Care of elderly man following fall
(13HDC00732, 26 June 2015)

District health board ~ Public hospital ~ Nursing care ~ Assessment ~ Pain medication ~ Nutrition ~ Right 4(1)

The family of an 89-year-old man complained about the care he received in a public hospital. He had a history of Type 2 diabetes (treated with insulin), ischaemic heart disease, hypertension, dyslipidaemia, psoriasis, and transurethral resection of the prostate. Previously he had had a triple bypass.

One day, the man fell while out walking. He was taken to hospital by ambulance. The man was found to have a hip fracture and was reviewed by the medical and orthopaedic teams. Due to his poor clinical condition, the plan was to address his medical issues prior to operating on his hip.

Throughout the man's 15-day stay at the hospital, he spent time in four different wards. He complained of hip pain frequently, and was vomiting. The pain team reviewed the man several times throughout his stay and made recommendations. A range of oral and intravenous medications was given to alleviate his pain, minimise his confusion and reduce his vomiting. However, often he refused oral medications, and sometimes the intravenous line did not work properly.

The man also frequently refused food and drink. He was given fluids intravenously and subcutaneously. Speech language therapists reviewed him but were unable to assess him because of his drowsiness and inability to follow instructions. A referral to a dietitian was made on day 14 of his admission.

The man had become confused since his fall, and was very restless during his time in hospital. He was given a low bed, and partway through his stay was transferred to a low stimulus area. A suprapubic catheter was inserted in an attempt to reduce his restlessness. At times the man had an observer in attendance. Laboratory tests indicated a possible urinary tract infection, which was treated with antibiotics. A CT scan of his head did not show anything of concern.

On day 8, a decision was made to proceed to hip surgery. Following some confusion between staff and the man's family as to what time he would have the surgery, the man went into theatre the following afternoon. The surgery was uneventful.

Early one morning a few days following surgery, the man's family called the hospital and were told that he was resting. Later, at 8am a nurse found him cold and unresponsive, and, soon afterwards, he died.

Critical thinking was lacking in relation to the evaluation of the man's pain and the management of his oral care, fluids and nutrition. It was held that the man's assessment and management were suboptimal with regard to his pain, oral care, nutrition and fluids. Overall, the DHB failed to provide services to the man with reasonable care and skill and, accordingly, breached Right 4(1).