Failure to provide appropriate respite care in rest home (15HDC00420, 15 June 2016)

Rest home and hospital ~ Registered nurse ~ Respite care ~ Metastatic prostate cancer ~ Urethral catheter ~ Admission ~ Care plan ~ Monitoring ~ Standard of care ~ Right 4(1)

A 77-year-old man with castrate resistant metastatic prostate cancer was admitted to a rest home for one week of respite care over a holiday period. The man had a long-term, large sized, urethral catheter in situ.

Prior to admission, staff from Needs Assessment and Support Coordination gave information to the rest home that set out that the man had ongoing issues with his catheter blocking, which would require hospital-level care, and that he had a large bladder mass severely obstructing urine flow.

The man was previously known to the rest home, having spent 11 nights there for respite care several months earlier. A short-stay nursing assessment and support plan had been completed for the man on his previous admission, but this was not updated on his next admission, nor was a specific catheter care plan initiated.

On the first night at the rest home, the man complained of pain related to urinating. His catheter had not drained any urine and a nurse performed bladder irrigation, which expelled blood clots and the catheter began draining well.

During the night, the man continued to complain of pain and was given pain relief. At 4.45am, caregivers reported to a nurse that the man's urine was bypassing the catheter and was "bleeding a little". The nurse noted that no urine had drained into the catheter bag since 1am. She attempted bladder irrigation without success, and then removed the man's catheter but did not recatheterise him. There was no correct sized catheter in stock at the rest home.

The man vomited the next morning. The nurse on shift recorded that she witnessed him passing a "reasonable" amount of urine. At 4pm a nurse inserted a correct sized catheter, which the man's daughter had supplied. A small amount of urine passed. The man continued to pass low levels of urine. He refused dinner and drank minimal fluids. No formal fluid balance monitoring occurred. The man experienced abdominal pain overnight. He was provided pain relief and bladder irrigation, which drained a small amount of urine.

On the morning of his third day at the rest home, the man vomited on several occasions. His low urine output continued. That afternoon the man's daughter, who had been expressing concerns about her father's deterioration, took her father to hospital and he died in hospital several days later.

It was held that the rest home breached Right 4(1) as it failed in its duty to ensure that the man received services of an appropriate standard while at the rest home, in the following ways:

- Care management plans were not updated on admission to reflect the man's current clinical presentation, nor were plans established to manage the regular and known problem of the man's catheter blocking.
- Bladder irrigation was performed several times without first seeking medical advice, as required by rest home policy, and without documenting the amount of saline fluid used.
- The man's catheter was removed without seeking medical advice, and he was not recatheterised promptly.
- No formal fluid balance chart was commenced, and the monitoring of the man's fluid balance was infrequent and inadequate.
- Concerns about the man's condition were not escalated to the on-call manager by nursing staff, and they did not seek medical advice.

It was recommended that the rest home provide staff with further education and training on several topics, including admission planning, monitoring of bladder irrigation, catheter removal and fluid balance monitoring. The rest home was asked to use this case for staff education at other facilities, and to apologise to the man's family.