# Lakes District Health Board

## A Report by the

## Health and Disability Commissioner

## Case 06HDC19538

## Parties involved

| | |
|---|---|
| Mrs A (dec) | Consumer |
| Mr A | Complainant/Consumer's husband |
| Dr B | Surgeon |
| Dr C | General practitioner |
| Dr D | Anaesthetist |
| Ms E | Registered Nurse |
| Ms F | Registered Nurse |
| Lakes District Health Board | Provider |

## Complaint

On 21 December 2006, the Commissioner received a complaint from Mr A about the services provided to his late wife by Lakes District Health Board. The following issue was identified for investigation:

> *The appropriateness of care provided to Mrs A by Lakes District Health Board from 10 October 2005 to the day of her surgery a few weeks later.*

An investigation was commenced on 5 June 2007.

## Information reviewed:

Information was received from:

- Mr A
- Dr D
- Dr B
- Rotorua District Coroner
- Lakes District Health Board

Independent expert advice was obtained from Dr Vaughan Laurenson and Dr Patrick Alley.

## Information gathered during investigation

*Background*
On 9 September 2005, Mrs A (aged 55) was reviewed by surgeon Dr B in relation to a mass in her right breast.

Dr B noted that Mrs A had an extensive medical history and was on a variety of medications. The conditions listed included morbid obesity, asthma, obstructive sleep apnoea and hypertension. Dr B said that although Mrs A was "generally well", she had "extreme dyspnoea,[1] even at rest".

Following further investigations, on 21 September 2005 the mass was confirmed as a grade 1 infiltrating ductal carcinoma. Having decided to perform surgery, Dr B advised Dr C, Mrs A's general practitioner, that her obesity was "going to make anaesthesia fraught with hazard". Dr B decided it was more appropriate for surgery to occur in the local public hospital (Rotorua Hospital), rather than a private hospital, so that Mrs A could have access to a High Dependency Unit (HDU).[2]

On 26 September 2005, Mrs A was placed on the urgent waiting list at Rotorua Hospital for a partial mastectomy and axillary clearance. Dr B documented that Mrs A would require an anaesthetic assessment prior to surgery.

*Cancelled surgery*
On 27 October 2005, Mrs A was admitted for the planned surgery. It was recorded on the preoperative assessment form that Mrs A was at a high risk of cardiovascular and respiratory complications. This form was "red-flagged", which meant that Mrs A was to be transferred to an HDU bed following surgery. It is noted on the form that the intended use of an HDU bed was discussed with Mrs A.

The clinical notes record that surgery was cancelled after consultation with the anaesthetist because of changes on the chest X-ray ("hilar shadow") which required further investigation. A CT scan of Mrs A's chest was performed on the same day (27 October 2005), and she was discharged home.[3]

However, Lakes DHB subsequently advised that surgery was postponed because there was no bed available in HDU that day:

> "The need for HDU was flagged on the clinical file and actioned on the first time [Mrs A] was booked for surgery [27 October 2005] to the extent that the surgery

[1] Dyspnoea: difficulty in breathing.

[2] High Dependency Unit: a unit where there is a higher ratio of nursing staff to patients, with specially trained staff, used for patients who require a higher level of clinical care. Rotorua Hospital has a combined ICU/HDU four-bed unit.

[3] The letter to Dr C dated 5 December 2005 stated: "CT chest/abdo as part of preoperative work-up was unremarkable …"

> was cancelled due to the lack of a bed in the HDU. It is my understanding that this information was not transferred to the second booking [a few weeks later]."

*Surgery*

A few weeks later, Mrs A was readmitted to Rotorua Hospital for the planned operation. Dr B stated that he contacted HDU and checked that a bed was available for Mrs A. Dr D stated that he also checked with Dr B that there was an HDU bed available for Mrs A for her care after surgery.

In contrast, the Associate Director of Nursing stated that there was no record of HDU expecting Mrs A to be admitted that day. She stated that a note would normally be made in the HDU diary to warn staff of an admission such as Mrs A's; on that date there was no such entry in the diary. She also spoke to the Unit's managers subsequent to the incident, and they were unaware of the plan to admit Mrs A.[4]

Mrs A underwent a right-sided partial mastectomy and axillary clearance. The operation took slightly over three hours, and was recorded as straightforward by the surgeons in the operation note.

*Post-anaesthetic care*

At 12.52pm, anaesthetist Dr D completed a verbal handover of care to registered nurse Ms E in the Post Anaesthetic Care Unit (PACU). Dr D stated that, after Mrs A's surgery commenced, the bed that he had been advised was available for her in HDU "became occupied by another patient from within the hospital".

Ms E recalls that there was no formal plan to transfer Mrs A to HDU, but "it was being considered". At 2pm, Ms E discussed Mrs A's condition with Dr D. Ms E stated that Dr D was "happy" with the clinical observations, and instructed Ms E to transfer Mrs A to the ward, "stating that he would review her there in half an hour". Having considered Mrs A's condition, Dr D decided that she could be transferred from PACU to a ward. He stated:

> "I was happy with [Mrs A's] observations in the [PACU] in the afternoon and decided to send her to the ward. I left clear instructions with the [PACU] nurse to hand over to the ward staff the need for pulse oximetry monitoring, supplemental oxygen and regular observations."

The postoperative instructions documented by Dr D, state (in entirety):

> "Morphine 0–20mg in PACU".

Ms E's clinical note relevant to instructions to ward staff states:

---

[4] The Associate Director of Nursing subsequently agreed that the HDU bed was not rebooked following the initial cancellation of surgery on 27 October, and agreed that Mrs A "fell through the cracks".

"As per clinical notes".

The postoperative instructions documented in the clinical record state:

"Breathing exercises
Arm exercises
TEDs[5]/Clexane
Mobilise when able please."

Dr B was not informed of the unavailability of the HDU bed, or that Mrs A was to be transferred to an orthopaedic ward from PACU.[6]

*Orthopaedic ward*
As the surgical ward had no empty beds, Mrs A was transferred at 2.15pm to an orthopaedic ward. Lakes DHB stated:

"[T]he Orthopaedic Unit is accustomed to accepting patients from theatre with surgical procedures and … does not provide a lesser standard of nursing care as compared with the Surgical Unit.

Inherent in the transfer to the Orthopaedic Unit was an expectation that [Mrs A] would be monitored with continuous pulse oximetry with relevant alarms. This did not occur."[7]

Registered nurse Ms F was responsible for Mrs A's care on her arrival in the ward. Ms F was busy that day owing to the number of high-dependency patients for whom she was caring. A total of five nurses were on duty for the afternoon/evening shift, caring for approximately 22 patients.

Lakes DHB advised that there was no specific care plan for Mrs A's management during her admission. In response to a request for a copy of the management plan, Lakes DHB referred to the correspondence between Dr B and Dr C, and to standardised postoperative plans for general postoperative patients and patients who had had mastectomies performed. The general postoperative plan states that vital signs should be recorded "half hourly until stable".

Despite Mrs A's obesity, she was nursed in a standard-sized hospital bed. Lakes DHB stated:

[5] TED: elastic stockings worn to prevent deep vein thrombosis.

[6] Dr B stated that he subsequently found out that the bed meant for Mrs A was allocated to a patient with a head injury who was being transferred to Rotorua Hospital by helicopter.

[7] Lakes DHB advised that the "oximeters used in the ward were portable ones and did not have alarms fitted". Pulse oximeters measure the amount of oxygen (oxygen saturation) in the blood. A reading of 95–100% would be considered normal.

> "A larger bed should have been arranged for [Mrs A] to be placed in on after her operation and this was not done. Communication was inadequate and we apologised that this had not been better managed for [Mrs A]."

Ms F recorded that Mrs A slept most of the afternoon. Late in the afternoon, Mrs A became very hot, and was transferred to a single room.[8] Ms F required the assistance of three of her nursing colleagues to change Mrs A's bed linen.

Mr A recalls:

> "[Mrs A] slept only fitfully in the afternoon. She was extremely hot, thirsty and restless, at one stage throwing her night gown and oxygen mask off.
>
> A family friend, who herself works in a hospital environment, was so concerned about [Mrs A's] distressed state that she visited [her] twice — late afternoon and early evening and both times went looking for a nurse and had difficulty finding one to come and check [her]. On one occasion she found that the fluid bag was empty.
>
> A larger bed was required from the start. [Her] niece also visited her in the afternoon and was told by a nurse to stand beside the bed to stop [her] from falling out while the nurse went away to get someone else to help. The niece felt that if [Mrs A] had moved at all, she would not have been able to stop her from falling to the floor."

At about 4pm, Ms F discussed Mrs A's condition with Dr D, the anaesthetist. Ms F stated:

> "We discussed the medical problems of [Mrs A], which mainly focused on her sleep apnoea. Since [that point] I was very alert in regard to her observations, I attached the oximeter and blood pressure machine to her for frequent automatic monitoring."

Ms F said that, although recordings for Mrs A were charted two to three hourly, she did monitor her more frequently.[9] Mrs A's blood pressure was measured using an electronic device. As it had run out of recording paper, the machine continuously emitted an audible "beep", which Mrs A's family and the other patients on the ward found distressing. Ms F told them to ignore the alarm and that it was of no concern.

At 10pm, Ms F recorded Mrs A's observations (blood pressure 100/65; 95% oxygen saturation). At 10.30pm, Ms F recorded Mrs A's oxygen saturation reading at 94%.

---

[8] Mr A stated that his wife was not transferred to a single room until "after 7.30pm".

[9] Observations were performed at 3.45pm, 5.30pm, 8pm, 10pm and 10.30pm. The oxygen saturations varied from 92% to 97%.

*Collapse and death*
At 10.35pm, Mrs A was found by Ms F to have stopped breathing. Her oxygen saturation reading was 58%, and a resuscitation procedure was commenced. However, the procedure was unsuccessful and Mrs A was pronounced dead at 11.05pm.

Dr B was not informed of Mrs A's condition until after she had died. He was "shocked" to learn that she had not been transferred to HDU/ITU, and had gone instead to an orthopaedic ward. Dr B advised that he would have expected to have been told by HDU/ICU or Dr D about the change in plan for Mrs A's postoperative care.

*Subsequent events*
When Mr A arrived at Rotorua Hospital — having been called urgently at 11.10pm — the hospital entrance was locked and no one was there to meet him.

Following the family's arrival on the ward, they found the nursing staff to be unhelpful, particularly in relation to questions asked about what steps to take next. Lakes DHB explained:

> "The nurses did not have a clear view of the Coroner's process and training is required to refresh staff on this process. There was no intention to be offhand or to be offensive and we apologised if that occurred."

Mrs A's family complained that, when they attended Mrs A after her death, there were "dead insects sprinkled over her sheets". Lakes DHB stated:

> "The trout flies are a real problem at this time of the year and ideally in preparation for the Coroner's post mortem staff would have made more effort to manage this. Screens for the windows are being sourced and fitted to reduce the number of insects, however this is an annual problem and it is difficult to eliminate them."

The family members were also upset to find that an endotracheal tube, which had been used during the unsuccessful resuscitation attempt, was still in place.

Following her death, Mrs A's family requested a copy of her clinical record, and received an unhelpful response from staff. Mr A stated in his complaint:

> "I decided to obtain [Mrs A's] clinical records. At first I was bluntly told 'you can't have them' for ten years. The office staff weren't interested in explaining that you could, in actual fact, have copies and I needed a solicitor's letter to uplift them."

Lakes DHB stated:

> "We acknowledge that this is unsatisfactory and will work with the records department to ensure they are more informative and helpful in the future."

On 30 November 2005, Mr A sent a letter to Rotorua Hospital expressing concerns about his wife's care and the subsequent dealings with the family, but no acknowledgement was received until early January 2006. Senior medical and nursing staff met with the family at Rotorua Hospital on 27 January 2006, and an apology was offered for the deficiencies in care and communication. This was followed up by a letter dated 14 February 2006. However, the family remained unhappy about what had happened, and subsequently complained to the Health and Disability Commissioner, prompting this investigation.

*Changes made by Lakes DHB*
Lakes DHB advised that, as a result of a review of the events surrounding Mrs A's death, the following changes have been made:

"…

- Suction upgrade so that all major post op patients must be nursed in a room with continuous wall suction.
- New system to ensure 'Red Flag Status' for HDU admission remains on patient information until surgery is completed.
- Upgrade of electrical points at each bed space to ensure adequate electrical outlets are available to provide modern health care.
- The purchase of new continuous pulse oximeters.
- The emergency trolley is now situated in the hallway rather than in an unlocked cupboard, for easier access.
- Approximately 95% of the staff in the unit have participated in an Advanced Certificate of Life Support Education.
- Mock arrests to test equipment and staff competency.
- There is an identified senior nurse as coordinator for each shift. This nurse carries a pager to enable easier communications with the hospital duty managers.
- The duty managers have a responsibility to meet relatives at the door of the hospital when they are called in an emergency.
- Window screens installed to reduce the occurrence of trout flies."

Lakes DHB reviewed its clinical guidelines following this incident. Consequently, new guidelines were developed for:

- Handover of patient from intraoperative care to post anaesthetic care unit (Appendix 1)

- Management of patient in PACU (Appendix 2)
- Patient transfer from PACU to unit (Appendix 3)
- Intravenous opioid administration
- Pre and postoperative nursing care — general (Appendix 4)
- Care of the deceased patient (Appendix 5).

Lakes DHB also advised that all surgical wards now have blood pressure and blood oxygenation monitoring equipment available, all postoperative rooms are fitted with wall suction, and there are guidelines for postoperative nursing care.

*Detecting and responding to deteriorating patients*
Mr A stated:

> "My family would like to see something positive come out of this and request that the Lakes District Health Board take a serious look at an observation system — NEWS (North Shore Early Warning System) that has been successfully used on the wards at North Shore Hospital. This system can quickly pick up any deterioration in a patient and has follow up steps to ensure that the patient receives the appropriate medical attention.
>
> The system not only ensures the best care for the patient but also safeguards staff.
>
> We feel strongly that there may have been a quite different outcome if [Mrs A] had been monitored more effectively."

Lakes DHB responded that it has now introduced an early warning system which is modelled on the North Shore Early Warning System.

## Independent advice to Commissioner

*Anaesthetic advice*
The following expert advice was obtained from Dr Vaughan Laurenson:

> "I have been asked by the Commissioner to provide an opinion on case number 06/19538 regarding the late [Mrs A]. I have read and agree to follow the Commissioner's guidelines for Independent advisers.
>
> I am a specialist anaesthetist in active clinical practice in a major metropolitan centre. I qualified MBChB 1972, FFARACS 1981, and FANZCA 1992.
>
> I have been asked by the Commissioner to provide expert advice on the following issues:

[At this point Dr Laurenson sets out the information sent to him, and the questions asked of him, which he repeats in the body of his report. These have been omitted for the purpose of brevity.]

…

*Summary of events*

On 9 September 2005, [Mrs A] (aged 55) was reviewed by her surgeon, [Dr B], for a persisting, asymptomatic mass in the tissue of her right breast. [Dr B] noted that [Mrs A] had an extensive medical history with the most pressing condition being morbid obesity. [Dr B] observed she had 'extreme dyspnoea, even at rest'.

On 21 September 2005 the mass was confirmed as a carcinoma. [Dr B] noted that [Mrs A's] morbid obesity was 'going to make anaesthesia fraught with hazard', and decided it was more appropriate for surgery to occur in the public hospital so that [Mrs A] would have access to ICU (intensive care unit) facilities if required.

On 10 October 2005, [Mrs A] was preadmitted for surgery. At that clinic visit she was assessed by her anaesthetist [Dr D]. He documented the problems of hypertension, hypothyroidism, asthma, obstructive sleep apnoea and obesity. He graded her as ASA III, commented on the need for HDU (high dependency unit) availability and wrote 'red flag' on the top of the assessment sheet. According to Lakes District Health Board (DHB) red flag is the start of the system that warns that an HDU bed is required.

She was admitted for surgery on 27 October 2005. The clinical notes state that surgery was cancelled after consultation with the anaesthetist because of changes on the chest X-ray which required further investigation. A CT of her chest was arranged and she was discharged home. (Note: the clinical notes are at odds with the Lakes DHB response which stated 'that surgery was cancelled due to the lack of the bed in the HDU'.)

On the morning of […], [Mrs A] underwent a right-side partial mastectomy and axillary clearance at Rotorua Hospital. The operation took slightly over three hours, and was recorded by the surgeon as straightforward. Lakes DHB note that, before surgery commenced, both the surgeon and anaesthetist enquired as to the availability of a HDU bed and were told one was available. However, during the course of the operation this bed was taken for another admission.

At 12.52pm, anaesthetist [Dr D] handed over her care to staff nurse [Ms E] in the Post Anaesthetic Care Unit (PACU). [Mrs A] did well, requiring only small amounts of pain relief, and her respiratory and cardiovascular recordings in PACU were as expected.

At approximately 2pm, [Ms E] discussed [Mrs A's] ongoing care with [Dr D]. [Ms E] recalled that [Dr D] was aware that [Mrs A] was to be transferred to a ward. At 2.55pm [Mrs A] was transferred to an orthopaedic ward.

Registered nurse [Ms F] stated that the orthopaedic ward was busy that day and her workload heavy due to the number of high dependency patients for whom she was caring. [Dr D] reviewed [Mrs A] at about 1600 hrs. He was obviously satisfied with their progress at that stage, but took the time and trouble to find [Ms F], her nurse, and explain the potential problems to her.

Between 1700 and 1800, [Mrs A] was described as being very hot and nauseated, so she was transferred to a single-room. At this time [Mrs A] apparently received antiemetic (I am not able to ascertain which drug from the information provided, but something was given at 1700hours). At about the same time [Mrs A] was washed. [Ms F] states that although recordings for [Mrs A] were charted 2–3 hourly, she did monitor her more closely. [Mrs A's] chart shows that her oxygen saturation levels were stable (92–96%) until 10.30pm. At 10.35pm [Ms F] found [Mrs A] lying on her side and her oxygen levels had dropped to 58%. [Mrs A] stopped breathing soon after that and CPR commenced. The cardiac arrest team arrived but their attempts to resuscitate her were futile and [Mrs A] was declared dead at 2305.

**Expert advice requested**

*Comment on the standard of care provided to [Mrs A] from 10 October to [the day of her surgery].*

[Mrs A] was seen by her anaesthetist preoperatively in the clinic environment in which there was adequate time for assessment and discussion of the potential clinical problems. The perioperative risk of obesity was identified and the red flag process initiated, apparently to organise a HDU bed postoperatively. However ASA III means that apart from her obesity [Dr D] did not think she was an excessive risk.

[Mrs A] was scheduled for surgery on the 27th of October. Apparently the preoperative chest X-ray showed some abnormality which required a CT to clarify or exclude the problem. Surgery was postponed to allow this to happen. There is nothing in the notes to support the Lakes DHB version of events. It is unfortunate that this abnormality on the chest X-ray report was not been picked up before her admission. This represents a low level systems error. The decision to postpone semi-elective surgery to clarify any potential problem is, in my opinion, the correct thing to do.

[A few weeks later] the surgeon and the anaesthetist proceeded with surgery in the expectation and belief that a HDU bed would be available. [Mrs A] did very well in PACU. Her progress was reviewed by the anaesthetist at about 1400 hrs and she

was discharged to a ward. The anaesthetist reassessed her at 1600 hrs. He apparently found no cause for concern.

In my opinion the perioperative period was appropriately managed by doctors and nurses performing at an appropriate skill level. The anaesthetist was forced by resource constraints to make the decision to let her go to the ward. This was done after due consideration, and he reviewed her several hours later to ensure [Mrs A] was progressing satisfactorily.

It is also my opinion that the decision to manage [Mrs A] on a ward instead of HDU was appropriate given the assessments made of her clinical progress during the day. The normal reason for HDC/ICU backup for a patient like this is the high likelihood of respiratory problems. While the ability to do blood gases may have been useful there is nothing in the notes to suggest that they would have been indicated. Given the rapid deterioration (observations were completely normal at 2200 hrs), and the pathologist's belief that [Mrs A's] death was the result of a cardiac event, it is unlikely that HDU environment would have made any difference.

*Comment on how the systems in place at Lakes DHB contributed to the standard of care provided to [Mrs A].*

The system for booking HDU/ICU beds appears to have failed. However it may have been that the clinician who admitted the other case while [Mrs A] was being operated on made a conscious triage decision. This is not clear from the information provided. It is also not clear to me whether the notes/reports are referring to a HDU bed or an ICU bed, or whether the terms have been used interchangeably.

The system for organizing beds for postoperative patients appears to have failed. Lakes DHB claimed that the red flag system failed to identify the need for a HDU bed but it appears that they did not even have a bed in the surgical ward available for [Mrs A].

I am not an expert in nursing matters, especially levels of competency and caseloads for nursing staff. My comments on the nursing care are made from the perception of an anaesthetist. The situation on the orthopaedic ward does not appear to have been satisfactory, either from the point of view of the family or from [Mrs A's] nurse. [Mrs A] was of such a size that four nurses (there were only five on the ward) were required to assist her onto a bed pan, wash her, and change her bed linen. Those tasks would have taken some time. This and other comments from [Ms F] raise doubts about the adequacy of nursing support on the ward for dealing with [Mrs A].

The failure to supply/replace the paper in the automated blood pressure machine which caused the alarm to continually sound was inappropriate. The nurses

apparently ignored it because they knew what it was. However alarm noises right beside the patient are very upsetting and certainly not conducive to recovery. Failure to attend to this apparently minor matter represents substandard care. I am unable to identify whether this problem was caused by supply problems (? was the paper available) or whether the nurses were too busy to reload the paper.

The systems and structures for managing patients, relatives and staff after the death of the patient seem to have failed.

It was not appropriate to leave the endotracheal tube in place after [Mrs A] was declared dead. It would have been appropriate if her death had occurred at induction of anaesthesia when the possibility of failure to correctly place the endotracheal tube may have contributed to her death. However in this situation she had already died and the tube was being placed in an attempt to resuscitate her. Leaving the tube in place only unnecessarily traumatizes the family.

Failure to arrange for her family to access the hospital when they were called back in was unnecessarily traumatic.

Failure to prevent insects having access to any postoperative surgical patient represents substandard care. I can imagine this was very distressing for the family.

Management of [Mrs A] and her family after her death appears to have lacked appropriate leadership. I am not aware of what procedures and protocols Lakes DHB may have in place to deal with this situation. This breach of standards may have been caused by a failure to implement protocols or a lack of protocols. From [Ms F's] comments it is obvious that the staff were traumatized by the events of the evening.

**Other comments**

It should be noted that there is no report from the anaesthetist involved. While it would have been interesting, I doubt it would alter the thrust of my report.

Comment has been made about the BP recordings. There is a major difference between the intraoperative recordings and the postoperative recordings. This does not concern me because [Dr D] was using anaesthetic agents to lower the BP, which often has the effect of reducing blood loss. Also he was using intra-arterial pressure which is more accurate than non-invasive blood pressure measurements used in recovery.

Other matters which I have been asked to consider commenting on by the Commissioner.

1. The treatment plan for the mastectomy was in the form of peri-operative protocols.

These concerned surgical matters and did not impact on the outcome of this case.

2. The documentation and planning of patients requiring HDU care post-surgery.

   Covered above.

3. The absence of a nursing care plan or management plan in [Mrs A's] clinical notes.

   I am not the appropriate person to be commenting on nursing care plans.

4. Having not been admitted to HDU, what would be the appropriate plan for [Mrs A's] ongoing care?

   Covered above.

5. Please comment on the appropriateness of the post-operative care, and the clinical observations performed on the ward following transfer from PACU.

   There were adequate observations done in the postoperative period. These did not meet the Lakes DHB Pre and Post-Operative Nursing Care — General — Guideline. The guideline I have been supplied with was dated February 2006 after the date of the event. I do not know what guidelines were in place at the time. [Ms F] states she was observing the saturation more often than she was writing it down. It does not appear that failure to record the observations has had any impact on the outcome.

6. The communication between clinical staff.

   This appears to have been good.

7. Any other aspects of the care provided to [Mrs A] that you consider warrants additional comment.

   No."

*Surgical/systems advice*
Independent expert advice was also obtained from Dr Pat Alley, who was asked to consider the systemic issues raised by this case.

"My name is Patrick Geoffrey Alley. I am a vocationally registered general surgeon employed by Waitemata District Health Board. Additionally I am the Director of Clinical Training for that DHB.

I graduated M.B.Ch.B from the University of Otago in 1967. I gained Fellowship of the Royal Australasian College of Surgeons by examination in 1973. After postgraduate work in England I was appointed as Full Time Surgeon at Green

Lane Hospital in 1977. In 1978 I joined the University Department of surgery in 1978 as Senior Lecturer in Surgery. I was appointed as Full Time Surgeon at North Shore Hospital when it opened in 1984. I am a Clinical Associate Professor of Surgery at the University of Auckland, have chaired the Auckland branch of the Doctors Health Advisory Service for many years and have formal qualification in Ethics which is utilised as a member of two institutional ethics committees. One is at Waitemata DHB, the other at Mercy Ascot Hospital. I declare no conflict of interest in this case.

I have been asked to comment on the standard of care provided to [Mrs A] (hereafter referred to as 'the patient') from 10 October to [the day of her surgery], with specific focus on the management of her care, the resources available, and the systems in place to co-ordinate her care. In particular, for these stages:

a. Preoperative;

b. Perioperative;

c. Postoperative;

d. Overall.

Further comment specifically on the following matters has also been requested.

1. The preoperative planning for patients requiring HDU care in the postoperative stage.

2. The absence of a management plan in this patient's clinical notes.

3. The appropriateness of the post-operative care, and the clinical observations performed on the ward following transfer from PACU.

4. Any other aspects of the care provided to the patient that warrant additional comment.

**Clinical Narrative**
It is not necessary to reiterate all the detail of the clinical circumstances of the admission, surgery and eventual death of the patient. There are however some notable features that require emphasis. I have divided this into the sections suggested in the request for commentary.

**PREOPERATIVE CARE**

1. The rationale for her surgery was clearly stated. The process whereby the suspected diagnosis of carcinoma of the right breast was secured, the outlining of the intended surgery and the discussions that this entailed are all satisfactorily done and duly recorded. Her significant anaesthetic risk was delineated in a letter

written by [Dr B] to [Dr C] (the patient's general practitioner dated 9 September 2005). In that letter [Dr B] commented *'[Mrs A] was generally well except for morbid obesity and extreme dyspnoea at rest'*.

2. [Dr B] further commented in another letter to [Dr C] dated 21 September 2005 *'there is a considerable problem of morbid obesity which is going to make anaesthesia fraught with hazard'*. Later in the same letter [Dr B] states *'prior to surgery I will make sure that [Mrs A] has a very good anaesthetic assessment … I will have to do [Mrs A] at the public hospital where we will be close to ICU (Intensive Care Unit) back up facilities'*.

3. On 26 September [Dr B] again wrote to [Dr C] reiterating the need for good anaesthetic assessment. I note that the surgical consent form was signed by [Dr B] as is appropriate given he was the practitioner going to embark on the surgery. His subsequent operation note was detailed and clear.

4. On 11 October 2005 the patient had a pre-operative assessment. I assume from the notes referred to me … that this was filled out by a nurse and then annotated with comments by [Dr D] the anaesthetist. In this assessment form hypertension, hypothyroidism, asthma, obstructive sleep apnoea and obesity are all again clearly identified as co-morbidities. The anticipated problem of respiratory and cardiovascular complications are recorded by the anaesthetist. There is a handwritten annotation 'HDU availability'. I am not sure whether this is a statement or a question, it is unsigned and undated. At the top of this page … is another undated, unsigned handwritten annotation 'red flag *', These appear to be the only written indications of an alert that this patient would require post operative care in a specialised environment.

5. The house surgeon admission notes added no new information to that already described.

6. [The] quality and risk manager of the Lakes District Health Board wrote to the Health and Disability Commissioner on 11 July 2007 … In that letter she states 'the surgery was cancelled due to the lack of a bed in the HDU' (high dependency unit). Perusal of the notes however indicates that the cancellation was not due to lack of availability of beds rather that an abnormality on a routine preoperative chest X-ray had been disclosed and that this required clarification by a CT scan. [She] also states in that letter that the need for an HDU was flagged, presumably referring to the annotation that I have mentioned already … .

**PERIOPERATIVE CARE**

1. Events in PACU are well outlined in the submission of [Ms E], a registered general nurse, who worked in that unit and who was responsible for her care after her operation. When she arrived in PACU her blood pressure was labile and from time to time quite high. Her oxygen saturations were acceptable between 92% and

95%. Staff Nurse [Ms E] says that at 1400 hours she spoke with [Dr D], the anaesthetist to discuss further orders regarding the patient's care. She says that [Dr D] asked that the patient be returned to the ward indicating that he would review her there in half an hour. It seems that this review by [Dr D] did not occur.

2. At 1410 hours a nurse from an orthopaedic ward came to collect the patient. This nurse was given a verbal and written report as to her previous history. There is no comment from [her] as to potential placement of the patient in an ICU or HDU. Perusal of the material provided does not reveal any comment about the patient's destination after her stay in PACU.

**POST OPERATIVE CARE**

1. … [another] Staff Nurse [on the orthopaedic ward] has written in the clinical record a succinct and clear account of her condition when she arrived on the ward.

2. A submission from Staff Nurse [Ms F] outlines her involvement with the patient. Between 1700 and 1800 hours the patient said that she was feeling hot and she was transferred to a single room. In this room she was attached to a pulse monitor to enable oxygen saturations to be recorded as well as her pulse however this was not alarmed. It is assumed that nursing staff were with the patient at 2030 when it is commented that [Mr A] left his wife's bedside.

3. The next time entry is at 2235 when the patient was found in extremis and a cardiac arrest call was instituted. There is therefore a two hour period in this patient's care where no one is really sure whether she was seen or not by nursing staff.

4. It has been described in other submissions that the suction in the side room was not working properly and this compounded difficulties with the management of her cardiac arrest.

**OVERALL CARE**

- Many health professionals involved with the care of this patient have made detailed accounts of the patient's co-morbidity. Almost all of these occurred pre-operatively therefore there was abundant and clear indication that she presented a more than considerable anaesthetic risk prior to her undergoing surgery.

- However informal the process was, with the somewhat random annotations previously alluded to, the patient was repeatedly and clearly identified as having greater than average risk of post operative complications. It is reasonable to assume that such a patient would not necessarily need a 'red flag' to alert staff to her situation. Her clinical circumstance would be so obvious as to demand that higher level of care be offered. It is not the case that her present condition at any

given postoperative point was the issue rather the potential for deterioration of the airway in such patients with obstructive sleep apnoea.

- Contributory factors to a fatal outcome for this patient are all found in her immediate post operative care. This is reminiscent of the congruence of errors described by James Reason in which a series of events that are normally singly correctible conjoin to produce a significant deleterious outcome. BMJ 2000; 320:768–770 (18 March).

- No ICU bed was apparently available. I can find no documentation that describes this lack of availability. She was admitted to a busy orthopaedic ward. The anaesthetist (presumably but not definitely) sanctioned this transfer. On admission to the ward her status was satisfactory but during the early evening, due to distress, she was placed in a side room effectively out of sight of the nurses around her. Whilst she was monitored with a pulse oximeter this was not alarmed so that when her saturations began to fall no nursing staff were aware of her deterioration.

The role of the practitioners involved in the patient's care is worthy of comment.

**SURGEONS**

The surgical care has been of a good standard. The letters indicate clearly the need for surgery, the alerting of co-morbidity and the need for special post operative care. Consent was properly obtained. I would however be concerned if the surgeon had not been apprised of the absence of an ICU bed necessitating transfer of the patient to a general ward. Whether he should have assured himself that her placement was appropriate or merely relied on the advice of others to tell him what the situation was in that regard is debatable. It would not be expected that a surgeon would stop his operating list to determine the best placement for such a patient. As with the anaesthetists however a post operative ward round may have indicated to him that she was in an unsuitable post operative care environment. I do not know if the surgeon was informed of the eventual placement of this patient.

**ANAESTHETISTS**

Further clarification from the anaesthetists about the patient's care would be valuable. I understand that [Dr D] is not available having now moved [overseas]. I would like to know who 'booked' the ICU bed if he did not, when he was told that such a bed was now not available and what his response to that was. It would also be of interest to know what conversations were had by nursing staff with him in respect of the disposition of the patient following her time in the post anaesthetic care unit. I note also that he undertook to visit the patient post operatively in the ward. There is no record that in fact he did so. He may well have been concerned to find her in the care situation that she was when she eventually died.

**NURSES**

At one level of direct nursing care the nursing staff seem to have generally done a good job. I would commend the quality of the recordings done both in the post anaesthetic care unit and when the patient was admitted first to the orthopaedic ward. I do not know if the decision to transfer the patient to a general rather than an ICU bed was made by a duty nurse manager or a medical specialist. The decision to subsequently put the patient in a side room, while superficially justified because of discomfort was unwise given the risk to the patient of an unattended airway. I am very well aware that this episode must have been a painful and difficult one for the nurses involved. I believe that the pathway to prevent a recurrence of the problem is best defined by the nursing community at Lakes DHB. I also believe there is real merit in that nursing community examining the relationship between the many protocols and guidelines that currently exist and actual clinical nursing practice.

**SUMMARY**

The major error in this case was the lack of appreciation of the potential post-operative hazards posed by this patient. Regrettably these were repeatedly and fully documented preoperatively by a variety of health professionals but nonetheless their import was not recognised in the preoperative and postoperative periods of her care. Given the extensive recording of the alerts, lack of appropriate action in the knowledge of those alerts and the fatal outcome I would regard this as a severe departure from standard practice.

**RECOMMENDATIONS**

The informal process described of alerting of patients with such significant pre-operative co morbidities needs to be corrected. There needs to be a proper 'default pathway' for patients who require such care after elective surgery.

- Elective surgical patients with significant problems deemed to required special care postoperatively need a formal identification to that effect on their charts.
- The bed should be 'booked' by the anaesthetist.
- If a bed in ICU is unavailable for such elective patients then the surgery should be deferred.
- If the ICU bed suddenly becomes unavailable because of an emergency situation (as presumably happened in this patient's case) with another patient then the elective patient should remain in the post anaesthetic care unit until such facility is available. Failing that, a special nurse should be employed to care for the patient until such time as an ICU bed is available.
- If that is not possible they should be in a general surgical ward rather than an orthopaedic ward and preferably one that is less busy.
- Whatever ward environment such patients are transferred to from PACU they should be in 4 bedded room equipped with properly alarmed monitoring and resuscitation devices.
- Single rooms in general wards should not be used for such high risk patients."

## Response to provisional opinion

*Lakes District Health Board*
In response to the provisional opinion, Lakes DHB acknowledged "the breach in the care provided to [Mrs A] under Rights 4(1), 4(2) and 4(5) of the Code of Rights".

The DHB submitted:

> "However untimely her death was it should be noted that the post-mortem report acknowledges that her death was cardiac of nature and that due to her heart disease [Mrs A] may have died at any time."

*Dr D*
Dr D stated that he accepted the preliminary conclusions, "in particular [his] lack of communication with [Dr B] regarding the transfer [of Mrs A] to the orthopaedic ward from the post-anaesthetic care unit".

## Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

*RIGHT 4*

*Right to Services of an Appropriate Standard*

*(1) Every consumer has the right to have services provided with reasonable care and skill.*

*(2) Every consumer has the right to have services provided that comply with legal, professional, ethical and other relevant standards.*

…

*(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

## Opinion: Breach — Lakes District Health Board

*Introduction*

The management of a patient in hospital requires the cooperation of a large team of clinical and non-clinical staff. This team is responsible for ensuring that the care provided to a patient is of an appropriate standard, from his or her first assessment until discharge from hospital. To this end, a hospital must have adequate systems in place to ensure that a patient's care is assessed, planned and delivered appropriately.

Mrs A did not receive care of an appropriate standard at Rotorua Hospital. Although her breast cancer surgery proceeded without incident, postoperative care was deficient in several respects, and her postoperative care was poorly planned and delivered. I accept the view of my independent expert, anaesthetist Dr Vaughan Laurenson, that it is unlikely that an HDU environment would have made any difference to the sad outcome for Mrs A, but that does not excuse the care failings. The situation was compounded by the shameful way that Mrs A's family was treated in the immediate aftermath of her death.

For the reasons given below, in my opinion Lakes District Health Board breached Rights 4(1), 4(2) and 4(5) of the Code of Health and Disability Services Consumers' Rights (the Code), by failing to meet the standards expected of a public hospital.

*Chest X-ray*

Mrs A was originally scheduled for surgery on 27 October 2005. There is some conflict in the evidence from Lakes DHB about why this surgery was cancelled — either because no HDU bed was available, or because an abnormality on her chest X-ray required further investigation. I endorse Dr Laurenson's view that the X-ray abnormality should have been identified at an earlier stage, and that this was a "low level systems error".

*HDU bed*

Mrs A was identified by the surgeon and anaesthetist as requiring an HDU bed following surgery because of her significant medical problems. However, when her surgery finally took place, although there was (according to Lakes DHB) an HDU bed available at the start of the procedure, none was available when she was finally ready for transfer from PACU.

Mrs A was reviewed in PACU by the anaesthetist and a decision made to transfer her to an orthopaedic ward, since even a regular surgical bed was not available. Dr Laurenson advised that this transfer was appropriate, "given the assessments made of her clinical progress during the day".

I note, however, that there is some conflict in Lakes DHB's explanation of why Mrs A was not transferred to an HDU bed. On one hand it advised that Mrs A's need for an HDU bed "was not transferred to the second booking" following the cancellation of 27 October 2005; on the other hand, I have been informed that both the surgeon and anaesthetist enquired as to the availability of an HDU bed immediately prior to surgery.

The Associate Director of Nursing for Lakes DHB stated that HDU had no record of Mrs A's intended admission, and the management of HDU were unaware of the intention to transfer Mrs A postoperatively. Ms E, the nurse in PACU, stated that there was no formal plan to transfer Mrs A, and it was simply being considered. I also note that there is no mention in any clinical record of a plan (or even a consideration) to transfer Mrs A to HDU. In any event, although I accept that Mrs A was not inappropriately transferred to a ward from PACU, there was clearly some confusion in Lakes DHB about the system of booking an HDU bed. Dr Laurenson advised, "The system for booking HDU beds appears to have failed." In my view, there is no question that that system *did* fail.

I endorse the view, accepted by the Associate Director of Nursing for Lakes DHB that Mrs A fell through the cracks in the system. This was an unsatisfactory state of affairs that jeopardised patient safety. It is also worthy of note that Dr B was not informed of the change of plan to transfer Mrs A to a ward, and was shocked to find out after her death that this had occurred. It is thus also clear that the anaesthetist failed to keep Dr B fully informed. The transfer was against the intentions of both the surgeon and the patient. Dr D should have discussed the proposed transfer with Dr B as soon as he became aware that there was no HDU bed available.

*Management of care on ward*
After Mrs A was transferred to the orthopaedic ward, some of the systems to ensure an appropriate standard of care broke down.

From her admission to the ward from PACU, Mrs A was nursed in a standard-sized hospital bed, which was unsuitable given her size. Lakes DHB accepts that a larger bed should have been available, but the "communication was inadequate".

A properly functioning District Health Board should have systems in place to ensure that a hospital patient who requires non-standard equipment has that equipment available. Mrs A was not an emergency admission; she was admitted for planned (albeit urgent) surgery. Her requirement for a larger bed should have been identified at her initial assessment, and appropriate actions taken to ensure that such a bed was available.

Mrs A was also nursed in a side-room, which appeared inconsistent with the need to observe her closely for postoperative complications. I note Dr Alley's advice that single rooms "should not be used for such high risk patients".

Mrs A had a number of comorbidities that necessitated special care, in particular her weight, breathing difficulties and hypertension. Yet no individualised nursing care plan was written. Although Lakes DHB has, since these events, introduced a more extensive postoperative protocol (see Appendix 4), at the time of Mrs A's admission the only guidance for staff was to perform half-hourly clinical observations until the patient was "stable". No parameters for "stable" were provided, and there was no advice about what clinical observations were appropriate.

Lakes DHB also advised that it had been an "expectation that Mrs A would be monitored with continuous pulse oximetry with relevant alarms". It is unacceptable that this "expectation" is not documented in any of Mrs A's records. Clinical instructions of such significance should be specifically documented.

As noted in the Capital and Coast DHB inquiry report:[10]

> "A proper plan would have set out the frequency and type of clinical observations required, and what actions should be taken if the observations altered significantly."

Although Dr D stated that he gave "clear instructions" to Ms E for Mrs A's care on the ward ("the need for pulse oximetry monitoring, supplemental oxygen and regular observations"), these instructions were not documented. In my opinion, Dr D should have documented his instructions.

An individualised management plan should have been developed, to take into account Mrs A's particular needs. This plan would have included clear instructions on type and frequency of clinical observations.

*Staffing*

Five nurses were on duty to care for 22 patients on the orthopaedic ward. Although this may be an adequate staffing level at a normal time, the time of Mrs A's admission was not a normal shift. Mrs A should have been nursed in HDU. She was highly dependent on the nursing staff to monitor her and assist with her care. I note that her allocated nurse required the assistance of three colleagues to assist with changing Mrs A's bed linen, and Mrs A's niece was asked to stand by the bed to stop Mrs A from falling from the bed while the nurse went for assistance. Another visitor recalls not being able to find a nurse on two separate occasions when she was concerned about Mrs A's condition. I share my experts' doubts about the adequacy of nursing support on the ward.

Even if Mrs A's initial clinical observations meant that it was appropriate for her to be transferred to a ward (rather than HDU) from PACU, it should have been anticipated that Mrs A was a patient who would require additional nursing support, and Lakes DHB should have responded to this situation accordingly.

*Equipment*

Blood pressure monitoring equipment attached to Mrs A when she was on the ward continually emitted a "beep" because it had run out of recording paper. This would have deprived the nursing staff of an important alert to any deterioration in Mrs A's condition. I note that Ms F recorded only one set of observations (at 3.45pm) during Mrs A's first three hours on the ward because of her workload. This is an inappropriate standard of care for a postoperative patient with significant risk factors, on a surgical ward.

[10] Opinion 05HDC11908 (22 March 2007), page 100.

The continuous beeping must have been disturbing for Mrs A and her family, let alone other patients on the ward. Nor would Ms F's advice to ignore the alarm have been reassuring. It seems inconceivable that such a situation could occur in a modern public hospital in 2005.

As noted above, Lakes DHB also advised that it had been an "expectation that Mrs A would be monitored with continuous pulse oximetry with relevant alarms". I have already commented on the failure of this instruction to be documented, but I note that the equipment available to nursing staff at that time did not include pulse oximeters with alarms. Again, this is inadequate. If a patient has been identified as requiring such equipment, it should have been provided. (I note that, according to Lakes DHB, appropriate equipment is now available.)

*Summary*

The numerous failings in the care provided to Mrs A were caused by poor planning of a scheduled operation for a patient with significant risk factors. An appropriately sized bed was not provided, and nursing staff were ill-supported to care for her in a non-HDU setting. There was no individualised plan designed to assist staff to manage Mrs A's specific needs, and the equipment used to monitor and record vital clinical observations was either not working correctly, or was not available. I also note that the anaesthetist failed to discuss with, or inform, the surgeon of Mrs A's intended transfer to a general ward.

I endorse the following comment of Dr Pat Alley, who advised me on the systems issues in this case:

> "The major error in this case was the lack of appreciation of the potential post-operative hazards posed by this patient. Regrettably these were repeatedly and fully documented preoperatively by a variety of health professionals but nonetheless their import was not recognised in the preoperative and postoperative periods of her care. Given the extensive recording of the alerts, lack of appropriate action in the knowledge of those alerts and the fatal outcome I would regard this as a severe departure from standard practice."

Mrs A did not receive postoperative care of an appropriate standard, and clinical staff did not properly co-ordinate their care. Lakes DHB failed Mrs A and her family. In these circumstances, Lakes DHB breached Rights 4(1), 4(2) and 4(5) of the Code.

## Other concerns

*Trout flies*
When Mrs A's family arrived on the ward after the traumatic news of her death, they were greeted by "dead insects sprinkled over the sheets". I am amazed that in a facility like Rotorua Hospital this problem cannot be satisfactorily rectified. I am not reassured by the response from Lakes DHB that "screens for the windows are being sourced and fitted to *reduce* the number of insects" (my emphasis).

*Communication with family*
When Mr A arrived at the hospital — having been called urgently at 11.10pm — the entrance was locked and no one was there to meet him. When he found his sister-in-law at his deceased wife's bedside, he found an endotracheal tube still in place.

At a time when accurate and sympathetic responses would have been of the greatest importance, the family did not receive the help they needed. Nursing staff failed to answer simple questions from grieving family members.

Lakes DHB has advised that the nursing staff "did not have a clear view of the Coroner's process", and that training has been put in place to deal with this. I note that Lakes DHB has made changes to its systems whereby there is now an "identified senior nurse coordinator for each shift". It is surprising that this was not in place at the time — Mrs A cannot have been the first patient to die unexpectedly at Rotorua Hospital.

When Mr A asked for a copy of his wife's clinical record after her death, he was told that he would have to wait for ten years. This was both inaccurate and unhelpful. Lakes DHB states that it "will work with the records department to ensure they are more informative and helpful in the future". It is lamentable that staff in the records department gave such inaccurate advice.

I also note that Mr A did not receive a written acknowledgement of his letter of complaint dated 30 November 2005 until early January 2006. This was a further failure by Lakes DHB.

The poor communication with Mrs A's family after her death was naturally very distressing to them. It showed a lack of compassion and a disregard of the duty that hospital staff owe to the family of a recently deceased patient.

As I stated in my Capital and Coast inquiry report:[11]

> "All too often, families are left in the dark after a patient is harmed or dies unexpectedly during a hospital admission. Hospital management and clinicians owe families a duty of candour in such circumstances — to openly discuss and honestly disclose what has happened, and to apologise for any shortcomings in care."

[11] 05HDC11908 (22 March 2007).

I note that in another recent case involving the unexpected death of a patient at Rotorua Hospital in January 2006,[12] I found that communication with the family was inadequate. Clearly, hospital staff need more training and support in this sensitive area.

## Non-referral to Director of Proceedings

Having found that Lakes DHB breached the Code of Health and Disability Services Consumers' Rights, I am required to consider whether it should be referred to the Director of Proceedings to decide whether further proceedings are warranted.

*Lakes DHB submission*
Lakes DHB submitted that it should not be referred to the Director of Proceedings:

> "You have proposed that Lakes DHB be referred to the Director of Proceedings for the purpose of deciding whether any proceedings should be initiated against the DHB. It is Lakes DHB's submission that this is not a matter for which the DHB ought to be referred to the Director of Proceedings, and you are requested to reconsider this proposal. In summary, the DHB states:
>
> (a) It is accepted that Lakes DHB has fallen short in the care provided to [Mrs A], and that a breach finding is warranted. Lakes DHB accepts that a Ministry of Health audit of the changes implemented by Lakes DHB is appropriate;
>
> (b) With there being a comprehensive and publicly available investigation report following your investigation, and recognising Lakes DHB's acknowledgement above, it is not in the public interest for the case to be the subject of further investigation and possible proceedings before the Human Rights Review Tribunal; and
>
> (c) A further investigation and the possible initiation of proceedings would in fact be contrary to the public interest in that it would have a significant impact on Lakes DHB's commitment, and ongoing ability, to deliver the best possible services to the community. Proceedings would redirect valuable resources away from the delivery of health services, and would have a significant adverse impact on morale at the DHB."
>
> Each of these points is now considered in further detail.

[12] 06HDC08129 (17 September 2007).

*Acceptance that Lakes DHB has fallen short*
Lakes DHB accepts that it has fallen short in the care provided to Mrs A. Lakes DHB accepts that a finding that Right 4 of the Code has been breached is warranted.

Lakes DHB has apologised to Mr A, and will do so again following conclusion of your investigation.

Lakes DHB has taken extensive steps to implement changes following the events surrounding Mrs A's care. These are referred to in [the] report. Lakes DHB is entirely supportive of the suggestion that the Ministry of Health audits the DHB to ensure that the changes have in fact been made. There is no objection to this recommendation in your report.

*Further investigation is not in the public interest*
…

It is Lakes DHB's position that there is no public interest in proceedings being instituted in the present case, and in particular there is no public health or public safety reason for further consideration of such proceedings. In support of this submission, Lakes DHB notes the following:

(a) As is clear from this letter, Lakes DHB accepts that it has fallen short in the care provided to [Mrs A], and that a finding of a breach of Right 4 of the Code is warranted;

(b) Your office has undertaken an extensive and comprehensive investigation which has resulted in a significant report that will be beneficial, not only to Lakes DHB, but to all DHBs and indeed the sector generally. It is noted that you intend to provide a copy of the final report to all DHBs, and to place the report on your website for educational purposes. It is submitted that there can be no doubt that the health sector and the public at large will have every opportunity to be adequately informed about the circumstances of the treatment of [Mrs A], and to learn from Lakes DHB's failings;

(c) Taking the above two points together, it is difficult to see any justification for initiating proceedings that could be based on any educational ground, or on any basis that proceedings would somehow set standards for the sector. These (laudable) objectives are readily achieved through the release of the final report. HDC reports do of course carry considerable weight in terms of medico-legal precedents. There is nothing to be gained from any further analysis of this case by a tribunal that may be less well equipped than your office to comment on appropriate standards of health providers in New Zealand;

(d) On the basis that there will be a final finding that Lakes DHB was in breach of the Code, the remedy available under section 54(1)(a) of the Act (being a declaration that the action of the provider is in breach of the Code) is now a

moot point. It is submitted that it could not possibly be said to be in the public interest to justify the considerable further expenditure of public funds, both within your office and within the DHB, in a proceeding to seek a declaration of a breach of the Code in these circumstances;

(e) The only other remedy potentially relevant under section 54(1) [of the] Act is the award of damages. This is not the place to discuss damages. However, if [Mrs A's] family have incurred any expenditure or suffered other loss, it may be there can be some sensible discussion around reimbursement. It is not necessary for the matter to require the continued investigation and consideration of proceedings in order to address such issues.

*Further investigation would be contrary to the public interest*
… Lakes DHB submits that any referral to the Director of Proceedings for the consideration of initiating proceedings is not only not in the public interest, but it is in fact contrary to the public interest.

In considering whether the DHB ought to be referred to the Director of Proceedings for the possible initiation of proceedings, the purpose of the HDC Act, and the strategies and objectives that must be taken into account when conducting investigations under the HDC Act, are relevant. The following points are emphasised:

(a) The purpose of the HDC Act is to protect and promote the rights of health consumers (section 6). If this objective can be achieved through the release of your final report, without initiating a further and costly process, that ought to be preferred;

(b) The obligation to take into account the broader impact of ongoing investigations on health consumers generally, and the community at large, is emphasised by the requirement in section 7 [of the] Act to take into account the objectives for district health boards as set out in section 22(1) New Zealand Public Health and Disability Act 2000 ('NZPHD Act'), so far as such objectives are applicable. It is submitted that the following objectives in section 22(1) [of the] NZPHD Act are directly applicable to the way in which the Commissioner must undertake and complete the investigatory functions generally, and how reports are prepared:

- Improving, promoting and protecting the health of people and communities (section 22(1)(a));
- Promoting effective care for those in need of health services (section 22(1)(c)); and
- Exhibiting a sense of social responsibility by having regard to the interests of health consumers (section 22(1)(g)).

Lakes DHB submits that the final report, when disseminated as proposed, will go as far as it is necessary to go in terms of achieving the Commissioner's statutory objectives, including the objectives in the NZPHD Act. Any further investigation and initiation of proceedings will be contrary to the statutory objectives referred to above, in that:

(a) nothing more will be achieved over and above what has already been achieved; and can be achieved quite independently from the initiation of proceedings;

(b) the initiation of proceedings will have a significant detrimental impact on Lakes DHB and its employees, with the almost inevitably high profile of such proceedings impacting on the morale of the organisation and the ability to attract staff, all to the detriment of the community at large; and

(c) significant resources, both financial and human, will need to be expended to respond to any proceedings. It is submitted that the public would be far better served by using such resources in striving to provide high quality services to the community, including purchasing new equipment, implementing systems for the analysis of adverse events, and so on.

It is submitted that the public interest is best served by allowing Lakes DHB to move forward and concentrate on the delivery of quality health services to the people of the region.

It is noted that in your 2006/07 annual report you referred to cases in that year referred to the Director of Proceedings to consider further proceedings '*because of major shortcomings in care or unethical practice'* (page 1). Lakes DHB submits that it could not possibly be said that, for all its shortcomings, that there were '*major shortcomings in care'* or '*unethical practice'* in the present case. Taking this and the points referred to above into account, it is submitted that it is not in the public interest to refer the matter to the Director of Proceedings."

*Decision not to refer Lakes DHB to Director of Proceedings*

I do not accept Lakes DHB's submission that "it could not possibly be said that there were 'major shortcomings in care' … in the present case". Although the surgery proceeded without incident, the lack of planning led to numerous failings in the postoperative care for Mrs A. There *were* major shortcomings from the time Mrs A left the Post Anaesthetic Care Unit until her death on the orthopaedic ward 11 hours later.

There is some force in the submission that further proceedings will be costly and will impact detrimentally on the staff of Lakes DHB. Of course, that will often be the case when a district health board faces the ultimate legal accountability — proceedings by the Director of Proceedings before the Human Rights Review Tribunal.

As I stated in the Capital and Coast inquiry report:[13]

> "Public identification in a Commissioner's Opinion that criticises a district health board's systems and finds it in breach of the Code will in most cases suffice as a means of accountability."

Mrs A's case is clearly a borderline case for referral. It is all too easy for a district health board to state that it should be allowed "to move forward and concentrate on the delivery of quality health services to the people of the region". Nevertheless, I accept that the public criticisms of Lakes DHB in this report and the finding that the DHB breached the Code is a sufficient form of accountability. I am satisfied that a thorough audit of Lakes DHB's hospital systems by the Ministry of Health will ensure that the necessary changes have indeed been made, to protect future patients. In all the circumstances, I do not consider that the public interest warrants a referral of Lakes DHB to the Director of Proceedings.

## Recommendation

I note that Lakes DHB has extensively reviewed various hospital systems and staff guidelines in the light of this case.

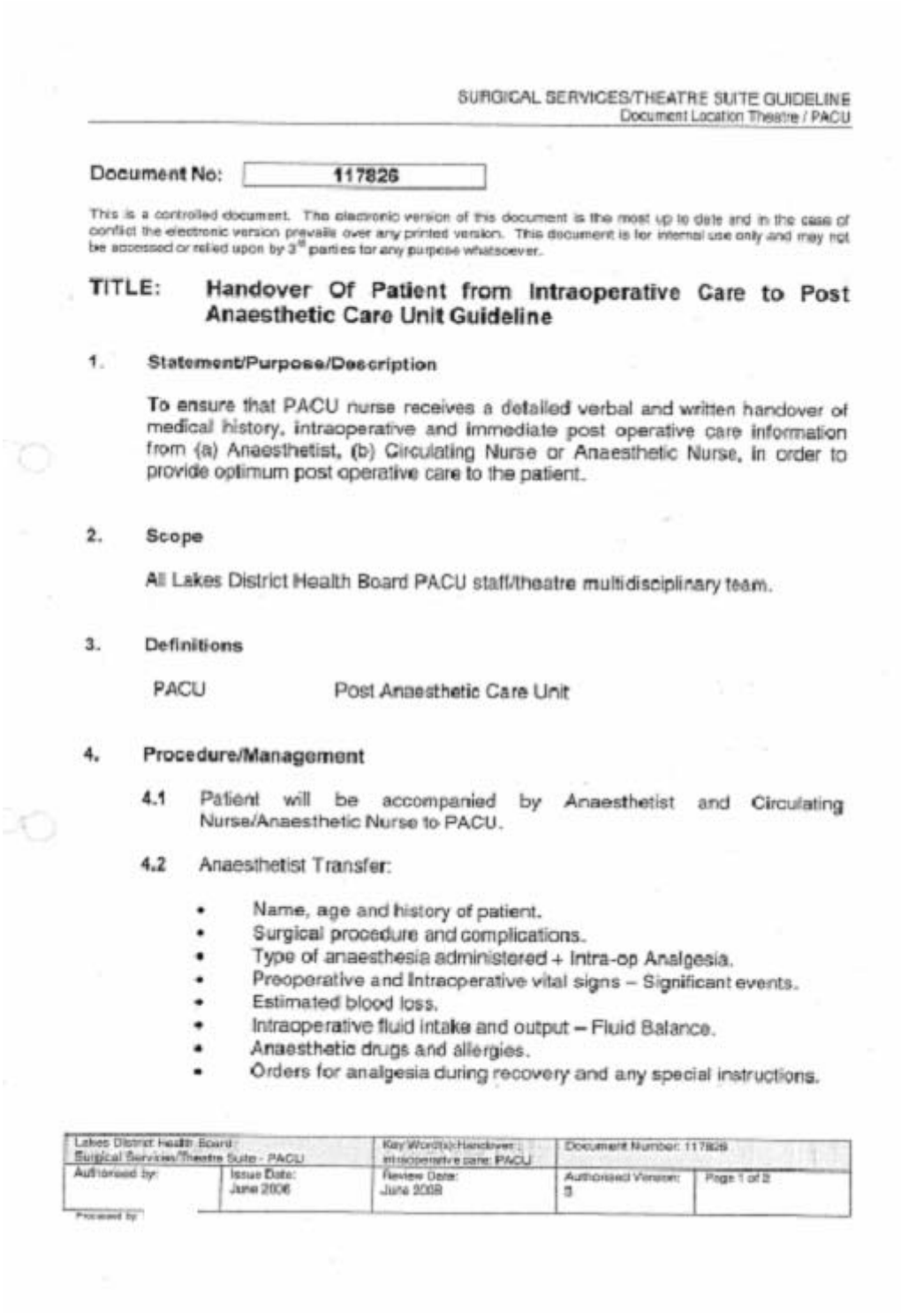
I recommend that the Ministry of Health undertake a thorough audit of Lakes DHB to ensure that various changes stated to have been made have in fact been made, and report its findings to me by **31 August 2008**.

## Follow-up actions

- A copy of this report will be sent to the Minister of Health and the Director-General of Health.
- A copy of this report, identifying Lakes DHB and Rotorua Hospital, but with details identifying all other parties removed, will be sent to the Quality Improvement Committee, Quality Health New Zealand, the Royal Australasian College of Surgeons, the Australian and New Zealand College of Anaesthetists, and all district health boards, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

[13] 05HDC11908 (22 March 2007).

## Appendix 1



SURGICAL SERVICES/THEATRE SUITE GUIDELINE
Document Location Theatre / PACU

**Document No:** 117826

This is a controlled document. The electronic version of this document is the most up to date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by 3rd parties for any purpose whatsoever.

**TITLE: Handover Of Patient from Intraoperative Care to Post Anaesthetic Care Unit Guideline**

**1. Statement/Purpose/Description**

To ensure that PACU nurse receives a detailed verbal and written handover of medical history, intraoperative and immediate post operative care information from (a) Anaesthetist, (b) Circulating Nurse or Anaesthetic Nurse, in order to provide optimum post operative care to the patient.

**2. Scope**

All Lakes District Health Board PACU staff/theatre multidisciplinary team.

**3. Definitions**

PACU — Post Anaesthetic Care Unit

**4. Procedure/Management**

4.1 Patient will be accompanied by Anaesthetist and Circulating Nurse/Anaesthetic Nurse to PACU.

4.2 Anaesthetist Transfer:

- Name, age and history of patient.
- Surgical procedure and complications.
- Type of anaesthesia administered + Intra-op Analgesia.
- Preoperative and Intraoperative vital signs – Significant events.
- Estimated blood loss.
- Intraoperative fluid intake and output – Fluid Balance.
- Anaesthetic drugs and allergies.
- Orders for analgesia during recovery and any special instructions.

| Lakes District Health Board: Surgical Services/Theatre Suite - PACU | | Key Word(s): Handover; intraoperative care; PACU | Document Number: 117826 | |
|---|---|---|---|---|
| Authorised by: | Issue Date: June 2006 | Review Date: June 2008 | Authorised Version: 5 | Page 1 of 2 |

Reviewed by:



*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

4.3 Transfer Nurse:

- Introduction of patient.
- Wound closure and covering.
- Presence of drains, packing, dressings and catheters.
- Any cultural considerations for the PACU Nurse to be aware of and implement. Body parts returned with patient.
- Special instructions for post operative care follow up.
- Patient's cognitive state, and affect pre-op.

**5. Equipment Used**

N/A

**6. Points to Note**

N/A

**7. Related Documentation**

- Intraoperative Record.
- Anaesthesia Record.
- I.V Fluids Record.
- Medication Chart.

**8. References**

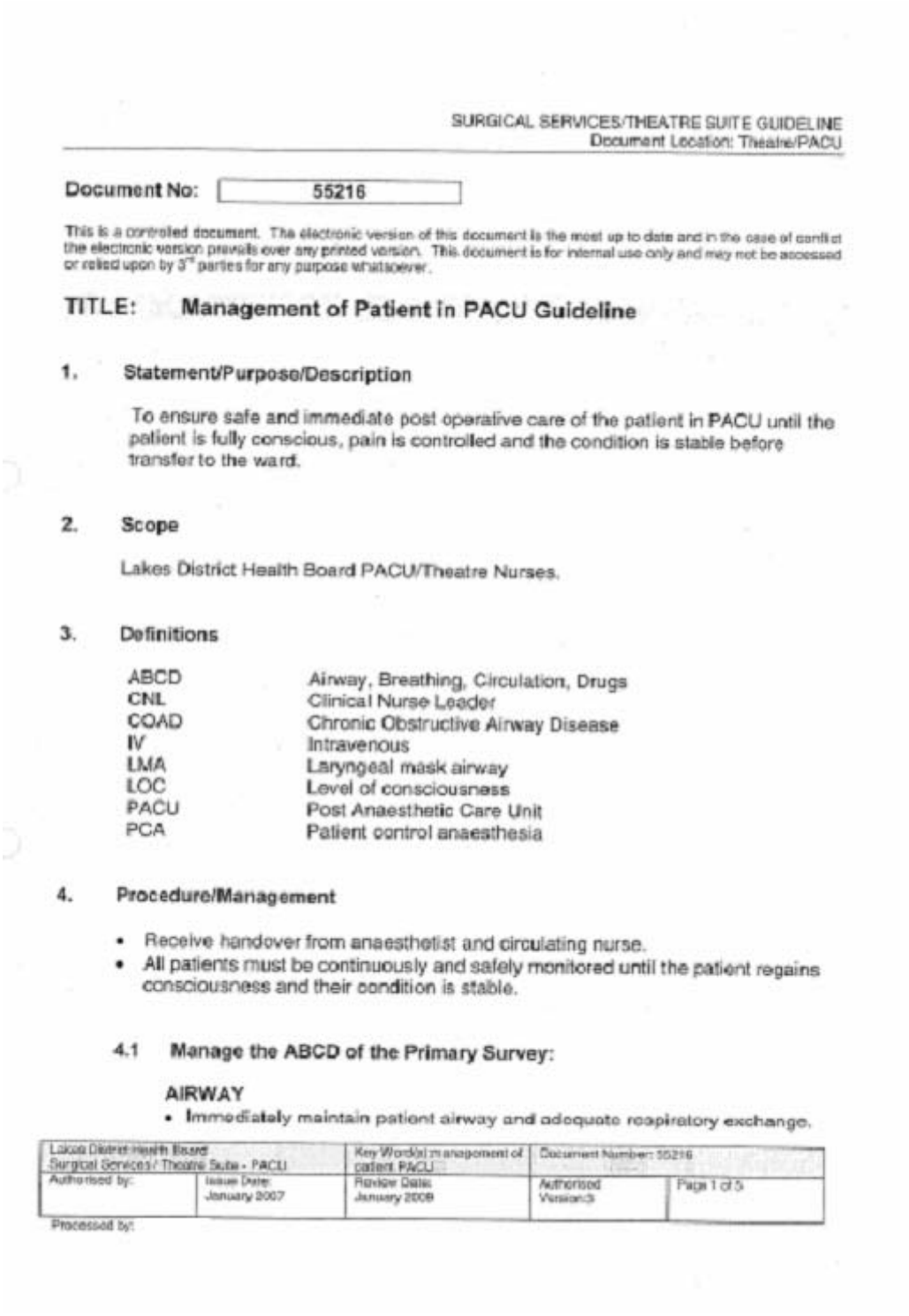
N/A

**Prepared by:** Staff Nurse, PACU
Staff Nurse PACU

**Authorised by:** **Clinical Nurse Leader, Theatre Suite**

.....

## Appendix 2



SURGICAL SERVICES/THEATRE SUITE GUIDELINE
Document Location: Theatre/PACU

**Document No:** 55216

This is a controlled document. The electronic version of this document is the most up to date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by 3rd parties for any purpose whatsoever.

**TITLE: Management of Patient in PACU Guideline**

**1. Statement/Purpose/Description**

To ensure safe and immediate post operative care of the patient in PACU until the patient is fully conscious, pain is controlled and the condition is stable before transfer to the ward.

**2. Scope**

Lakes District Health Board PACU/Theatre Nurses.

**3. Definitions**

| | |
|---|---|
| ABCD | Airway, Breathing, Circulation, Drugs |
| CNL | Clinical Nurse Leader |
| COAD | Chronic Obstructive Airway Disease |
| IV | Intravenous |
| LMA | Laryngeal mask airway |
| LOC | Level of consciousness |
| PACU | Post Anaesthetic Care Unit |
| PCA | Patient control anaesthesia |

**4. Procedure/Management**

- Receive handover from anaesthetist and circulating nurse.
- All patients must be continuously and safely monitored until the patient regains consciousness and their condition is stable.

**4.1 Manage the ABCD of the Primary Survey:**

**AIRWAY**

- Immediately maintain patient airway and adequate respiratory exchange.

| | | | | |
|---|---|---|---|---|
| Lakes District Health Board Surgical Services / Theatre Suite - PACU | | Key Word(s) management of patient PACU | Document Number: 55216 | |
| Authorised by: | Issue Date: January 2007 | Review Date: January 2009 | Authorised Version:3 | Page 1 of 5 |

Processed by:



*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

- Administer Oxygen:
  a) Adults 6 litres/minute
  b) Children 4-6 litres/minute

***NB: Different rate for nasal prongs and masks***

***2 litres per nasal prongs (max 4 litres)***
***6 litres per Hudson mask (not less that 5 litres for adults)***

- If patient has LMA or oesophageal airway in situ, observe for when they can be safely removed.
- Observe for signs of airway obstruction and apply appropriate chin lift/jaw thrust technique.

**BREATHING**

a) Breathing – depth, rate, rhythm and respiration with intercostal diaphragmatic effort.
b) Colour – skin, lips and nail beds.
c) Attach pulse oximetry and record.

**CIRCULATION**

a) Pulses – apical and radial.
b) Peripheral perfusion – Capillary filling of fingers and toes.
c) Blood pressure monitoring
d) Cardiac monitoring if requested / indicated

**CONSCIOUSNESS LEVEL**

Determine **LOC:**

**0** - Calm and co-operative
**1** - Easy to rouse
**2** - Very sedated (falls asleep during conversation)
**3** - Unrousable

**DRUGS**

Ensure patient is prescribed sufficient pain relief, and any specific drugs as may be requested.

**5. Equipment Used**

Pulse Oximetry
Non Invasive Blood Pressure Monitoring
Cardiac Monitoring

| | | | | |
|---|---|---|---|---|
| Lakes District Health Board<br>Surgical Services / Theatre Suite - PACU | | Key Words: management of patient PACU | Document Number: 55218 | |
| Authorised by: | Issue Date:<br>January 2007 | Review Date:<br>January 2009 | Authorised<br>Version:2 | Page 2 of 5 |

Processed by:

Thermometer
IV therapy / pump / PCA
Suction and oxygen adjuncts.

## 6. Points to Note

### 6.1 Airway / Breathing

- If patient has obstructive airways and is receiving oxygen, he/she should be monitored for signs of hyperventilation, confusion or becoming semi comatose.
- If partial airway obstruction occurs, it may be the result of muscle relaxants, foreign body, narcotics, mucus accumulation or the position of the patient on the bed.
- When the patient's tongue falls towards the back of the throat and obstructs the airway, the head can be hyper extended and the chin brought forward, also position patient laterally on bed to facilitate breathing. Insert airway as is necessary.
- Observe for signs of non-reversal.

### 6.2 Circulation

- PACU nurse needs to be astute to the signs of patient anxiety, arrhythmias, shock, left ventricular failure, pulmonary embolism and systemic embolism.
- Vital signs to be monitored every 5-10 minutes and compared to peri-operative and intra-operative readings. If large variations exist, the anaesthetist and surgeon should be notified immediately.
- Patients should be observed for shock. Shock indicates the inability of the circulatory system to meet oxygen demands of the body.
- Common post operative causes of shock are:
  Vasomotor collapse caused by deep anaesthesia or overdose of narcotics.
  a) Hypovolemia caused by excessive loss of blood or plasma.
  b) Toxaemia due to bacterial infection.

### 6.3 L.O.C

- Patient's level of consciousness should be assessed every 5-10 minutes while in PACU.
- During emergence from general anaesthesia, the patient will react to painful stimuli or to motor/reflex activity.

- When patient is semi-conscious, he/she may respond to verbal stimuli, but drifts off to sleep easily, he/she responds to commands slowly.
- The conscious patient will be drowsy, but awake, alert and orientated to time, place and person.

**6.4 Pulse Oximetry**

- Shows trends in the patient's oxygenation and helps detect states of hypoxia quickly.
- PACU nurse must be able to interpret the data from the monitoring equipment in relation to Pre-op status and medical conditions, i.e. COAD.

**6.5 Assessment of Dressings, Drains and Casting Materials**

- Post operative dressings need to be checked every 10-15 minutes for type of drainage (if any), the amount, the colour and consistency. Dressings may be "mapped/outlined" and time documented on PACU form.
- Surgical drains, such as Medinorm, should be connected to the appropriate drainage apparatus and checked for patency and excessive loss noted and surgeon advised, every 15 minutes from immediate post operative period until discharged from PACU. All assessments of dressings and materials excreted into drainage apparatus should be documented for amount, colour and consistency.
- Orthopaedic procedures should be assessed every 10-15 minutes for signs of circulatory impairment.
- Colour, warmth, movement and sensation of extremities of limb involved.
- Clinical manifestations of circulatory impairment, swelling, decreased return of colour after pressure has been applied to the exposed distal portion of the extremity – capillary refill. Patient's skin may "feel cold" and cyanotic in colour.
- If circulatory impairment is imminent, the Surgeon should be notified immediately.
- If blood is noted seeping through the castor dressing, the boundaries to be identified and the time noted, so that excessive bleeding can be readily determined.

**6.6 Pain Management**

- PCA pump or titration through IV line when a PCA is unavailable.
- May be given subcutaneously.
- Rectal suppositories.
- Oral therapy.
- Wound infiltration.

- Intrathecal.
- Epidural.
- Steroid injection.

**7. Related Documentation**

- PACU chart (CRS/CR/003)
- Fluid balance chart (CRG/OR.004)
- Drug Chart (CRG/B/001)

**8. References**


- Australia and New Zealand College of Anaesthetists (2000)

*Recommendations for the post-anaesthesia recovery room.*
*ANZCA Professional document, PS4*
*Retrieved November 2nd, 2004 from http://www.anzca.edu.au/pdfdocs/ps4-2000.pdf*

- Emcare (2002) *Post anaesthetic care unit nursing course*
National Patient Simulation Centre – Capital & Coast District Health Board, Wellington.

- Fortunato, N.H. (9th ed.)(2000). Berry & Kohn's operating room technique. Mosby: St Louis.

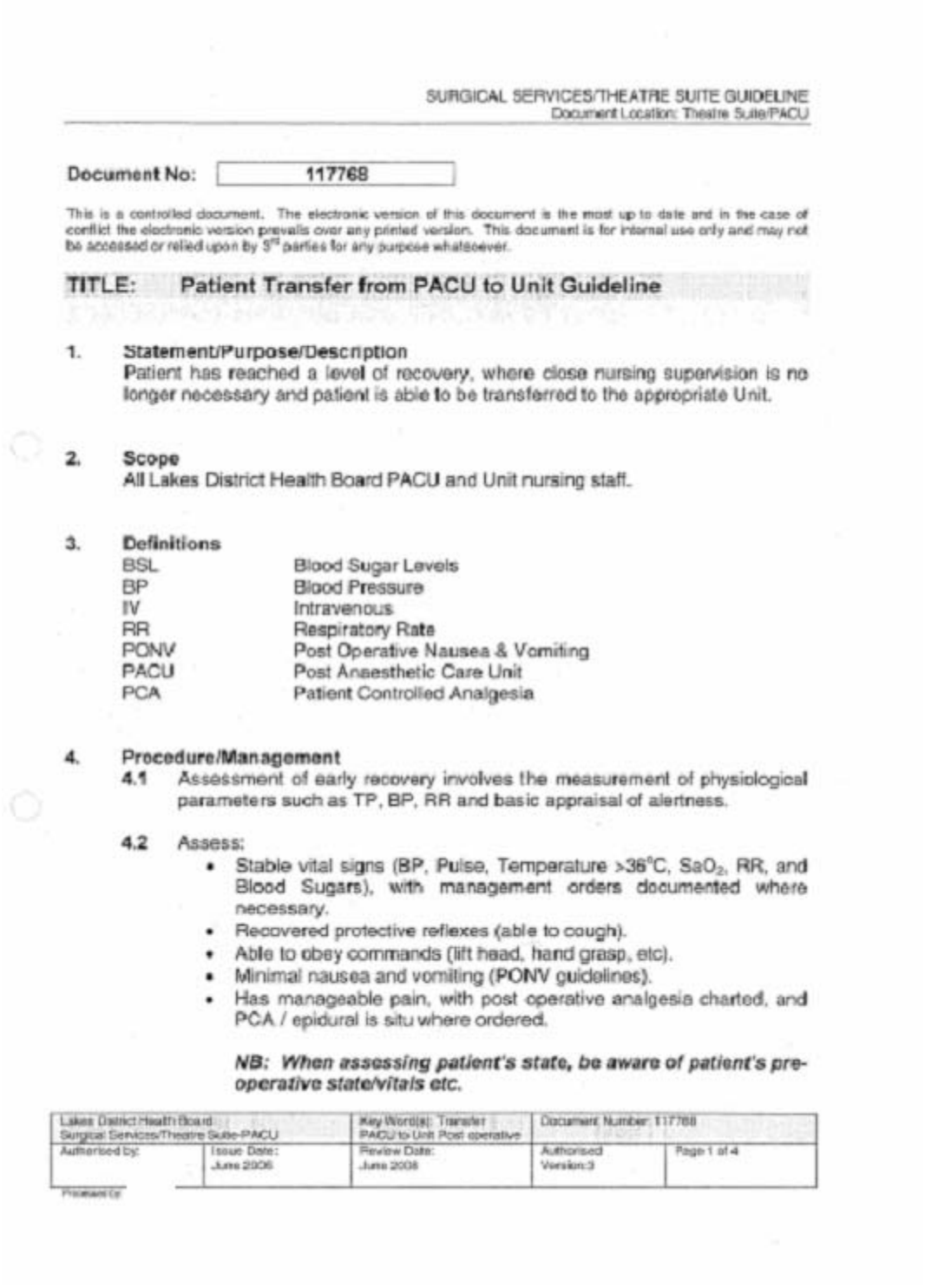
- Hatfield,A.,& Tronson, M (3rd ed.). (2001). The complete recovery room book. Oxford: New York.

- Trauma Nursing Core Course- Provider manual. (5th ed.). (2000). Emergency Nurses Section of NZNO.


**Authorised by:** **Clinical Nurse Leader, Theatre Suite**

.....

## Appendix 3



SURGICAL SERVICES/THEATRE SUITE GUIDELINE
Document Location: Theatre Suite/PACU

**Document No:** 117768

This is a controlled document. The electronic version of this document is the most up to date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by 3rd parties for any purpose whatsoever.

**TITLE: Patient Transfer from PACU to Unit Guideline**

1. **Statement/Purpose/Description**
Patient has reached a level of recovery, where close nursing supervision is no longer necessary and patient is able to be transferred to the appropriate Unit.

2. **Scope**
All Lakes District Health Board PACU and Unit nursing staff.

3. **Definitions**

| | |
|---|---|
| BSL | Blood Sugar Levels |
| BP | Blood Pressure |
| IV | Intravenous |
| RR | Respiratory Rate |
| PONV | Post Operative Nausea & Vomiting |
| PACU | Post Anaesthetic Care Unit |
| PCA | Patient Controlled Analgesia |

4. **Procedure/Management**

4.1 Assessment of early recovery involves the measurement of physiological parameters such as TP, BP, RR and basic appraisal of alertness.

4.2 Assess:

- Stable vital signs (BP, Pulse, Temperature >36°C, $SaO_2$, RR, and Blood Sugars), with management orders documented where necessary.
- Recovered protective reflexes (able to cough).
- Able to obey commands (lift head, hand grasp, etc).
- Minimal nausea and vomiting (PONV guidelines).
- Has manageable pain, with post operative analgesia charted, and PCA / epidural is situ where ordered.

***NB: When assessing patient's state, be aware of patient's pre-operative state/vitals etc.***

| Lakes District Health Board Surgical Services/Theatre Suite-PACU | | Key Word(s): Transfer PACU to Unit Post operative | Document Number: 117768 | |
|---|---|---|---|---|
| Authorised by: | Issue Date: June 2006 | Review Date: June 2008 | Authorised Version:3 | Page 1 of 4 |

Printed on



*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

4.3 If unsure of fitness for discharge, refer Patient Discharge Guidelines (Appendix A).

4.4 Check wound, drains (patency and drainage).

4.5 Check post operative documentation which may include:
- IV fluids
- Analgesia
- Antibiotics
- Discharge advice
- Wound care
- Advice re: eating and drinking
- Patient Controlled Analgesia form
- PCA Traceability form

**5. Equipment Used**
N/A

**6. Points to Note**

6.1 See individual protocols and guidelines regarding specialised care, i.e. PCA, epidurals, etc.

6.2 If Unit Nurse is unhappy with the patient's condition, it is to be discussed with PACU staff, and/or referred to attending Anaesthetist.

**7. Related Documentation**

7.1 Anaesthetic / PACU Record Form, which may include post operative instructions.

7.2 Fluid Balance Chart.

7.3 Prescription Sheet, which may include anti-emetics, analgesia, antibiotics, oxygen and IV fluids.

7.4 Patient Controlled Analgesia Form.

**8. References**
N/A





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

**Prepared by:** Staff Nurse, PACU
Staff Nurse, PACU

**Authorised by:** **Clinical Nurse Leader, Theatre Suite**

.....





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

## Appendix 4



**Document No:** 105775

This is a controlled document. The electronic version of this document is the most up to date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by 3rd parties for any purpose whatsoever.

**TITLE: Pre and Post-Operative Nursing Care – General - Guideline**

**1. Statement/Purpose/Description**

To manage pre and post-operative nursing care appropriately.

**2. Scope**

All Lakes District Health Board nursing staff.

**3. Definitions**

| | |
|---|---|
| BP | Blood pressure |
| FBC | Fluid Balance Chart |
| IDC | Indwelling catheter |
| IVF | Intra venous fluid |
| NBM | Nil by mouth |
| NGT | Nasogastric tube |
| PACU | Post Anaesthetic Care Unit |
| PRN | As required |
| Q8H | 8 hourly |
| RR | Respiration Rate |
| $SPO_2$ | Pulse Oximetry |
| TED Stockings | Thromboembolic compression stockings |
| TPR | Temperature Pulse Respiration |
| TQ4H | 4 hourly temperature |

**4. Procedure/Management**

**4.1 Pre-operative Management**

1. Routine admission observations/weight/urinalysis.
2. Admission assessment completed.
3. Explanation of surgery.
4. Orientation to the unit.
5. Clip appropriate area.
6. Measure patient for anti-thromboembolic (TED) stockings.





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

7. Commence discharge planning as appropriate. Referrals to appropriate auxiliary services, i.e. ostomy/Social Worker/Occupational Therapy/Physiotherapy/Speech Language/Dietician.
8. All investigation reports available in notes/with patient.
9. Maintain NBM 6 hours prior to procedure.

**4.2 Post-operative Management**

1. Collect stable patient from PACU and return to unit.
2. Initial TPR, BP, SPO2 and wound check, then half-hourly for 2 hours, one-hourly for 2 hours, two-hourly, then four-hourly, if stable.
3. IVF as charted, continue fluid balance chart while on IVF, IDC, drains etc.
4. Wound drain:
   i. Redivac, maintain suction, mark on bottle and record drainage on FBC 0800 hours each day.
   ii. Other wound drains, record on FBC, drainage Q8H, i.e. 0800, 1600 and 2400 hours.
   iii. **NB:** Change wound bag every 72 hours using aseptic technique.
5. NGT: on free drainage, aspirate Q4H and PRN record on FBC.
6. IDC: **NB:** Output should be >30mls/hr, pin to bed below level of bladder. Do not leave to lie on floor. Record output at least Q8H, i.e. 0800, 1600 and 2400 hours on FBC, unless requested to check more regularly.
7. Analgesia to be given regularly as charted. If not sufficient, contact doctor to chart more analgesia or more regularly. Record effect of analgesia, document pain score on TPR chart. Record R on drug chart if analgesia refused. Document in clinical notes why analgesia refused.
8. Encourage deep breathing and leg exercises to all post-operative patients. Referral to physiotherapy as appropriate.
9. TED stockings to remain on until patient is fully mobilised.
10. Document patients passing of flatus/bowel motions.
11. Commence progressive diet on surgeon's instructions.

**4. Equipment Used**

- TPR chart
- Dynamap
- $SPO_2$
- TED stockings and measuring tape
- Thermometer
- FBC chart

| | | | | |
|---|---|---|---|---|
| Lakes District Health Board Surgical Services / Surgical Unit | | Key Words(s): Pre and Post operative nursing care | Document Number: 105775 | |
| Authorised by: | Issue Date: February 2006 | Review Date: February 2008 | Authorised Version: 2 | Page 2 of 3 |



*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

**6. Points to Note**

N/A

**7. Related Documentation**

Internal referral form.
Community health referral.
Fluid Balance Chart
All patient assessment, care planning, discharge documentation.

**8. References**

N/A

**Prepared by:** , **Clinical Nurse Leader, Surgical Unit**

**Authorised by:** **Associate Director of Nursing, Surgical Services**

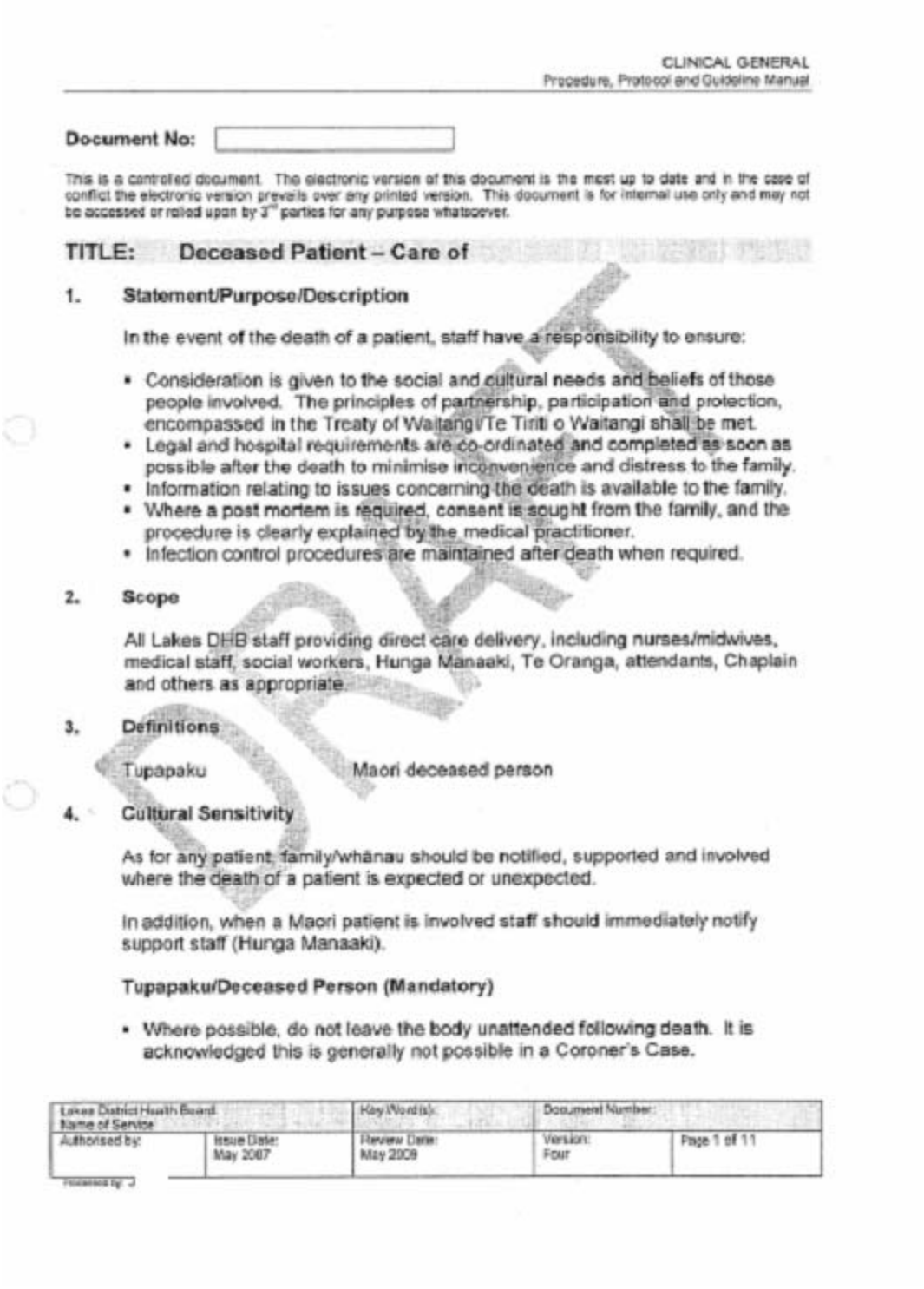
.....





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

## Appendix 5



CLINICAL GENERAL
Procedure, Protocol and Guideline Manual

**Document No:**

This is a controlled document. The electronic version of this document is the most up to date and in the case of conflict the electronic version prevails over any printed version. This document is for internal use only and may not be accessed or relied upon by 3rd parties for any purpose whatsoever.

**TITLE: Deceased Patient – Care of**

**1. Statement/Purpose/Description**

In the event of the death of a patient, staff have a responsibility to ensure:

- Consideration is given to the social and cultural needs and beliefs of those people involved. The principles of partnership, participation and protection, encompassed in the Treaty of Waitangi/Te Tiriti o Waitangi shall be met.
- Legal and hospital requirements are co-ordinated and completed as soon as possible after the death to minimise inconvenience and distress to the family.
- Information relating to issues concerning the death is available to the family.
- Where a post mortem is required, consent is sought from the family, and the procedure is clearly explained by the medical practitioner.
- Infection control procedures are maintained after death when required.

**2. Scope**

All Lakes DHB staff providing direct care delivery, including nurses/midwives, medical staff, social workers, Hunga Manaaki, Te Oranga, attendants, Chaplain and others as appropriate.

**3. Definitions**

Tupapaku — Maori deceased person

**4. Cultural Sensitivity**

As for any patient, family/whānau should be notified, supported and involved where the death of a patient is expected or unexpected.

In addition, when a Maori patient is involved staff should immediately notify support staff (Hunga Manaaki).

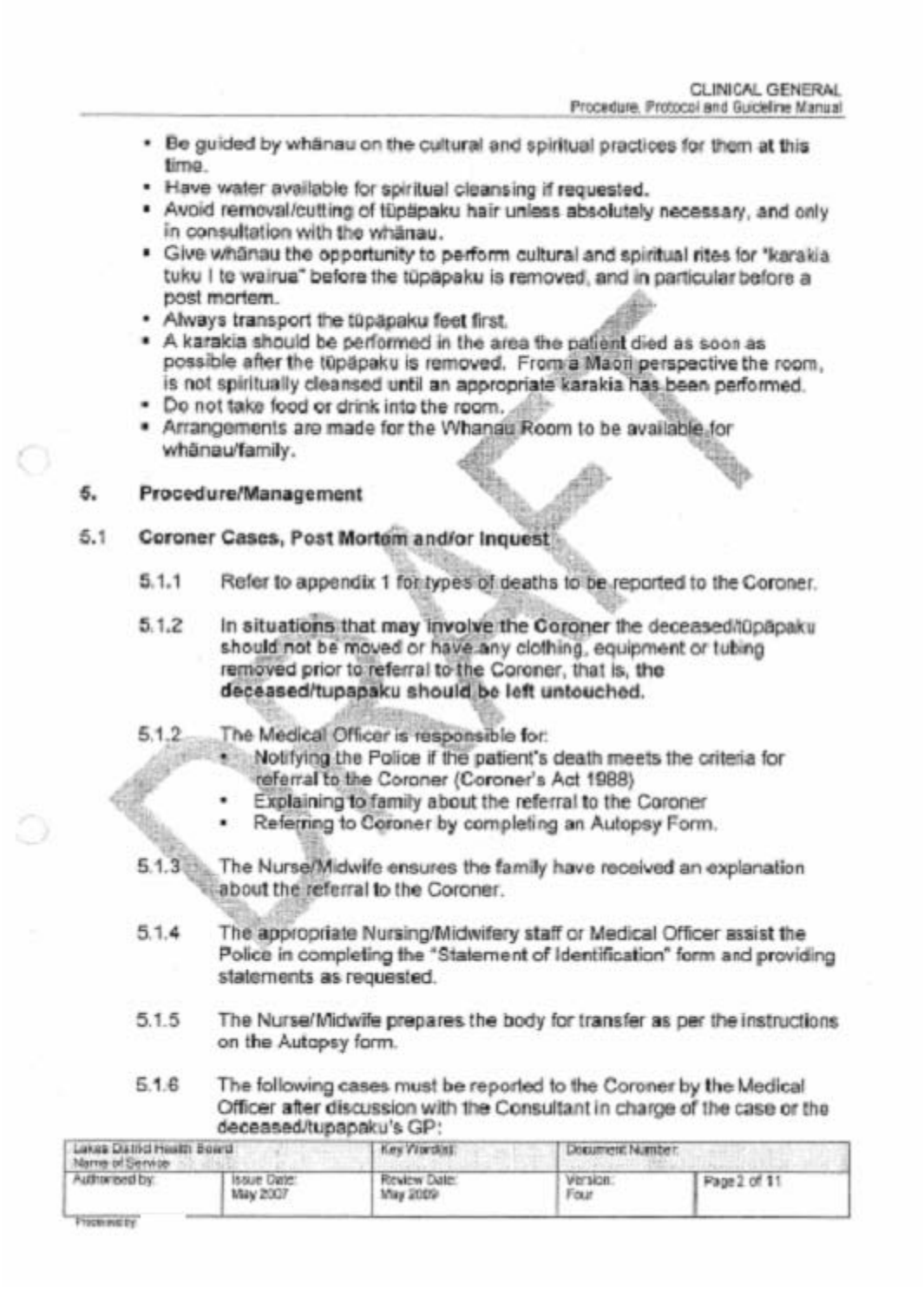
**Tupapaku/Deceased Person (Mandatory)**

- Where possible, do not leave the body unattended following death. It is acknowledged this is generally not possible in a Coroner's Case.

| Lakes District Health Board Name of Service | | Key Word(s): | Document Number: | |
|---|---|---|---|---|
| Authorised by: | Issue Date: May 2007 | Review Date: May 2009 | Version: Four | Page 1 of 11 |



*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*





- Be guided by whānau on the cultural and spiritual practices for them at this time.
- Have water available for spiritual cleansing if requested.
- Avoid removal/cutting of tūpāpaku hair unless absolutely necessary, and only in consultation with the whānau.
- Give whānau the opportunity to perform cultural and spiritual rites for "karakia tuku I te wairua" before the tūpāpaku is removed, and in particular before a post mortem.
- Always transport the tūpāpaku feet first.
- A karakia should be performed in the area the patient died as soon as possible after the tūpāpaku is removed. From a Maori perspective the room, is not spiritually cleansed until an appropriate karakia has been performed.
- Do not take food or drink into the room.
- Arrangements are made for the Whanau Room to be available for whānau/family.

**5. Procedure/Management**

**5.1 Coroner Cases, Post Mortem and/or Inquest**

5.1.1 Refer to appendix 1 for types of deaths to be reported to the Coroner.

5.1.2 In situations that may involve the Coroner the deceased/tūpāpaku should not be moved or have any clothing, equipment or tubing removed prior to referral to the Coroner, that is, the deceased/tupapaku should be left untouched.

5.1.2 The Medical Officer is responsible for:
- Notifying the Police if the patient's death meets the criteria for referral to the Coroner (Coroner's Act 1988)
- Explaining to family about the referral to the Coroner
- Referring to Coroner by completing an Autopsy Form.

5.1.3 The Nurse/Midwife ensures the family have received an explanation about the referral to the Coroner.

5.1.4 The appropriate Nursing/Midwifery staff or Medical Officer assist the Police in completing the "Statement of Identification" form and providing statements as requested.

5.1.5 The Nurse/Midwife prepares the body for transfer as per the instructions on the Autopsy form.

5.1.6 The following cases must be reported to the Coroner by the Medical Officer after discussion with the Consultant in charge of the case or the deceased/tupapaku's GP:

| Lakes District Health Board Name of Service | | Key Word(s): | Document Number: | |
|---|---|---|---|---|
| Authorised by: | Issue Date: May 2007 | Review Date: May 2009 | Version: Four | Page 2 of 11 |

Reviewed by:

- Persons brought to hospital and found to be dead on arrival
- Persons dying in the Emergency Department
- All cases where injuries, recent or remote, that may have been the cause or an accessory cause of death (including burns, tetanus and patient falls).
- Cases of poisoning or suspected poisoning.
- Cases of death during any medical or surgical procedure or immediately after. Deaths associated with transfusions, anaesthesia, major or minor surgery and cases where death is delayed for some days but is due directly to some procedure or treatment.
- Death where any allegations are made of incompetence or neglect of treatment.
- Cases in which the cause of death is unknown.

**Note**: 1.The Police will be involved in the situations described above – often before the coroner has been notified. In the situations that may involve the coroner, the deceased should not be moved or have any clothing, equipment or tubing removed prior to referral to the coroner, ie the deceased should be left untouched. Exception – the removal of clothing during lifesaving measures, where the consultant in charge of the case decides that the equipment or tubing has had no material impact on the outcome and eg in the case of children there is a need for family to be in a position to grieve appropriately.(Use of equipment , tubing here must be well documented however.)

**6. Emergency Department**

- Nursing staff may decline making statements to police without legal representation – contact the Duty Manager after hours or the Clinical Nurse Manager
- Police are responsible for notifying relatives and continuing care of the case.
- All clothing and property cut or removed from the patient during treatment in the Emergency Department must be secured in property bags and labelled for police collection.
- Relatives must not be left with the deceased patient without supervision until Police arrive.
- The Police escort the deceased to the mortuary.
- Children are on occasions cared for with family , in the chapel , prior to post mortem.. The decision for this to occur needs to be made by the consultant in charge of the case.
- Funeral Directors arriving at the ambulance bay with a deceased person from the community may request a medical officer to go out and pronounce life extinct. The medical officer is responsible for the paperwork required.
- Deceased patients who have been in ED for three (3) hours or more must be admitted to ED under the appropriate specialty.

## 7. Deceased Patient in Wards

### 7.1 Immediate Notification

- The Registered Nurse/Midwife responsible for the patient at the time of death, is responsible for care of the deceased/tūpāpaku.
- The Nurse/Midwife contacts the doctor to certify that the patient is dead:
  - Between the hours of 088-1630 Monday to Friday, the House Surgeon who has been attending to the deceased person's care.
  - After hours, the on-call Medical Officer
- The Nurse/Midwife contacts the CNL/CML or Duty Manager to notify of the death.
- If the case is unexpected or the consultant has previously indicated a need to be informed ,the medical officer phones either the consultant on call or the relevant consultant "in charge " , depending on prior communication , documented in the notes, "common sense" as discussed with the Duty Manager etc.
- Admissions and Switchboard are notified as soon as possible.

### 7.2 Next of Kin Notification

- The Nurse/Midwife notifies the next-of-kin (if not present) that the patient has died. Where possible, ensure relatives, particularly the elderly, are not alone when notified. Police are helpful in these circumstances.
- The Nurse/Midwife ascertains the family's wish to remain with, or to visit the deceased/tupapaku on the Unit prior to transfer to the Mortuary, Funeral home or Chapel.
  - If the deceased/tupapaku is a child or the death of the adult patient is unexpected, the family should be called to the Unit prior to transfer
  - If the family wish to spend time with the deceased person prior to the body being transferred to the funeral home, then the Hospital Chapel or the Mortuary viewing room may be used if there is no appropriate private space on the Unit.
- The Nurse/Midwife facilitates appropriate spiritual support for the family by contacting the Chaplain or other religious/spiritual representative.
- The Nurse/Midwife facilitates appropriate cultural support for the family by contacting Hunga Manaaki or Te Oranga.

### 7.3 Documentation and Medical Staff Certification of Death

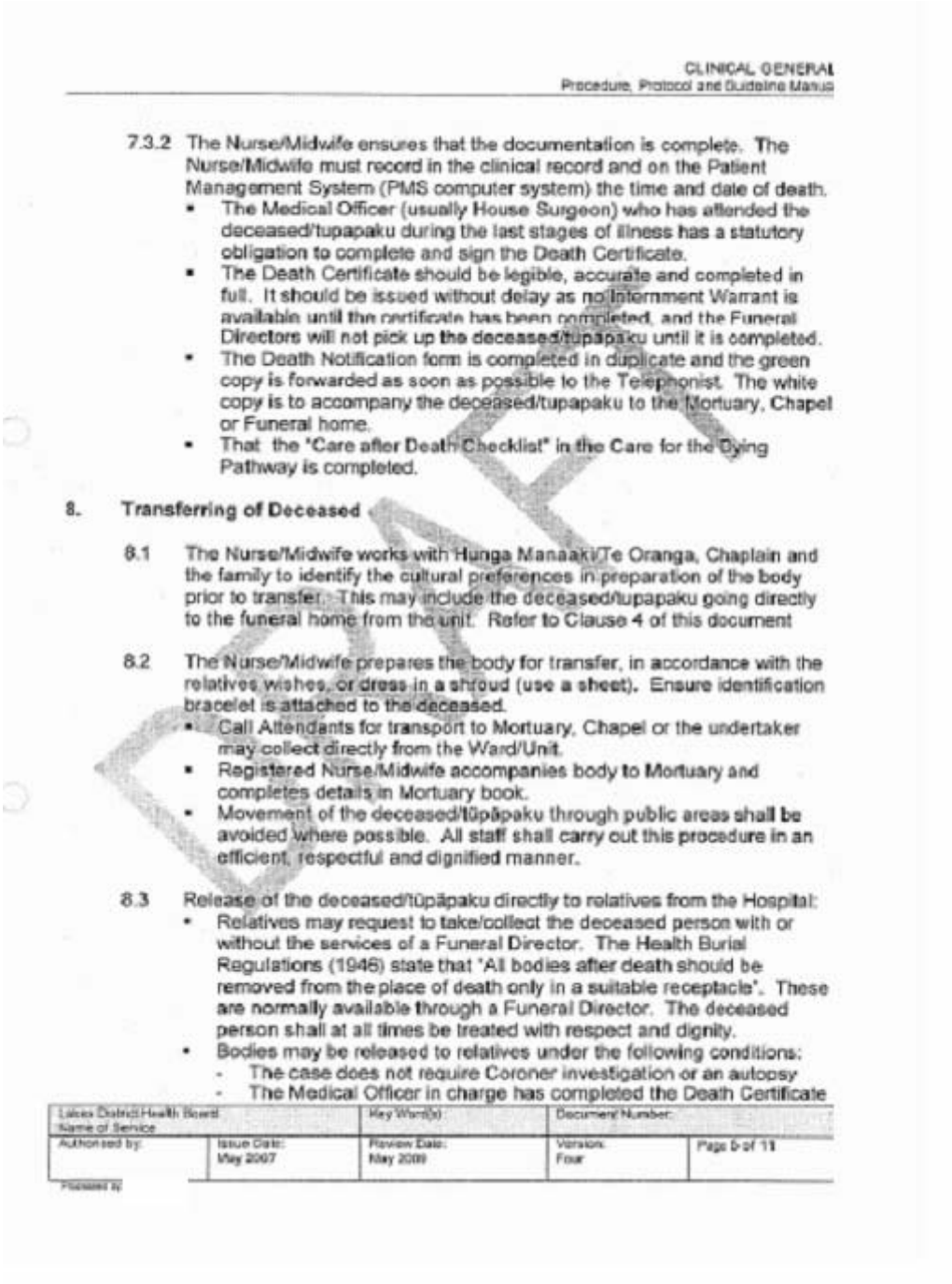
7.3.1 The Medical Officer is called to:

- To certify and pronounce death, and to document this in the clinical record
- Complete the Death Certificate and Cremation Certificate (if it is intended that the deceased is to be cremated).





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*



CLINICAL GENERAL
Procedure, Protocol and Guideline Manual

7.3.2 The Nurse/Midwife ensures that the documentation is complete. The Nurse/Midwife must record in the clinical record and on the Patient Management System (PMS computer system) the time and date of death.

- The Medical Officer (usually House Surgeon) who has attended the deceased/tupapaku during the last stages of illness has a statutory obligation to complete and sign the Death Certificate.
- The Death Certificate should be legible, accurate and completed in full. It should be issued without delay as no Interment Warrant is available until the certificate has been completed, and the Funeral Directors will not pick up the deceased/tupapaku until it is completed.
- The Death Notification form is completed in duplicate and the green copy is forwarded as soon as possible to the Telephonist. The white copy is to accompany the deceased/tupapaku to the Mortuary, Chapel or Funeral home.
- That the "Care after Death Checklist" in the Care for the Dying Pathway is completed.

**8. Transferring of Deceased**

8.1 The Nurse/Midwife works with Hunga Manaaki/Te Oranga, Chaplain and the family to identify the cultural preferences in preparation of the body prior to transfer. This may include the deceased/tupapaku going directly to the funeral home from the unit. Refer to Clause 4 of this document

8.2 The Nurse/Midwife prepares the body for transfer, in accordance with the relatives wishes, or dress in a shroud (use a sheet). Ensure identification bracelet is attached to the deceased.

- Call Attendants for transport to Mortuary, Chapel or the undertaker may collect directly from the Ward/Unit.
- Registered Nurse/Midwife accompanies body to Mortuary and completes details in Mortuary book.
- Movement of the deceased/tūpāpaku through public areas shall be avoided where possible. All staff shall carry out this procedure in an efficient, respectful and dignified manner.

8.3 Release of the deceased/tūpāpaku directly to relatives from the Hospital:

- Relatives may request to take/collect the deceased person with or without the services of a Funeral Director. The Health Burial Regulations (1946) state that 'All bodies after death should be removed from the place of death only in a suitable receptacle'. These are normally available through a Funeral Director. The deceased person shall at all times be treated with respect and dignity.
- Bodies may be released to relatives under the following conditions:
  - The case does not require Coroner investigation or an autopsy
  - The Medical Officer in charge has completed the Death Certificate

| Lakes District Health Board Name of Service | | Key Word(s): | Document Number: | |
|---|---|---|---|---|
| Authorised by: | Issue Date: May 2007 | Review Date: May 2009 | Version: Four | Page 8 of 11 |

Reviewed by:



*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

- The relatives are advised to present the Death Certificate to register the death at the Court-house. The relatives must understand it is a legal requirement that they must register the death within seven (7) days.

**9. Deceased Patient in Theatre Suite**

- Patient not to be removed from Theatre until Police clearance
- Police to be notified by Consultant in charge of patient
- Protocol re Coroner's case as outlined in clause ..... of this document
- Police request for information documentation to be referred to Theatre Manager
- Police request for documentation form must be completed (Doc #.....)
- Ensure Theatre is blessed by appropriate personnel.

**10. Perinatal Death**

There is no legal requirement to certify a foetal death of less than twenty weeks (except termination of pregnancy). However, if a foetus of less than twenty weeks, weighs 400gms or more, a certificate must be completed.

NOTE: Protocols relating to perinatal death are available in the maternity unit or SCBU. Small wooden boxes are available in ED and Delivery Suite for the baby/foetus to be placed in. DO NOT discard any foetus or products of conception. Place in appropriate receptacle.

**11. Maternal Death**

- This includes any death occurring during pregnancy or within a period of three months after pregnancy as a result of **accident or disease**, or the death of a woman who at the time of her death was suffering from chorion epithelioma or hydatidiform mole.
- **Legal Requirements**: The attending Medical Officer is required to notify within 24 hours the local Medical Officer of Health of any such death.
- All maternal deaths are investigated by the Maternal Mortality Committee

**12. Termination of Pregnancy**

- Termination of Pregnancy (TOP) has to be carried out in a hospital which is registered to undertake the procedure. Rotorua Hospital is designated to carry out TOPs.
- Whenever any therapeutic abortion or other operation that could lead to or effect an abortion or subsequent unnatural miscarriage is performed, a record of the operation and reason for it should be made and details (without the patient's name) forwarded to the Chief Executive Officer, who then

forwards to the Director General. This needs to occur within one month of the TOP being carried out (refer Hospital Amendment Act 1975).

**13. Care of the Deceased/Tūpāpaku Property and Valuables**

12.1.1 **The Nurse/Midwife assembles the deceased/tūpāpaku property**

a) Valuables, ie cash, jewellery and personal documents are placed in a "Valuables" envelope. The envelope is labelled with the deceased person's Identification sticker (ID label).
- If appropriate relative present, all property and valuables may be given to that person at the time and this documented in the clinical record.
- If there is no relative present, the valuables are to be sent to the Hospital Cashier or, after hours to the Telephonist. A receipt must be obtained and put with any remaining property. The Nurse/Midwife must contact the relatives and ask them to come to the Ward/Unit and pick up the property. Valuables can then be collected from the Hospital Cashier's office by presenting the official receipt.

13.1.2 **Rings and Jewellery**: It is the policy of Lakes DHB to leave the wedding ring on the deceased unless specifically requested by the relatives to do otherwise. This must be confirmed with the Attendant/Funeral Director collecting the deceased person and documented in records.

13.1.3 **Blessing of Room** – the room is blessed as per Lakes DHB recommendations. The Nurse/Midwife contacts Hunga Manaaki or Hospital Chaplain to carry this out. Refer to Clause 4 of this document.

**14. Deceased/Tūpāpaku with known/suspected Communicable Infections or Notifiable Diseases**

Many non-notifiable diseases requiring additional transmission-based forms of isolation in hospital **do not** require continuation of precautions after death, eg MRSA.

There are some instances when diseases defined under the Health (Infectious and Notifiable Diseases) Regulations 1966 (Section A) as "Notifiable". May require precautions after death. These precautions may include the deceased/tūpāpaku being placed in a sealed coffin or body bag prior to leaving the ward. Body bags are available from the Duty Manager(?) or Funeral Director.

Examples of when this may be required include: Cholera, Creutzfeldt Jakob Disease (refer to – CJD - Patient Management Disinfection and Sterilisation





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

Protocol (EDMS # 40203), Dengue Fever, Legionella Disease, meningococcal disease (without 24 hour antibiotic treatment) or infectious Pulmonary Tuberculosis.

**NB:** Some of these conditions do not require the patient to be isolated before death but precautions are taken after death. Refer to the Medical Officer of Health for instructions regarding precautions.

**Notification**

The Medical Practitioner certifying the death must:

- Check the disease has been notified to the Medical Officer of Health;
- Inform the Medical Officer of Health of the death;
- Document notification of the death to the Medical Officer of Health and any further requirements in the deceased's/tūpāpaku clinical record, and communicate these to the staff involved with the deceased/tūpāpaku.

Ward stuff must alert the attendants, orderlies, funeral director and/or mortuary staff about any precautions and personal protective equipment required to be used.

**Note:** Where the deceased/tūpāpaku is removed directly from the ward, staff must liaise with the Medical Officer of Health regarding instructions about additional precautions required for the person taking charge of the body. It is desirable for this information to be in writing to ensure clear instructions.

**15. Return of Body Tissue**

Ward staff must check in the clinical record to determine whether there is any body tissue to be returned. If so the funeral director, family/whānau must be notified as soon as possible that there is body tissue to be returned and arrangements made for its return. Refer Retrieval of Body Tissue by the Client or Family (EDMS #39168).

**16. Equipment Used**

Nil.

**17. Related Documentation**

Notification of Next of Kin Patient Management Guideline (can't find one!!)
Tikanga (document – in progress)
Autopsy Form
Care of the Dying Pathway (Document #90703)
Death Certificate (Document # )





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

Cremation Certificate (Document # )
Theatre Police request for documentation form (Doc #.....)
Statement of Identification form
Creutzfeldt Jakob Disease (CJD) – Patient Management Disinfection and Sterilisation Protocol (EDMS # 40203)
Notifiable Diseases Protocol (EDMS #40226)
Retrieval of Body Tissue by the Client or Family (EDMS #39168)

**18. References**

The Coroner's Act 1988
Health Burial Regulations 1946
Hospital Amendment Act 1975
Health (Infectious and Notifiable Diseases) Regulations 1966

**Authorised by:**

**Director of Nursing & Midwifery**

**Medical Director**

**APPENDIX 1**

**CORONER INVOLVEMENT**

A) DEATHS TO BE REPORTED TO THE CORONER

- Deaths which must be referred by **medical practitioners** through the Police to the Coroner for their decision as to whether an inquest is to be held are set out in the Coroner's Act 1988 Section 4. That section requires that the following deaths shall be reported to the Police as soon as practicable:
  a) Every death that appears to have been:
     i) Without known cause; or
     ii) Suicide; or
     iii) Unnatural or violent

- Where a patient having been admitted due to poisoning or hazardous substance injury dies at any time after admission, despite the cause of the illness being confirmed, and considerable treatment given, the death must be reported to the Coroner.

  b) Every death in respect of which no doctor has given a doctor's certificate (Medical Certificate of Causes of Death BDM 50, or equivalent).

  c) Every death:

     [i] That occurred while the person concerned was undergoing a medical, surgical or dental operation or procedure or some similar operation or procedure; or
     [ii] That appears to have been the result of any such operation of procedure; or
     [iii] That occurred while the person was affected by an anaesthetic; or
     [iv] That appears to have been the result of the administration to the person of an anaesthetic.

  d) The death of any patient detained in an institution pursuant to an order under Section 9 of the Alcoholism and Drug Addiction Act 1966;

  e) The death of any child or young person in a residence established under Section 364 of the Children, Young Persons and Their Families Act 1989;

  f) The death of any child or young person while that child or young person is in the custody or care of an [iwi, social service or a cultural social service] or the Director of a Child and Family Support Service.

  g) The death of any special or committed patient [within the meaning of the Mental Health Act 1992] in a hospital;





*Names have been removed (other than Rotorua Hospital/Lakes DHB) to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.*

h) The death of any inmate [within the meaning of the Penal Institutions Act 1954];

i) The death of any person in the custody of the Police: [(ia) The death of any person in the custody of a security officer (within the meaning of the Penal Institutions Act 1954)];

j) The death of any person in such circumstances that an enactment other than this act requires the holding of an inquest

*Coroner's Act 1988*

**Note:** Paragraphs (d) to (h) referred to above apply to a death when it occurs within a Lakes DHB facility. It is the responsibility of the medical practitioner to refer the death to the Coroner through the Police.

- If there is any doubt as to whether a case should be reported, the Medical Practitioner must consult the Coroner.
- Any death the Coroner accepts for investigation must also be reported to the Quality and Risk Manager by filling in an incident form (PAGI) to notify LDHB insurers. The incident form should be filled out by the same person reporting the death to the coroner, or by a health professional designated to do this by the Medical Practitioner.

B) CORONER'S AUTHORITY

Once the person's death is reported to the Coroner by the Police, the body remains under the Coroner's authority until written notice for the release of the body is issued by the Coroner.

C) POST-MORTEM EXAMINATION IN CORONER CASES

- This can only be requested by the Coroner or by delegation to a nominated Justice of the Peace (Coroner's Act 1988, No.111, Section 9) for cases contained in Section 4 of the Act.
- Sometimes the Medical Practitioner for the patient will be aware of problems that need to be elucidated by a post mortem examination in the "need to establish the cause of death and contributing factors". In such cases they should state clearly to the Police/Coroner's representatives, that a post mortem is desirable and for what reason. A form is carried by the Police for such a purpose.