Care of rest-home resident with leg ulcers
16HDC01437, 7 August 2019

Rest home ~ Wound care ~ Sepsis ~ Documentation ~ Right 4(1)

A 71-year-old woman was initially discharged from a public hospital to a rest home following an InterRAI assessment that concluded that she required long-term hospital-level care. The woman had a background of severe peripheral vascular disease (PVD), congestive heart failure (CHF), and Type 2 diabetes. She had had a below-knee amputation and an angioplasty.

The hospital recorded that if her right leg ulcers did not improve, the woman would require surgical review. Its discharge plan to the rest home included the recommendation that the woman have ongoing podiatry input.

The woman developed five further wounds while at the rest home, and staff documented these wounds in wound care plans and continuous wound assessment charts (CWACs).

The woman's clinical records in the last two months make frequent reference to her wounds being malodorous during dressing changes, with varying degrees of exudate. A care plan for pressure injury prevention was not put in place for some time, and there is no documentation to show that there was ongoing assessment of the woman's wounds overall.

The woman experienced considerable pain during wound reviews and procedures relating to them. There is no evidence that any form of pain relief was offered to the woman prior to dressing her wounds, and there was no specific care plan in place for managing the pain associated with her wounds. Rest-home staff used a "+" sign as a measurement of pain in the CWAC documentation, which could not be interpreted consistently between staff.

The woman was noted to be "weak but … responding", and the next day became unresponsive and an ambulance was called. She was transferred to hospital. Her hospital records show that she was admitted with deteriorating chronic leg and sacral wounds, necrosis at her amputation site, and two sacral pressure sores with significant erythema.

The following day, a nurse recorded: "[Below-knee amputation] — necrotic stump extending over knee, [no] exudate noted, malodorous, maggots present." It was noted that maggots were also found in the woman's right foot wounds, and that the woman's right toes all had necrotic tissue. The woman died as a result of sepsis secondary to her infected ulcers.

After these events, the rest home was sold. The former director advised that he held no relevant information about the rest home because he no longer had possession of the laptop where the information was stored, nor was the information stored elsewhere.

Findings

The rest home was found to have breached Right 4(1) because it failed to provide services to the woman with reasonable care and skill with regard to her wound care, documentation and assessment, reporting processes, oversight of her overall condition, pain management, and GP and specialist referral.

The rest home was also criticised for failing to have important information relevant to the woman's care securely stored or backed up so that it could be accessed as required.

Recommendations

It was recommended that the rest home provide a written apology to the woman's family.

It was further recommended that the rest home's current owners provide evidence of (a) relevant changes it has implemented since these events; (b) training for rest home staff in relevant areas; (c) development of relevant guidelines; and (d) an audit regarding accurate completion of wounds care plans and incident forms.