Documentation of care plan and deterioration of patient
17HDC00187, 21 March 2019

District health board ~ Lymphoma ~Fall ~Deterioration ~ Patient Admission to Discharge Plan ~ Documentation ~ Right 4(1)

A woman was admitted to a public hospital for the ongoing treatment and management of lymphoma. Numerous staff provided care, including specialists and nurses. A Patient Admission to Discharge Plan (PADP) was not completed for the woman on the day of her admission and, as a result, there was no clear baseline to assist staff to detect changes in the woman's condition and to revise her care. A PADP includes risks assessments for falls and delirium and an individualised Patient Care Plan. Some parts of the PADP were completed on the third day but other parts were incomplete.

Over the next few days the woman's general condition deteriorated, and various documents note a number of indicators that she was at increased risk of falling, including her fatigue and need for assistance, and her breathlessness and disorientation. However, the Patient Care Plan and falls and delirium assessments were not completed regularly.

Several days after the woman's admission, she fell and hit her head at 6.20am. No injuries were visible apart from redness on the back of her neck. She was reviewed by a doctor at 7.40am but did not receive a full assessment until 9.40am. During this assessment the haematology registrar noted a small skin laceration and bruising, and ordered a CT scan. At 12pm a physiotherapist recorded that the woman was displaying some confusion and that her neurological condition was worsening. The house officer agreed that there were new symptoms. A CT scan was performed at 1pm, and at 1.30pm the woman was examined by a consultant haematologist. At this stage, the woman's fall and her condition were discussed with her family for the first time since the fall. The family were advised that it was likely that the woman had central nervous system lymphoma and that her prognosis was poor.

The woman's neurological status continued to deteriorate, and at 2pm she was recorded as "virtually unresponsive". Neurological observations were taken during the afternoon, and she was reviewed by a number of healthcare providers. Apart from a brief entry by the nurse who took the woman for the CT scan, there were no nursing entries in the progress notes until 4.05pm. The woman received ongoing care, and died two days later.

Findings

District health board (DHB) staff did not complete a PADP on the day of the woman's admission, and subsequently did not update the PADP accurately. In addition, following the woman's fall, full assessments of her condition were not completed adequately, her changing condition was not monitored accurately, and there was an unacceptable delay in communicating with the family regarding the fall. Accordingly, the DHB failed to provide services to the woman with reasonable care and skill, and breached Right 4(1).

Recommendations

The DHB advised that it has conducted regular audits of staff compliance with PADP documentation, and that significant improvements have been made to staff training on the completion of PADPs. The DHB also advised that it will review the way in which the use of the PADP documentation can support staff to assess an individual patient's needs and recognise deterioration.

It was recommended that the DHB provide HDC with the outcome of its review, and provide a letter of apology to the woman's family.