Failure to recognise deterioration in elderly patient (11HDC01101, 19 May 2014)

District health board ~ Older person's health service ~ Rehabilitation ward ~ Vertebral trauma ~ Deterioration ~ Falls management ~ Medical review ~ Handover ~ Communication ~ Continuity of care ~ Rights 4(1), 4(5)

An elderly woman in her 90's was referred to a DHB's older person's health service. She had presented to her family doctor a few weeks earlier with low back pain and restricted mobility. She was subsequently admitted to a rehabilitation ward at a public hospital; a rest home; a medical ward at a second public hospital; and again to the rehabilitation ward at the first public hospital.

On the first admission to the rehabilitation ward the woman had a spinal X-ray showing a compression deformity at the T12 vertebra. She was assessed as a high falls risk. Morphine was charted as required. Her mood was very low.

Initially the woman was considered as being suited for discharge to hospital level care. However, after a family meeting it was planned that she be discharged to a local rest home for rest home level care. The discharge was to happen the day after a long weekend.

During her admission to the rehabilitation ward, the woman had seven reviews documented by doctors over the first 16 days. No medical review was documented in the final 11 days of her admission, despite her deterioration, which included increased levels of pain and a fall. Over the long weekend there were no routine ward rounds or multidisciplinary team meetings, and no doctors were asked to see the woman.

The rest home was not contacted by DHB staff the day before or the day of discharge, and was therefore not ready to accept the woman when she arrived. The woman stayed at the rest home for three days, before being acutely admitted with abdominal pain to the medical ward of the second public hospital.

On admission to the medical ward the woman had investigations relating to her abdominal pain. She had an unwitnessed fall and the sensor clip she was wearing was found not to have batteries in it. The woman had MRI tests and was placed on antibiotics for presumed infections. Test results led to an incidental finding of a T12 fracture and spinal canal narrowing.

The woman was transferred back to the rehabilitation ward at the first public hospital. A spinal MRI was ordered. Initially no sensor mats were available on the ward to assist with falls management. Despite changes to falls strategies, the woman had two further falls. The MRI showed a new T11 fracture and further compression of T12 causing spinal stenosis.

After discussions with family and neurosurgeons, a conservative approach to care was taken. A placement for private hospital level care was arranged and the woman was transferred. The woman died a few weeks later.

The DHB team caring for the woman failed to interpret and recognise the signs of a declining patient who was in pain, particularly in the 11 days leading up to her discharge from the rehabilitation ward. This failure was a significant contributing factor to her not undergoing medical review during that time. Consequently, the level of assessment of the degree of vertebral trauma in this period was affected. There

were nursing deficiencies in falls management, and a lack of clarity and rigor in the assessment of the woman's suitability for discharge to rest home care. The DHB's care and management of the woman was below standard. Accordingly, the DHB breached Right 4(1).

Rehabilitation ward staff did not communicate appropriately with the rest home about the arrangements for the woman's discharge. This included both a failure to confirm transfer arrangements, and a failure to conduct any clinical handover. These failures had significant consequences for the woman's quality and continuity of care and, accordingly, the DHB breached Right 4(5).