Inadequate management of weight loss in elderly rest home patient (04HDC18516, 4 May 2006)

Rest home and hospital ~ Nurse ~ General practitioner ~ Dietitian ~ Nutritional care ~ Communication ~ Rights 4(1), 6(1)(a)

A 77-year-old man was admitted to a rest home and hospital requiring a significant level of nursing care as he had previously suffered a stroke. Although he was mobile with an electric wheelchair, he had a permanent urinary catheter, required full assistance with his hygiene care, and suffered from some dementia and depression.

During his stay at the rest home, he suffered from recurrent urinary tract infections and abdominal pain, which on two occasions required admission to a public hospital. The GP requested that the man be referred to a dietitian as his weight had fallen from 59.1kg on admission in December 2003, to 43.7kg in September 2004. At the end of October 2004, the man left the rest home in his electric wheelchair unescorted. While attempting to negotiate a road curb outside the rest home grounds, he fell from his wheelchair. An ambulance was called and he was admitted to a public hospital.

Following his admission to hospital, a complaint was made to the District Health Board (DHB) by a social worker concerned about his malnourished condition. The man died a short time later in hospital. The autopsy report described bronchopneumonia as the cause of death, and inanition (a condition of exhaustion caused by lack of nutrients in the blood, arising through malnutrition or intestinal disease) as a secondary cause.

It was held that the actions taken to monitor and manage the man's continuing weight loss were seriously inadequate; pain management by nursing staff at the rest home was below the standard to be expected; insufficient actions were taken to ensure either that he received an adequate fluid intake or that his fluid intake was accurately measured; and that the man was not adequately supervised. The rest home was responsible for these failures, and breached Right 4(1). It was also held that an effective system of communication between the man's family and nursing staff was required because of his complex care needs. No such system was in place. The rest home breached Right 6(1)(a) by failing to keep the man's family properly informed about his condition. The rest home was referred to the Director of Proceedings.

The principal nurse was held to have not provided services of an appropriate standard by her lack of adequate clinical oversight, thus breaching Right 4(1). The GP failed to recognise and respond to the man's state of malnutrition, and was also held to have breached Right 4(1).

It was noted that the dietitian should have asked more questions about the care provided to the man. Had she reviewed the clinical records more closely, she would have seen the poor documentation of his nutritional care, including inadequate fluid charts and, in particular, no evidence that he had been receiving dietary supplements in the quantities advised to her. In order to adequately manage the man's complex care, in particular his nutritional needs, a multidisciplinary approach involving nursing staff, general practitioner, and community dietitian was required. The clinical

staff involved in the man’s care did not work together effectively to ensure that he had an adequate nutritional intake.

The Director of Proceedings decided to issue proceedings against the rest home before the Human Rights Review Tribunal. The proceedings were discontinued on the basis of a confidential settlement agreement.