Wound care and medication administration to woman in rest home
15HDC00423, 30 June 2017

Rest home and hospital ~ Registered nurse ~
Medication administration ~ Wound care ~ Right 4(1)

A woman was a resident at a rest home and required hospital-level care. She suffered from multiple sclerosis and, as a result, was paraplegic and largely bed bound, blind in her left eye, and required a long-term urinary catheter. She was also diabetic, requiring insulin, had a cardiac pacemaker for complete heart block, and suffered from syndrome of inappropriate anti-diuretic hormone secretion (SIADH) and depression.

The woman was prescribed zopiclone for insomnia. Following review, her general practitioner (GP) charted an additional dose of zopiclone as required at night. Often the second dose of zopiclone was administered at the woman's request after 2am, and as late as 6.30am. This caused regular daytime sleepiness and associated reduced appetite and nutrition.

One of the woman's caregivers observed a pressure area on her sacrum. A wound care plan and an evaluation record were commenced and, over the next week, the wound area was re-dressed regularly. The woman's GP assessed the pressure wound as superficial. He expected it to respond well to good nursing care. Unfortunately, the sacral pressure wound did not respond well, and from that evening began to deteriorate.

Over the next fortnight, nursing staff undertaking wound care recorded the increasing deterioration in the wound, and in the woman's general condition. However, no action was taken to refer the woman to a wound care specialist nurse or to seek a reassessment by her GP.

Later that month, nursing staff noted the woman's deteriorating general condition and diminished appetite, and the sacral pressure wound was noted to have deteriorated again, but no further medical advice was sought. The same day, the woman was administered zopiclone at 2pm.

Two days later, staff found the woman to be unresponsive. By the time her vital signs were taken in the early afternoon, she was acutely unwell with a high fever, low blood pressure, diabetic ketoacidosis, and shock. The GP's practice was alerted by fax and telephone call, and two hours later recommended that the woman be sent to a secondary level hospital by ambulance.

The woman was transferred to a tertiary level hospital, and underwent urgent surgical debridement of the sacral pressure wound. The woman died from septic shock as a result of necrotising fasciitis associated with the sacral pressure wound.

Findings

Rest home staff failed to assess, think critically, and act appropriately in response to the woman's deteriorating wound and general condition. Staff repeatedly continued

to administer zopiclone PRN at inappropriate times without reference to the prescriber to seek advice. Accordingly, the rest home failed to provide the woman with services with reasonable care and skill, and breached Right 4(1).

The Clinical Manager was found to have breached Right 4(1) in relation to her assessment of the woman's wound deterioration, and in her management of the administration of PRN zopiclone. The Unit Coordinator also breached Right 4(1) in failing to act appropriately in response to the deteriorating wound, and failing to respond appropriately when the woman was found to be acutely unwell. The woman's allocated nurse also breached Right 4(1) in relation to wound management and the administration of PRN zopiclone.

Adverse comment was made in respect of the oversight of the administration of PRN zopiclone by the prescriber, the woman's general practitioner.

Recommendations

It was recommended that the rest home update HDC on the finalisation and implementation of the Pressure Injury Prevention and Management policy and education pack, and the Short Term Care Plans policy; its implementation of the electronic medication management and electronic incident management systems; its Clinical Manager Framework and Orientation Programme; the position description for the Clinical Manager; and the implementation of the proposed new role of roving Clinical Manager.

It was also recommended that the rest home, the Clinical Manager, the Unit Coordinator, and the woman's allocated nurse each provide a written apology to the woman's family.

The rest home, the Unit Coordinator, and the woman's allocated nurse were referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be taken.

The Director of Proceedings filed proceedings by consent against the rest home in the Human Rights Review Tribunal. The Tribunal issued a declaration that the rest home breached Right 4(1) by failing to provide services with reasonable care and skill. The Director did not take any proceedings against the Unit Coordinator or the woman's allocated nurse.