**Care of elderly woman in rest home**
**16HDC01013, 19 June 2019**

*Rest home ~ Pressure injuries ~ Bowel care ~ Pain management ~ Right 4(1)*

An 87-year-old woman was a resident of a rest home. It was identified that she had a very high risk of developing pressure injuries.

The woman developed a broken area of skin in her sacral region. The wound was noted to have healed after two weeks. A few days later, the woman developed a grade 2 pressure injury on her sacrum. It is unclear if or when the pressure injury resolved; however, updated assessments noted that there were "no wounds present".

A few weeks later, a second grade 2 sacral pressure injury was documented. The pressure area became progressively worse, and became a grade 4 pressure injury. A swab was taken and the matter was escalated to the GP, who prescribed morphine for use prior to debridement and dressing changes. The wound was reviewed by the clinical manager, and a referral to a wound specialist was made. In total, the wound was dressed for 29 days. There was no assessment of the effectiveness of the woman's new pain regimen.

There were no documented actions in response to the woman's lack of bowel activity over a period of 12 days.

In the period leading up to her admission to the public hospital, entries in the woman's progress notes on some occasions refer to good intake, and, at other times, to poor eating and drinking. The woman's fluid output was not documented.

The woman's daughter raised concern that her mother was confused, and in the evening the woman vomited up most of her bedtime medications. Early the following morning, a bureau nurse documented that the woman had vomited again, and continued to vomit when turned. It was also documented that her temperature was 35.2°C, and her abdomen was distended and rigid with some tenderness on palpation. At 5am, the bureau nurse recorded that the woman was complaining of lower abdominal pain, felt cold and clammy, and appeared slightly confused. The bureau nurse also documented that she had spoken to the clinical manager about admission to hospital, but was told to monitor the woman until the morning and then to reassess her. The clinical manager denied that the bureau nurse queried admission or mentioned the woman's vomiting episodes.

At 6.30am, the woman was noted to have cyanosed lips and fingernails and a weak pulse, and she was disorientated. She was transferred to the public hospital's ED, where she was diagnosed with an ischaemic bowel. Sadly, the woman died a short time later.

**Findings**

It was held that the wound care provided to the woman was not of an acceptable standard, and did not comply with the rest home policy on wound management. It was also considered that there was a lack of compliance with the pain management policy, and poor documentation in respect of the woman's input and output. Further, it was concerning that the woman's constipation was treated infrequently, and that medical attention was not sought when her condition deteriorated.

Overall, by failing to ensure that the woman received services with reasonable care and skill, the rest home breached Right 4(1).

**Recommendations**

In recognition of the sale of the rest home, it was recommended that the company satisfy itself that the deficiencies in the care identified in this investigation are not of concern in other facilities operated by the company. It was also recommended that the rest home provide a written apology to the woman's family.