Management of deterioration of rest home resident (02HDC15234, 19 April 2005)

Rest home ~ General practitioner ~ Nurse ~ Caregiver ~ Dementia ~ Diabetes ~ Declining health ~ Gangrene ~ Incontinence ~ Palliative care ~ Communication ~ Family involvement ~ Documentation ~ Procedures and practice ~ Standard of care

When an 88-year-old rest home resident died, a complaint was made by his family against the rest home's hospital and the attending general practitioner. It was claimed that they had not responded adequately to the man's deteriorating condition, nor adequately informed his son, who had power of attorney, of the man's deteriorating condition and options for treatment. Of particular concern to the son was the development of gangrene in the man's right foot, although other aspects of care such as incontinence issues and skin care were raised. The man was transferred to the secure unit as his dementia worsened. His health went into decline in the ensuing five months.

It was held that the main causes of the deterioration of the man's feet and toes, and his lack of response to treatment, were the man's complex medical condition, history of smoking, and age, and no breach was found. Treatment, pain management, monitoring, and referrals were all appropriately managed. Reasonable efforts were made to communicate regularly with the man's son and daughter-in-law, who lived some distance away, and to keep the son up to date with progress. Treatment options were outlined, and appointments were made with specialists to discuss treatment options. The teamwork between the attending GP and the hospital staff was held to be of a very high standard.

There was, however, some divergence between hospital protocols and their implementation, which meant that some of the documentation of the man's treatment and progress was not as clear as it might have been. Although this was not found to have compromised the man's care, it was noted that policies need to reflect the reality of everyday practice. In particular, there seemed to be a lack of oversight of caregivers by registered nurses, and a reliance on progress notes as a basis for guiding daily care, rather than using a systematic, planned and consistent approach in which registered nurses planned care and then evaluated it and modified it as necessary. The risk was that information would get buried in progress notes and missed: progress notes were intended to record significant changes, not be used to record every aspect of care in detail. In a situation such as this, where the man's needs were complex, rapidly deteriorating and requiring specialised services, there was a risk that the fragmentary nature of a number of people recording clinical information in the progress notes could result in discontinuity of care.