Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion - Case 98HDC12302

Complaint

The Commissioner received a complaint about the services provided to the complainant's 18-year-old son by a Hospital. The complaint is that:

- *In early September 1997 the charge nurse on night duty in a ward at the hospital did not ensure that the consumer was safe and unable to fall out of his bed.*
- *The charge nurse showed disrespect to the consumer when advising his mother that he had fallen out of bed. The Charge Nurse laughed when recounting the incident.*
- *The doctors responsible for the consumer did not provide services of an appropriate standard on a date in early September 1997.*
- *The Crown Health Enterprise did not notify the Armed Forces Camp where the consumer lived of the consumer's health status the next day.*
- *The consumer's mother complained to the Crown Health Enterprise's Complaints Co-ordinator about the services provided to her son. She has not received a response to her complaint.*
- *The surgeon who performed the appendectomy was not fully aware of the consumer's health status prior to the operation.*

Investigation

The Commissioner received the complaint on 18 February 1998 and carried out an investigation. Information was received from:

The Complainant
The Provider/Charge Nurse
The Provider/Surgical Registrar

Information was received from the hospital's employing authority and the consumer's medical records were obtained from the hospital.

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Outcome of Investigation

At about 6.00pm on a date in early September 1997 the consumer was admitted to a hospital with abdominal pain. He was seen by a surgical registrar, who recorded the consumer's blood pressure as 107/57, pulse rate 103, temperature 38.6 and his recent history of watery bowel motions. The registrar diagnosed acute appendicitis which confirmed the opinion of the army doctor. The registrar also recorded the consumer's past history of high potassium blood levels that were treated by a nephrologist when he was admitted to the hospital two weeks previously.

The registrar advised that:

> "[A captain at the consumer's Camp] *had rung me up at the hospital and discussed his case over the telephone and had also written a detailed letter about his past medical history. I enclose a copy of that letter. That letter refers to the treatment that* [the consumer] *had at* [the hospital] *including his elevated potassium levels."*

The registrar commenced intravenous therapy and arranged for the consumer to go to theatre for an appendectomy. It is documented that the consumer was "*uncommunicative"* and that he was incontinent of urine and faeces.

The consumer had an appendix removed at about 10.30pm and was taken to the recovery ward at 11.55pm that night. The registrar noted that the appendix appeared normal. Following the consumer's recovery, a charge nurse went to the recovery ward at 1.00am the next morning to take him to another ward. The anaesthetist asked her to keep an eye on him.

On return to the ward the consumer was very drowsy and sweating profusely, his temperature was 37.9 and the charge nurse took measures to reduce his temperature although these are not recorded. The charge nurse also notes that the consumer was "*uncommunicative"*. The charge nurse recorded the consumer's blood pressure at 1.00am, she checked his intravenous fluids at 1.30am, gave him panadol at 5.20am but no other observations are recorded. She advised that the consumer was not restless and there were no bedrails on his bed.

At some stage after this point the consumer fell from his bed.

Continued on next page

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion - Case 98HDC12302, continued

Outcome of Investigation ***continued***

The charge nurse documented:

> "*06.45am Pt on floor, incontinent of urine ?Bitten his tongue blood in mouth. R) Leg rigid. Ex by* [a doctor] *?focal seizure. Mother aware of fall. She is not surprised by his not communicating. She will try to get down from* [the town she was in] *today. Incident form written.*"

The charge nurse advised that she checked the consumer frequently because his intravenous fluids were not controlled by a pump.

The charge nurse advised that:

> "*...Bedrails were not put in place on* [the consumer's] *return from the recovery ward, as it is not usual to do so for an 18 year old post appendectomy patient, who while monosyllabic in his response with staff, was nevertheless communicating. Bedrails were put in place following* [the consumer's] *fall.* [The consumer] *was in* [a room in] *a surgical ward. He was not the only patient in the room. He was visible to the nursing staff on duty every time they attended other patients or passed through* [his room] *to access* [another room]. [The consumer's] *pulse, temperature and blood pressure were recorded at 1.30am and again at 5am. His temperature was elevated on both occasions to 37.9 and 37.8. Guidelines require staff to organise blood cultures only when a temperature of 38.5 and above is recorded.* [The consumer's] *pulse was within the normal range in relation to the elevated temperature and his blood pressure was also within the normal range.* [The consumer] *was regularly checked by the nursing staff on duty and it is considered that the environment was safe for a post operative appendectomy patient albeit one with a raised temperature.*"

Just after the consumer fell out of bed, his mother rang the hospital to enquire about her son's condition. The charge nurse informed her of the fall and that the doctor was assessing him at that time. The consumer's mother states that she received no response when she asked why the sides of the bed were not up and why a nurse was not present.

Continued on next page

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion - Case 98HDC12302, continued

Outcome of Investigation ***continued***

The Crown Health Enterprise also advised the Commissioner that it is not usual practice to put bed gates in place for an 18-year-old post-appendectomy patient. The consumer's mother told the charge nurse that her son was generally uncommunicative and she would come down and "*sort him out"*.

The consumer's mother stated that the charge nurse told her that she had something funny to tell her:

> *"He* [the consumer] *fell out of bed. Ha Ha."*

The charge nurse advised that she had not laughed at him falling out of bed but rather when the consumer's mother said she would come down from the town she was in and "*sort him out*". The charge nurse stated that she laughed because "*it is the sort of comment I would make about my teenage son"*.

The consumer's mother stated that she asked if the consumer's Camp had been notified of her son's condition and was told that they had not been but "*someone would get onto it as soon as possible*". After being told of her son's fall, the consumer's mother again asked if her son's employer at the Camp had been notified, and was again told that this had not yet happened. The consumer's mother then rang the Armed Forces Camp herself to get an officer to go to the hospital to calm her son down. However, no one on staff recorded receiving these requests.

The Crown Health Enterprise ("CHE") advised:

> "*It is* [the CHE's] *policy to identify on admission one contact person that the patient is happy to share his/her medical information with. In* [the consumer's] *case, the identified person was* [the consumer's mother] *with a telephone call"*.

The day after first being admitted to hospital the consumer remained unwell. He was incontinent of urine, would not respond verbally and he was unable to sit out of bed. Antibiotics were commenced. The medical staff saw the consumer and ordered an urgent CT Scan of his head.

Following the scan, the consumer was sent to the intensive care unit where he could be more closely monitored. It was also discovered that the consumer was unable to speak and had a marked right-sided weakness.

Continued on next page

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Outcome of Investigation *continued*

The CT scan shows *"the appearances are most in keeping with a large infarct in the territory of the left middle cerebral artery. This is most unusual at this age"*.

The next day an echocardiogram found that the consumer had an infection of a valve in his heart. A second CT scan confirmed the findings of the day before.

Three days later the consumer was moved from the intensive care unit into a ward at 4pm. The records indicate:

> "*Patient responsive and alert nodding yes and no appropriately to questions.*"

Although the CHE stated that the consumer's mother was introduced to customers relations co-ordinator by the staff at the CHE's on-site marae-style accommodation (where the consumer's mother stayed), the consumer's patient notes indicate that his mother raised her concerns to the surgical registrar, who provided her with information regarding the complaint person. The notes record:

> *"Patient's mother expressing dissatisfaction with aspect of patient's earlier treatment and care. Spoken to by* [the Registrar]*, given complaints extension to ring."*

The consumer's mother met with the complaints co-ordinator. It was agreed that the consumer's mother needed additional information regarding the clinical aspects of her son's condition. The complaints co-ordinator contacted a charge nurse, who met with the consumer's mother. In mid-September 1997 the charge nurse noted in the consumer's record:

> "*Following request by* [Complaints Co-ordinator] [sic]*, I have spoken with* [the consumer's mother] *on the events leading to and after* [the consumer's] *fall in* [the ward]. *She seems reassured that the fall was not due to negligence, but rather to manifestation of neurological symptoms beginning.* [The consumer's mother] *is requesting a copy of all notes both present and past, ward assistant notified to organise these."*

Continued on next page

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Outcome of Investigation *continued*

Following that meeting, both the charge nurse and the complaints co-ordinator assumed that the issues had been resolved. The CHE received no formal complaint from the consumer's mother. It is not clear if the consumer's mother was advised of the formal complaints procedure.

The consumer's mother expressed concern that it took five days for anyone to tell her that her son's appendix was normal. She indicated in her letter of complaint that she would *"sue for negligence"*. The surgical registrar stated:

> *"I did an appendectomy… and found that his appendix was absolutely normal. I could not find any other pathology inside his abdomen hence I proceeded to take out his normal appendix which is the current surgical practice*."

He added:

> *"The decision to do an operation was not taken lightly and it is well established in literature that out of every 100 appendectomies we do, we remove about 10 – 20 normal appendices"*.

The histology report which notes that the appendix had no abnormality was not issued until two days after being admitted. Although the report is signed, it is not clear when it became available to clinical staff or when it was placed in the consumer's notes.

The consumer was discharged as an inpatient in mid-October 1997 but stayed at the on-site marae-style accommodation with his mother until late December 1997. The consumer attended rehabilitation physiotherapy daily. Prior to the consumer's discharge, his mother spoke with the Kaiwhakahaere of the Health and Disability Commissioner and stated that she was still not satisfied with the information she received following her complaint. These comments were relayed to the complaints co-ordinator, who advised the Commissioner that she saw the consumer's mother a number of times but had no indication that she remained dissatisfied with the care her son had received. The day they left the marae-style accommodation the consumer's mother wrote to a Health and Disability Advocacy Service with her complaint. She was visited by an advocate but there was no follow-up by the Advocacy Service until they referred her complaint to the Commissioner in mid-February 1998.

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Code of Health and Disability Services Consumers' Rights

RIGHT 1
Right to be Treated with Respect

1) *Every consumer has the right to be treated with respect.*
2) *Every consumer has the right to have his or her privacy respected.*

RIGHT 4
Right to Services of an Appropriate Standard

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

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*
   a) *An explanation of his or her condition; and*
   e) *Any other information required by legal, professional, ethical, and other relevant standards.*

RIGHT 10
Right to Complain

3) *Every provider must facilitate the fair, simple, speedy, and efficient resolution of complaints.*
6) *Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -*
   b) *The consumer is informed of any relevant internal and external complaints procedures, including the availability of -*
      i. *Independent advocates provided under the Health and Disability Commissioner Act 1994; and*
      ii. *The Health and Disability Commissioner.*

Continued on next page

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Code of Health and Disability Services Consumers' Rights *continued*

3 Provider Compliance

1) A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.

2) The onus is on the provider to prove that it took reasonable actions.

3) For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.

Opinion: No Breach – Charge Nurse

Right 1(1)

In my opinion, the charge nurse did not breach Right 1(1) and Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

Right 1(1)

The charge nurse was talking to the consumer's mother on the phone and explaining that he had just fallen out of bed. The charge nurse laughed in response to a comment made by the consumer's mother. The consumer's mother's perspective was that the charge nurse was laughing at her son's misfortune. I accept the charge nurse's account that she did not laugh at the consumer falling out of bed, although in my opinion this laughter was inappropriate at that time.

Right 4(2)

In my opinion, the charge nurse did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights when the consumer fell out of bed.

The consumer was 18 years old and, although he was uncommunicative, he was fully awake and conscious. There is no indication from the observations that he was restless or incapable of standing. He was in a room with other patients and was seen regularly by nursing staff. In my opinion, the charge nurse's actions were reasonable in the circumstances.

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Opinion: No Breach – Surgical Registrar

Right 4(2)
In my opinion, the surgical registrar did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights.

The registrar had a letter from the Army Camp, which gave a detailed medical history of the consumer's care and treatment from the hospital prior to his admission. The registrar has documented this information in his admission notes and a copy of the referring letter is in the medical records. At the time the consumer went to theatre his potassium level was normal.

The consumer was examined by two doctors who agreed on the diagnosis. The registrar commenced the operation to remove what he thought would be an infected appendix. Once the surgery was underway, it was found this was not the case. The decision to operate on the consumer was not taken lightly. I accept the registrar's evidence that removal of a healthy appendix during an appendectomy is current surgical practice.

Opinion: No Breach - Crown Health Enterprise

In my opinion, the Crown Health Enterprise's staff did not breach Rights 1(2), 6(1) and 10(3) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 1(2)
The Crown Health Enterprise (CHE) did not notify the Armed Forces Camp where the consumer lived about the consumer's condition. However, the consumer nominated his mother as his contact person. The CHE's policy is that only the nominated contact person is informed about a patient's condition. The staff complied with that policy.

Continued on next page

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Opinion:
No Breach – Crown Health Enterprise, ***continued***

Right 6(1)
Consumers must be provided with the information that a reasonable consumer in those circumstances would expect to receive, including an explanation of their condition, and all other information required by relevant standards.

The consumer's mother complained that she did not know about the removal of her son's normal appendix for five days after his operation. The consumer's medical notes indicate that the focus of medical attention in the days immediately following his operation was his neurological state. Five days after the consumer was admitted his condition had stabilised. Further, the laboratory report confirming the consumer's appendix as normal was not available until two days after being admitted. In my opinion, it was reasonable in the circumstances to wait until the histology report was available before advising the consumer's mother of the result.

The consumer's mother had been nominated as a contact person and in these particular circumstances it was reasonable for the CHE to have informed her of the fact that her son's appendix was normal. The consumer was still unwell and the CHE was attempting to ascertain the cause.

Right 10(3)
The consumer's mother met with the complaints co-ordinator and subsequently a meeting was arranged with the second charge nurse who could answer her questions regarding her son's care. After the meeting, the charge nurse recorded that the consumer seemed satisfied with this explanation. The complaints co-ordinator was of the opinion that the consumer's mother's approach was for more information and she was not making a formal complaint. I accept that in some circumstances there is a thin line between a request for information and a formal complaint. However, in my opinion it was reasonable in the circumstances for the CHE to conclude that a formal complaint had not been made. It would have been a simple matter to have written to the consumer's mother at the time her son's medical notes were sent, to ensure her concerns were addressed to her satisfaction.

Surgical Registrar / Charge Nurse / Crown Health Enterprise

Report on Opinion – Case 98HDC12302, continued

Opinion: Breach – Crown Health Enterprise

In my opinion, the Crown Health Enterprise breached Right 10(6)(b) of the Code as follows:

I am not convinced that the consumer's mother was advised of the CHE's complaint process or of the availability of advocacy services. The Complaints Co-ordinator should have ensured the consumer's mother was informed about her Rights, including details of complaint procedures, advocacy services and the Commissioner. It is unclear from the evidence whether staff referred the consumer's mother to the CHE's formal complaint procedure and the onus is on the CHE to demonstrate this.

Actions

I recommend that the Crown Health Enterprise provide a written apology to the consumer's mother for the breach of Right 10(6)(b) of the Code of Health and Disability Services Consumers' Rights. This letter is to be sent to the Commissioner who will forward it to the consumer's mother.

The CHE should ensure that its staff advises any dissatisfied consumers or their relatives of the CHE's formal complaint procedure. Actions taken should be documented.