Lack of appropriate falls management and pain monitoring of aged-care resident

19HDC02144, 29 August 2022

This case highlights the importance of residential aged-care facilities having appropriate falls management policies in place and of ensuring that nursing staff assess and record the use and efficacy of pain medication consistently. The case also highlights the importance of effective communication and collaboration between general practitioners (GPs) and residential aged-care facilities who are jointly responsible for delivering an appropriate standard of care to residents.

An elderly man who was a resident at aged-care facility Millvale House Levin Limited (Millvale House) broke his hip and underwent surgery at a hospital before being discharged back to Millvale House. About two weeks later, the man experienced increased pain, and a GP prescribed stronger pain medication. In the following days, the man sustained two falls — the first from his chair, and the second, three days later, by rolling from his bed onto a floor mattress.

The man's fall from bed occurred in the early hours of the morning. At the time of events, Millvale House's falls management policy excluded a "roll" from bed in its definition of a "fall", and a full assessment, examination, and reporting, which usually is required following a fall, was therefore not carried out. He was monitored throughout the day. In the late afternoon, about eight hours after his fall from bed, the man was observed to be in extreme pain and he was transferred to hospital, where he was diagnosed with a leg fracture.

Findings

The Aged Care Commissioner considered that the care provided by Millvale House fell short of acceptable standards, and that this may have contributed to a delay in identifying the man's injury.

The Aged Care Commissioner considered that Millvale House's falls policy was not fit for purpose because the exclusion of a roll from bed as being a "fall" was not consistent with standard practice across other aged-care providers. The Aged Care Commissioner noted that this resulted in the man not being assessed and examined adequately following his fall from bed, and that an incident form was not completed. Further, the Aged Care Commissioner was critical that nursing staff at Millvale House had not been using the appropriate assessment tool consistently to monitor the man's pain, and had been recording the man's pain levels and use of pain medication in a fragmented manner in several different places, which made it difficult to assess the efficacy of the medication. The Aged Care Commissioner noted that this may also have contributed to a delay in identifying the man's injury as the cause of his pain on the day he fell from his bed. As these issues were evident in the care by a number of nurses over several weeks, the Aged Care Commissioner considered that this demonstrated a poor pattern of care for which ultimately Millvale House was responsible at a service level.

For these reasons, Millvale House was found to have failed to provide services with reasonable care and skill, in breach of Right 4(1) of the Code of Health and Disability Services Consumers' Rights.

The Aged Care Commissioner also made adverse comment about inadequacies in the communication between Millvale House and the GP who provided services to the man. In particular, she commented that when Millvale House staff contacted the GP to request a review of the man after his fall from bed, staff told the GP about the man's previous fall from a chair, but it was unclear whether they advised the GP of the man's fall from bed that morning. She also noted that following review by the GP, Millvale House staff recorded differing accounts of the GP's recommendation for the man to have an X-ray in the coming days. Further to this, the Aged Care Commissioner was critical that in the week before the man's fall from bed, the GP had intended to change the man's pain medication prescription, but there was a four-day delay in updating the medication chart due to an apparent miscommunication between Millvale House and the GP. She noted that effective collaboration and communication between GPs and aged-care facilities is vital to adequate care coordination and better outcomes for their residents, and considered that in this case, gaps in communication also contributed to the delay in identifying the man's injury and need for transfer to hospital.

Recommendations

The Aged Care Commissioner recommended that Millvale House:

- Provide HDC with six months of internal pain management audits and evidence of the corrective actions implemented in response to its quality improvement initiative for monitoring of residents' pain and the use and evaluation of pain medication.
- Provide evidence that it has communicated to its staff the change in its falls policy (as to the definition of a fall), and that training on the policy changes has been undertaken.
- Undertake a review of its falls, pain management, and pain medication policies, procedures, and guidelines in conjunction with Te Whatu Ora — Health New Zealand and/or HealthCERT to ensure that they are consistent with current accepted practice, and provide evidence that any changes in relevant policies have been communicated to staff, and that training on the changes has been provided.
- Use an anonymised version of this case as a learning resource for its nursing staff to think critically about when it may be prudent to undertake further assessments of residents.