given to the senior registered nurse to complete the baseline observations. It was noted that at the time of events, she was in her first year of nursing practice, and the senior registered nurse should have been able to ascertain the information from reviewing the notes, as she was responsible for completing the admission.

Recommendations

It was recommended that the rest home:

a) consider the implementation of a system in a written format to capture outstanding tasks, including any ongoing monitoring requirements and any concerns of care staff that need to be handed over between shifts;
b) consider the initiation of out-of-hours access to a senior nurse, especially for new graduate nurses who may be on a shift without a registered nurse colleague; and
c) provide a written apology to the family for its breach of the Code.

In line with the recommendations in the provisional opinion, the nurses found in breach of the Code provided written letters of apology to the family.