Wound care at rest home
(12HDC01286, 16 January 2015)

Rest home ~ Clinical manager ~ Facility manager ~ Wound care ~ Documentation ~ Rights 4(1), 4(2)

A 90-year-old woman was a resident at a rest home facility that also provided hospital-level care. The woman had a skin cancer lesion removed from her lower left leg at a public hospital (the hospital) and was subsequently discharged back to the rest home the same day. The discharge summary stated that the woman should stay in the hospital wing of the rest home however the woman remained in her room in the resident's wing, as there were no available beds in the hospital wing. A new care plan was not implemented when the woman returned to the rest home.

Over the next 12 days, the woman continued to have follow-up at the hospital's outpatient plastics clinic with regard to her wound care. Her wound care was then undertaken at the rest home.

Approximately four weeks following surgery, a swab taken from the woman's wound indicated an infection, and the woman's general practitioner (GP) prescribed antibiotics for her. There is no record that either the woman or her daughter were informed that the woman had an infection.

Approximately two months following her surgery, the woman's daughter found the woman in her room in a confused and distressed state. The facility manager reviewed the woman; however there is no record of that assessment. The GP visited the rest home that afternoon but he did not review the woman.

The following morning the woman was again confused and disorientated, and had slurred speech and visible right-sided drooping of her mouth. The facility manager assessed the woman and considered that she had had a stroke. The GP assessed the woman a few hours later and arranged her transfer to the hospital. The medical team at the hospital concluded that the woman had overwhelming sepsis and pneumonia (not related to the infection previously discovered in the woman's wound). The woman died one week following admission to the hospital.

It was held that the rest home's documentation of the woman's care and treatment did not meet the New Zealand Health and Disability Sector Standards, and fell well below an acceptable standard. Accordingly, the rest home breached Right 4(2). The rest home also failed to ensure that the woman received clinical care that was of an appropriate standard, breaching Right 4(1). Adverse comment was made with regard to the rest home's responsibility for its staff's communication with the woman and her daughter, as her primary contact person.

The facility manager failed to ensure that she and the other staff provided adequate care and treatment, and breached Right 4(1). The facility manager also failed to ensure that she and the other staff complied with policy and professional standards with regard to documentation and breached Right 4(2). Adverse comment was made about the facility manager, with regard to the failure of staff to communicate adequately with the woman's daughter regarding her transfer to hospital.

The clinical manager failed to ensure that the woman received adequate clinical care with regard to her wounds in breach of Right 4(1). The clinical manager also failed to ensure that she and other staff complied with policy and professional standards with regard to documentation and breached Right 4(2). Adverse comment was made about the clinical manager with regard to the failure of staff to communicate with the woman regarding the infection in her leg.

Adverse comment was also made with regard to an RN's failure to implement a wound care plan when the woman returned to the rest home following her surgery.