Sedation and inadequate care of patient in rest home (00HDC11595, 5 June 2003)

Nurse ~ Rest home ~ Standard of care ~ Informed consent ~ Sedation ~ Rights 4(1), 4(2), 7(1)

A woman complained about the standard of service her 90-year-old mother received from a rest home. In particular, the daughter complained that, as her mother's power of attorney, she had not been notified of her mother's deteriorating condition, and that her consent to the administration of sedation had not been obtained. Further, her mother's deteriorating condition had not been addressed, medical assistance had not been sought following a number of falls, and uncharted drugs had been dispensed and unauthorised instructions written to nursing staff in respect of drugs to be administered.

The patient's mental condition began to deteriorate shortly after her admission to the rest home, and staff found it increasingly difficult to control her wandering and challenging behaviour. Her prescribed medications included half to one tablet of Imovane at night. The registered nurse and the rest home manager planned to take leave around the same time and were concerned about the staff's ability to manage the patient. Without consulting the GP, the nurse changed the dose of Imovane to half a tablet morning and night, intending that the pharmacy would send the prescription to the GP for signing. Subsequently the dose was increased to half a tablet three times a day, resulting in the patient experiencing daytime drowsiness and increased falls.

When ordering medication, the practice at the rest home was for the registered nurse or manager to fax to the pharmacy the prescription cards, which recorded the prescribing doctor's signed and dated changes. The pharmacist then converted the cards to computer-generated prescriptions, which were sent in batches to the doctor to sign. When prescriptions for rest home residents are changed or telephoned through to a pharmacy, it is common practice for pharmacists to send doctors bundles of prescriptions to be signed and returned for processing. Doctors usually take it on faith that the scripts are written as discussed with the pharmacist, or are true to those signed in the rest home. When the GP signed the prescriptions he was unaware that they had been altered by the nurse, and, when the change was noted by the pharmacy, the GP was not consulted. However, doctors and other prescribers are legally responsible for the prescriptions they sign, and in signing the patient's prescriptions without close scrutiny the GP was held in breach of Right 4(2).

It was held that the nurse breached Rights 4(1) and 4(2) in dispensing the drug and writing unauthorised instructions to staff. As a registered nurse with considerable experience in care of the elderly, she should have known the effect of giving such a dose of sedative to a very small, frail elderly woman.

When the patient was admitted to the rest home she was already markedly underweight and, after 16 months at the home, she had lost a further 10kg. No accurate assessment or any significant action was undertaken to deal with the problem. Nor was the patient's dehydration adequately monitored and reviewed, and her falls were not always documented. The nurse failed to take positive steps to manage the woman's increasing frailty and propensity to fall, and did not notify the woman's daughter of her mother's deteriorating condition. Nor did the nurse obtain the daughter's consent to the administration of Imovane, and thus breached Right 7(1).

The owner/manager of the rest home breached Rights 4(1) and 4(2) as she should have been aware of, and (in consultation with the family and GP) responded to, the patient's ongoing health problems and significant weight loss. Instead she relied on the nurse. As owner/manager of the rest home she was responsible for ensuring that the patient's day-to-day care was managed effectively and in accordance with professional standards.

The matter was referred to the Director of Proceedings, who prosecuted the nurse before the Nursing Council of New Zealand. The Council upheld a charge of professional misconduct in relation to: the incorrect administration of Imovane; drafting of a prescription of Imovane without consultation with the prescriber; and failure to assess, monitor, evaluate and respond to the patient's weight loss and falls. A penalty of censure and payment of $15,400 (30% of the costs of the hearing) was imposed.