

Care and communication at rest home (11HDC00812, 11 October 2013)

*Rest Home ~ Registered nurse ~ Wound care ~ Medication ~ Falls ~ Communication
~ Care planning ~ Documentation ~ Rights 4(1), 4(5)*

An 87-year-old woman was admitted to hospital with a fractured femur. That day, she had a total hip replacement. Three weeks later, she was discharged home into the care of her daughter. Two days after discharge, the woman suffered a fall at home and was returned to hospital. Arrangements were made for the woman to have short-term respite care at a rest home.

The rest home's admission assessment and documentation was incomplete, and the woman's care plan was not updated during her stay at the rest home, despite her changing health status. In addition, the woman had blisters on her heels and a reddening on her sacrum when she arrived at the rest home. The district health board's district nursing service was responsible for caring for the woman's wounds.

The woman's regular medications included lorazepam, used to treat anxiety. Three weeks after the woman's admission to the rest home, her supply of lorazepam ran out on a Friday. The following day, the woman contacted her daughter in a distressed state. The daughter telephoned the rest home, but no action was taken to obtain a repeat prescription until the following Monday.

During her admission, the woman had four falls. The woman's family was not contacted after the first three falls (the woman requested that her family not be notified after the first fall only). When the woman fell for the fourth time, she hit her head on some drawers, causing a small cut. The GP was contacted and the woman's daughter was advised.

The next day, a district nurse visited and found the woman's legs were oedematous and fluid was oozing from them. The woman was sent to hospital. She was discharged home and referred for community palliative care. She died a short time later.

It was held that as a result of poor oversight and communication, the rest home did not ensure that the woman received the medication she was prescribed. Accordingly, the rest home failed to provide services with reasonable care and skill, and breached Right 4(1).

There were lapses in communication between staff and the woman's family, and there was sub-optimal documentation of the woman's condition and care. Rest home staff failed to communicate effectively with one another and with the family to ensure that the woman received continuity of care, and so breached Right 4(5).

Adverse comment was made about the district health board's failure to carry out and record a formal risk assessment and carry out sufficient care planning in relation to pressure ulcer prevention during the woman's hospital admission.