Management of rest home resident's fall; follow-up of PSA test (08HDC17309, 26 May 2010)

General practitioner ~ Rest home ~ Falls ~ Standard of care ~Communication and co-operation ~ Rights 4(1), 4(5)

A family complained about the care provided to their father by a GP and rest home staff following two falls. Prior to his admission to the rest home, the man had been diagnosed with prostate cancer and received treatment. Two months after admission, the GP requested that the man's PSA level be checked and noted that he should continue to have monthly PSA tests. It was also noted that if the man's PSA level rose above 10µg/L, treatment should be restarted. The man's PSA was checked two months later, but his records were misfiled and it was then six months before his next check. By that time, the man's PSA level had risen to 38.8µg/L. Treatment was prescribed and given.

A fortnight later, the man had a fall. He was checked by nursing staff, who found no evidence of injury. The man's son was informed, and he advised rest home staff that previously the same prostate treatment had affected his father's balance. Early the next morning, the man was found by a caregiver on the floor of his bathroom. He was checked by nursing staff. The man did not want to go to hospital, and it was agreed he should be seen by a doctor. The GP was contacted two hours later, by which time there was swelling and bruising around the man's left eye, and bruising to his right elbow and sides. The GP reviewed the man early that afternoon. No significant injury was identified.

The following morning the man's condition deteriorated. The GP had arrived at the home that morning for a scheduled round but was not alerted to the man's deterioration and did not see him until four hours later. It was agreed that the man should be admitted to hospital. The GP made a routine request for ambulance transport, and the ambulance arrived about two hours later. The man was found to have a fractured left eye socket, an odontoid peg fracture (part of the cervical spine), and a possible fracture of the fusion between his 2nd and 3rd vertebrae, although this may have been an old fracture. He was dehydrated. The man died the following day.

It was held that there were problems with the GP's systems for the storage and retrieval of patient records, and with the arrangement with the home to ensure diagnostic testing was carried out as required. This resulted in a failure to monitor the man's PSA appropriately. The man's care was also compromised by a lack of co-operation between the GP and the rest home staff at the time of the falls. The GP was found in breach of Rights 4(1) and 4(5).

It was also held that following the man's second fall, nursing staff did not act in accordance with the falls policy. They should have sought medical assistance more promptly and monitored his condition more closely. Staff failed to communicate effectively with one another and with the GP to ensure quality and continuity of services. The home was found in breach of Rights 4(1) and 4(5).