

Nursing assessment and care of rest home resident (11HDC00423, 28 June 2013)

Rest home ~ Registered nurse ~ Manager ~ Dehydration ~ Depression ~ Medication management ~ Care plan ~ Policies ~ Documentation ~ Rights 4(1), 4(2)

A 77-year-old man was discharged from hospital to a rest home, after having been treated at the hospital for a chest infection, dehydration, and depression.

When the man was admitted to the rest home, the facility manager completed half the admission form, and a registered nurse assumed responsibility for completing the initial nursing assessment and care plan. The initial nursing assessment was not completed because the registered nurse was not able to talk to the man's wife, which was required as part of the assessment. However, the registered nurse completed a detailed care plan. The care plan identified the man's risks associated with poor diet and food intake due to depression, and noted a number of interventions to manage that risk, including weekly weighs, reporting changes in his appetite, and starting a food chart when his appetite decreased. He was noted to have a wound on his right shin.

The clinical records indicate that the man's mood was low and he frequently refused food or fluids, or took only a few spoonfuls of food. Staff did not initiate interventions as set out in the care plan. There was no evidence that changes in his appetite were reported, that a food chart was commenced, that a weekly weigh was undertaken, or that further medical or nursing reviews were requested. At the request of the family, he was admitted to hospital, where he was found to be frail and dehydrated, and to have had a heart attack. The man passed away a few days later.

Although the care plan written by the registered nurse reflected the man's needs and was appropriate, the registered nurse used a flawed process in the development of that plan. In particular, the nursing assessment on which the plan was based was not completed, and the registered nurse documented that the care plan was developed with input from the family when it clearly had not been, which jeopardised the integrity of the record. Furthermore, although there was no evidence that the man's medication was administered incorrectly during his time at the rest home, his medication management was not aligned to best practice because there was a delay in the GP signing the medication sheet. It was held that the registered nurse's care fell below expected standards, and she breached Right 4(1).

The facility manager had overall responsibility for ensuring a quality service was provided. She failed in that responsibility in that she did not ensure that staff complied with the man's care plan, did not ensure the man was reviewed by a nurse or doctor when his condition deteriorated, and deliberately chose to wait until the man's next general practitioner appointment to have the medication sheet signed. The facility manager also breached Right 4(1).

The rest home breached Right 4(1) because it failed in its responsibility to ensure that staff complied with policies and provided services of an appropriate standard. The rest home also breached Right 4(2), because its documentation was suboptimal.