Care of pressure areas in rest home
15HDC01232, 5 March 2018

Rest home ~ Registered nurse ~ Aged care ~
Wound care ~ Pressure areas ~ Communication ~ Right 4(1)

A hospital-level resident at a rest home developed pressure areas on her heels and sacrum. Over the following months, the wounds were assessed regularly and the conditions described on wound care plans by various rest home staff. The sacral wound descriptions were sometimes contradictory in respect of how well the wound was healing.

There are different versions of events regarding the number of attempts made by the clinical and nurse manager to contact the regional wound care specialist for advice on managing the pressure areas.

The woman was reviewed regularly at the rest home by general practitioners (GPs) from a local medical centre, but the sacral wound was not reviewed physically by a GP until some time later, when it was noted to be at risk of infection, and antibiotics were prescribed. Sadly, the woman died a week later.

Findings

The rest home had the ultimate responsibility to ensure that the woman received care that was of an appropriate standard. It was found that the descriptions of the woman's sacral wound in the wound care plans, made by various staff, were inaccurate and inconsistent over a period of approximately three months. The wound care policy and form contributed to the inaccurate and inconsistent wound descriptions by staff because it did not guide staff to assess wounds objectively. Further, rest home staff did not provide the GPs with full and accurate information to enable them to make sound, accurate decisions.

Overall, the care provided to the woman by the rest home was not adequate. Accordingly, it was found that the rest home did not provide services to the woman with reasonable care and skill, and breached Right 4(1). Adverse comment was also made about the management of the rest home and the communication with the woman's family.

The clinical and nurse manager was responsible for the clinical oversight of other staff and for ensuring effective nursing care. It was found that she should have done more to advocate for the woman and ensure that she received appropriate wound care. In all of the circumstances, the clinical and nurse manager did not provide care to the woman with appropriate care and skill and, accordingly, breached Right 4(1).

Other comment was made that based on the information available to the GPs at the time of the reviews, it was acceptable that they did not review the woman's sacral wound physically. Comment was also made about the different versions of events regarding what was communicated between the clinical and nurse manager and the regional wound care specialist.

Recommendations

It was recommended that the rest home arrange training for its staff on wound care, effective communication with family members, clinical documentation skills, and effective communication with GPs and other clinical personnel.

It was recommended that the rest home and the local district health board work together to agree on a standard process for requesting advice from the specialist wound care team.

Finally, it was recommended that the rest home and the clinical and nurse manager each provided a written apology to the woman's family.