Handover instructions for care after discharge
17HDC00572, 27 June 2019

District health board ~ Rest home ~ Fracture ~ Co-ordination ~ Communication ~ Right 4(1)

An elderly woman fractured her right leg, and was admitted to a public hospital. A range of motion (ROM) brace was fitted to her leg and she was placed on 12 weeks' bed rest. A doctor gave a directive that the skin under the brace was to be monitored for pressure sores, but this directive was not recorded in the Patient Care Plan. The doctor also asked for the woman to be referred to the Pain Clinic, but the referral was not made.

The woman was discharged to a rest home, and the rest home was advised that she was to remain on bed rest for 12 weeks. The woman developed a urinary tract infection, and symptoms that included severe pain and delirium, and was readmitted to the public hospital.

A doctor at the public hospital noted a pressure area on the woman's right knee and sacral area. He instructed that the brace be removed, and the wound reviewed daily. This instruction was not entered into the Patient Care Plan, and there is no documentation about whether the instruction was carried out.

The woman was discharged to the rest home, and was seen a week later at the Fracture Clinic at the public hospital as an outpatient. Staff at the rest home did not remove the brace for another week, and a necrotic area of skin over the woman's knee was discovered. She was transferred to the public hospital, and died the following day.

Findings

The decision by the district health board (DHB) to manage the woman's fracture with a ROM brace was considered to have been appropriate, but the Deputy Commissioner criticised a number of aspects of the care provided by multiple staff at the DHB:

- The verbal handover instructions, provided at the first and second discharges, were not recorded adequately.
- On the first discharge, the DHB did not clearly record the documents that were provided to the rest home, or provide instructions for the care of the brace and the skin underneath it.
- On the second discharge, the DHB did not provide the rest home with all the necessary documents pursuant to its discharge policy, and did not note the existence of the pressure area or the care that was required for it.
- Directives given by medical staff during the first and second admissions to the public hospital were not recorded in the Patient Care Plan, and were not actioned.

As a consequence of these actions, rest home staff did not have clear information about the appropriate care to be provided to the woman on discharge. A deconditioning plan was not considered, and a referral to the Pain Clinic was not actioned. As a result, the woman did not have the benefit of the Pain Clinic's expertise.

It was held that while individual staff hold some degree of responsibility for their failings, the deficiencies indicate a pattern of poor co-ordination and communication, within both the DHB and the rest home. Numerous staff at the DHB did not record key information about the woman's care in the appropriate documents, and when it was recorded it was not actioned. The handover information that was provided to the rest home was poor. This information, or lack of it, may have affected the care provided by subsequent healthcare providers. Accordingly, the DHB failed to provide services with reasonable care and skill, and breached Right 4(1).

Adverse comment was made about the management of the brace by the rest home.

Recommendations

The Deputy Commissioner recommended that the DHB conduct an audit of staff compliance with the discharge policy; update HDC on the results of the investigation into the development of the deconditioning plan for selected patients; update HDC on the review of its process for referral to the Pain Clinic; and provide the family with a formal apology.

The rest home's assets were sold and the contracts of all staff were terminated. Accordingly, no recommendations were made for the rest home.