End-of-life care provided to rest home resident (13HDC00196, 11 June 2015)

Rest home ~ End of life ~ Care planning ~ Pain management ~ Right 4(1)

An 83-year-old man was admitted to a facility for rest home level care. He had a diagnosis of prostate cancer, as well as other co-morbidities, but was mobile, relatively independent, and prescribed pain relief medication only on an as-needed basis.

Three months later the man's condition deteriorated. The rest home's general practitioner prescribed the man regular pain relief medication and, two days later, end-of-life care was commenced for the man. Standing orders, which allowed for the man to have more medication to keep him comfortable, were commenced the next day. The Liverpool Care Pathway was commenced two days later. The man died in the early hours of the following day.

Although there was some care planning for the man on his admission, no update was made to his care plan when his condition changed. The man's progress notes record that, while he was receiving end-of-life care, on a number of occasions he was in pain. The documentation shows that, rather than being actively and consistently assessed, monitored, and documented, pain management was provided in an ad hoc manner. These deficiencies in care stemmed from a lack of understanding amongst staff about the importance of care planning and pain management in the context of end-of-life care.

It was held that the standard of care provided to the man fell below an appropriate standard. The lack of appropriate care planning, inadequate pain management, and the general lack of understanding amongst staff about end-of-life care amounted to a failure to provide services with reasonable care and skill. Responsibility for that failure lay with the rest home. Accordingly, the rest home breached Right 4(1) of the Code.