Care of elderly man following fall; DHB complaint handling (09HDC01357, 30 June 2011)

Public hospital ~ District health board ~ Paraphimosis ~ Pseudo-obstruction ~ Seconded staff ~ Communication ~ Administration of medication ~ Complaint handling ~ No breach ~ Adverse comment

The daughter of an 86-year-old man complained about the care he received when he was admitted to a public hospital following a fall at home. His daughter, who was also his primary carer, stayed with him during most of his month-long hospital stay. Following emergency department and orthopaedic review confirming a vertebral compression fracture, the man was admitted under the general medical team's care but as an outlier to a surgical ward.

Standard of care

The man developed a complication due to his catheter (paraphimosis), which was attended to by the surgical registrar once identified. The man experienced constipation due to opiate pain relief medication, abdominal distension and dehydration. A diagnosis of pseudo-obstruction was considered. The treatment plan included having a nasogastric tube on free drainage to rest his bowel.

The man steadily progressed, was moved to the medical ward, and was able to be transferred to rehabilitation services a week later.

While some communication deficiencies were identified during the man's stay on the ward (predominantly concerning his pain relief regime, nutrition plan and eventual transfer to the medical ward) which the DHB apologised for and reflected on, the overall standard of clinical care provided to the man was reasonable in the circumstances and did not amount to a breach of the Code.

Medication issue

The man's daughter raised concerns during the hospital stay that, during an extremely busy shift requiring additional staff being seconded to the ward from elsewhere in the hospital, her father was incorrectly given another patient's medication. Despite sufficient DHB policies in place governing incident reporting, a series of nursing shortcomings and miscommunications meant the daughter's concerns were not sufficiently looked into by DHB staff. The eventual DHB investigation could not prove whether or not a medication error occurred, however, it found that the DHB did not take appropriate steps to promptly and effectively look into and resolve the complaint at the time of the events.

It was not possible for HDC to ascertain definitely whether the man received his own medication late or received another patient's medication.

With regard to the possibility that he received his medication late, the available evidence indicated:

- the man's medication was withdrawn from the Pyxis machine at around 8.06pm;
- his medication was recorded as being administered at around 8.30 pm;

- his daughter left his room and did not see him receive his medication;
- the nurses involved were unable to recall the events.

As there were no further withdrawals for the man, it is clear he did not get his own medication twice. The alternative explanation is that the man was administered another patient's medication at around 10pm. The nurse who administered the medication at around 10pm did not record it in the man's notes or in any other patient's notes. The administration of another patient's medication was not able to be discounted entirely, but there was insufficient evidence to conclude that this had occurred.

Adverse comment was made about the lack of an explicit DHB guideline relating to seconded staff administering medication, and because there was no explicit requirement that the staff member who administers medication must be the person who records the administration in the patient's records.