25 September 2002

Dr Mr A and Ms B

Complaint
Following an investigation I have now formed my final opinion on the complaint made by Mr A and Ms B which I summarised as follows:

"At some time during her admission to [the Rest Home and Hospital] between 18 November 1999 and 12 September 2001, Mrs C dislocated her left prosthetic hip. Staff at the [Rest Home and Hospital] failed to diagnose the dislocation, investigate the source of pain experienced by Mrs C or provide adequate treatment for this pain."

Information
During this investigation I have carefully reviewed information from the complainants, the Rest Home and Hospital, the public hospital, Dr D, and Dr E.

Medical
Mrs C's medical condition is described in her records as:

- Chronic Obstructive Pulmonary Disease
- Congestive heart failure
- Atrial fibrillation
- Chronic renal impairment
- Cognitive impairment
- Gout
- Hypertension
- Osteoarthritis

Independent expert advice
I have also received independent expert nursing advice from Ms Jan Featherston and enclose a copy of her advice.

Ms Featherston advised me that, although the notes did not indicate any particular date when the dislocation occurred, it would have been detected if there had been regular reviews or assessments of Mrs C's physical and cognitive function. She said that Mrs C did show signs of pain that was demonstrated by her increasing anxiety when she was moved or transferred and increasing confusion. This should have led nursing staff to assess her for pain. Ms Featherston advised that such reviews are common practice and noted that a full pain assessment on Mrs C was never undertaken.

Ms Featherston also informed me that much of the nursing literature identified how patients with dementia are not adequately assessed for pain and that patients (such as Mrs C) who are confused express pain in different ways. Ms Featherston said that it appears staff considered this but thought Mrs C's expression of pain was due to her confusion. My expert advisor also said Mrs C's medication indicated that she was treated for anxiety and confusion rather than pain.

Decision

In my opinion the Rest Home and Hospital breached Right 4(3) of the Code, which states that every consumer has the right to have services provided in a manner consistent with his or her needs.

My decision is made on the following grounds:

- I accept the advice of my expert advisor, Ms Featherston, that the Rest Home and Hospital did not regularly review Mrs C's physical and cognitive condition and if they had staff would probably have detected the dislocation in her left hip. This view is supported by the fact that, although Mrs C was admitted to the Public Hospital on 12 September 2001 with increasing confusion, calling out and deteriorating ability to swallow, it was noticed on admission that she had pain in her left leg on movement and she was referred for an x-ray which revealed the dislocation. During this admission staff considered that Mrs C had been increasingly agitated because of her progressive cognitive impairment and pain from her dislocated hip. It was also recorded that she was prescribed morphine PRN (as required) and received two small doses when staff considered that she was in pain from her dislocation.

- I also accept the advice of Ms Featherston that the staff at the Hospital treated Mrs C's expressions of pain as confusion. This view is also supported by Mr C who told me that staff had said that his mother's screaming when being moved was "anxiety". Ms B also said to me that her mother had mentioned pain in her leg a few times, however when she asked staff about it they said her mother was "disturbed". This is also supported by Mrs C's medication, which my expert advisor said indicated that she was treated for anxiety and confusion rather than pain.

- Although I accept that it is not possible to determine the date when Mrs C's hip became dislocated, an x-ray taken on 13 September 2001 during her admission to Public Hospital was reported as indicating upward dislocation of the femoral component and bone arching over the head of the femoral component. The report stated that this suggests the dislocation had been present for some time and a false joint was forming. The orthopaedic registrar also concluded on the basis of the x-ray that Mrs C's hip had been dislocated for "a long time".

- Mrs C was admitted to the Rest Home and Hospital in November 1999 from the Public Hospital where she had received treatment for an acute dislocation of her left prosthetic hip. Her medical records indicate that she had two previous hip replacements. In view of this medical history I consider that staff at the Rest Home and Hospital should have been more vigilant concerning Mrs C's physical condition.

Response to provisional opinion

In its response to my provisional opinion the Rest Home and Hospital accepted that it knew about Mrs C's previous hip problems and that the dislocation of her hip had been present for a considerable period of time.

However the Rest Home and Hospital also stated that Mrs C was capable of expressing pain but did not do so in relation to the movement of her hip. It said that, although she expressed anxiety or confusion, this related to her fear of falling when being moved or transferred by staff, but it was not associated with pain. Therefore it was reasonable that staff did not detect Mrs C's dislocation.

I consider it probable that Mrs C was in pain because of the dislocation of her hip and that she was not able to clearly express this in view of her confusion and anxiety. It is likely that her expression of pain was subtle and not easily detectable. The Hospital should have had a system, as part of Mrs C's care, to ensure that regular physical and mental reviews of her condition and a pain assessment were conducted. As noted above, staff at the Public Hospital detected that Mrs C's hip was dislocated very soon after her admission there in September 2001, yet staff at the Rest Home and Hospital, who had been caring for Mrs C on a 24 hour basis, had not detected her dislocated hip.

It was essential that the care received by Mrs C at the Rest Home and Hospital was of an appropriate standard, particularly since she was unable to clearly and consistently express her pain due to her anxiety or confusion. Mrs C was in a very vulnerable situation and she relied on health care providers to meet her needs. In failing to adequately meet those needs, the Rest Home and Hospital breached Right 4(3) of the Code.

Notwithstanding my decision that the Rest Home and Hospital breached Right 4(3) of the Code, I agree with my expert advisor that the Hospital carried out a thorough investigation of the complaint.

In its response to my provisional opinion, the Hospital said that it was following my recommendation and was establishing three monthly multi-disciplinary reviews, which will include the resident and the family. These will be undertaken in conjunction with a full medical check. The Hospital also advised that it had followed the other recommendation in my provisional opinion and now required staff who make entries in the progress notes record their designation.

I also acknowledge that the Rest Home and Hospital was very cooperative during my investigation.

Actions

- A copy of my final opinion will be sent to the Ministry of Health Licensing Section and Private Hospitals Association New Zealand.
- A copy of my final opinion, with identifying features removed, will be sent to Age Concern New Zealand Incorporated and Alzheimers Society NZ.

Yours sincerely

Ron Paterson
Health and Disability Commissioner

Enc

Ref: 01/12197/KH

Independent Expert Advice

"I have been asked to provide expert advice on care provided to Mrs [C] during her stay at [a Rest Home and Hospital] between 18 November 1999 and 12 September 2001.

Supporting information

- Letter of Complaint and other information provided by the complainants
- Letter from the Commissioner to [the rest home] notifying it of the complaint dated 30 April 2002
- Information provided by [the rest home]
- Information provided by the [District Health Board]
- Information provided by Dr D
- Action notes dated 28 May, 24 June, and 9 July 2002.

History

Mrs [C] was admitted to [the rest home] on 18 November 1999 following a manipulation of L total Hip Replacement. Her significant medical problems are listed on her discharge report as being
COAD
Osteoarthritis R Knee
Mild renal impairment
Cognitive impairment
Hypertension
Gout
Congestive Heart Failure

Her medications on admission to [the rest home] were
Flucloxacillan 250 mg TDS for 5 days – antibiotic
Allopurinol 100 mg Mane – used for Gout
Enalapril 5 mg mane – used for Hypertension and congestive heart failure
Frusemide 40 mg – used as a diuretic
Zantac 150 mg – treatment of duodenal ulcer
Paracetamol 1gm – QID – PRN – used as an analgesic
Lactulose 10-20mls PRN – used as a laxative
Plus creams used for skin care

Her nursing admission includes a front sheet which includes a photo and next of kin details. The second page is a nursing history – there is limited information completed on this form. *Reason for admission* is listed as on going care. There is nothing written for
Patient's expectation, insight regarding admission, careers expectations, living arrangements, etc.
The second page is entitled *Physical Health.* There is limited information completed on this page, no note of Allergies is documented, no baseline recordings are listed. These would include temp, pulse, blood pressure, respiration, weight.

There is a tick, which lists the patient at risk of falls.
The next area is entitled *Mental Health* and staff have ticked 'confused' and written 'slightly'. Memory is listed as some impairment.
The third page is a list of *Activities of Daily Living.* This page indicated that Mrs [C] needs some assistance with diet, has dentures, some assistance required with elimination of both bowel and bladder, hearing and speech listed as normal, settles at 2100hrs with legs elevated on a pillow, mobility lists that she needs assistance of 2-3 people, and skin care list what creams are to be applied.
Page four has a *Lifting Profile.* There is nothing written here except besides bathing where hoist is written.
The fifth and sixth pages are a *Daily care intervention*. It lists her daily care activities: Shower Monday and Thursday, sponge on the days not showered.
The mobility section lists 2-3 person transfers. Pain management states "regular Paracetamol elixir for pain related to L hip dislocation. This page is not dated or signed.
The next section of the nursing admission is the *Nursing Care Plan*.
This section is dated the 22.11.99.
It lists the problems as:

1. Self Care deficits due to decreased mobility. Appropriate goals and nursing interventions are also listed.
2. Altered nutrition – less than body requirements decrease in oral intake. Appropriate goals and intervention are listed.
3. Decreased cognitive function related to confusion, the goal is to remain as confusion free as possible, three appropriate nursing actions are listed. There is no date on this page.

The next page is listed as *Continuous evaluation.* There are three entries dated 9/1/00 and an entry dated 21/1/00.
This appears to be the nursing assessment and documentation in relation to Mrs. [C].

The nursing staff then document care in the *Progress Notes.*

Entries appear to be daily to start with, then as required. The progress notes state that Mrs [C] was quite distressed on admission. Staff have listed how they have assisted in daily care. Mrs [C] was first seen by the Physiotherapist on the 26/11/99. Her entry notes that she attempted to stand Mrs [C] and due to Mrs [C's] anxiety she was not successful. There are regular entries by the Physiotherapist. They indicate that Mrs [C] was reluctant at first then improved in walking and standing. The second to last entry on the 10/3/00 notes that "[Mrs C] is a lot more confident to walk now, not enough extension in her hips & knees to weightbear properly, but at least willing to try". Contained within the clinical notes is the Physiotherapy Care Plan. The initial entry was on the 29/11/99. This was reviewed on the 19/06/01 and the 29/2/00. There is an entry in the Physiotherapy notes dated the 14/06/01 in which it states "[Mrs C] is to fearful to use equipment on, so we can't recommend? hoist", it goes on to state how to lift Mrs [C]. The last entry in the progress notes on 4/4/00 states: "Tried to get [Mrs C] up again – anxious and fearful to stand again will try again on Friday."

The nursing notes follow care given in a logical order. Many of the entries are listed as "All cares given". There are periods when several days have gone past where there are very limited entries in the nursing notes e.g. from 29/1/00 to 1/3/00 only one nursing entry was written that being on the 12/2/00: "[Mrs C] has been fine today".
The nursing progress notes indicate that Mrs [C] had periods when she became anxious and yelled out. Staff have documented how they were able to change her position and this settled her. The notes indicate that Mrs [C] was always anxious on transferring. On the 6th June the hospital changed to computerised notes. It appears staff then entered on at least a daily basis. Again many of the entries are "slept well overnight" and "good this shift".

An entry on the 14 June 2000 by [a nurse]: "very worried and anxious this morning whilst getting dressed. In tears if moved, not because of pain but because of anxiety." Entries around the month of June/July 2000 indicate that Mrs [C] was becoming more anxious. She appeared to be calling out more and staff were finding it very difficult to settle her. Staff state that she was very anxious when being moved, (5/7/00). On July 11 she was seen by Dr [D] who suggested a "trial of paracetamol BD (twice a day) ? in pain especially in the morning after lying still all night, joint pain".

The following entries were also made:
15 June: Leg not looking so good today
17 June: L ankle very swollen
28 June: Change medications
29 June: Painful lower leg

There is limited evidence that any pain assessment occurred either in the progress notes or in the nursing assessment notes.

Mrs [C] continued to be cared for with limited input obvious from the physiotherapist at this time. The nursing progress notes show that Mrs [C] was becoming frailer and that she required increasing nursing input.

Medications
Mrs [C] was continued on the medication that she was discharged from public hospital on. Her regular medication included Methotrimeprazine (Nozinan) 12.5 mg in evening. That was changed to 12.5 mg twice a day on the 14/7/00. This medication would have been put in the blister packs as it was charted on the regular medication instructions form.

On 23/11/99 Mrs [C] was charted sleeping pills. On 13/3/00 she was charted Melleril 10 mg one table QID PRN to settle. This was charted on short course and PRN (which means when required). This medication was given at intervals when staff assessed Mrs [C] to be very anxious or calling out.

All entries in the progress notes are signed on the drug administration form. Pain relief appears to be paracetamol, which was charted 1gm twice a day. There does not appear to be any inconsistencies in the medication administration.

Is it reasonable to expect staff at [the rest home] to have detected that Mrs [C] had dislocated her hip during her stay there?

The opinion of the external auditor was that it was not possible to detect the dislocation of L hip. I acknowledge that the notes do not point to any particular date in which a separate event could have caused her dislocation. In June and July 2000 Mrs [C] became more anxious and distressed but again there was no one event that was documented that could point to a dislocation.

Throughout Mrs [C's] stay there was not a full review of her in relation to her increasing anxiety. Nursing care staff appears to have gone along treating each event rather than a full multidisciplinary review. It is common practice that regular reviews are undertaken. They may be anywhere from three to six monthly. This type of formal evaluation of the patient's condition and progress ensures that:

1. There is good communication between all members of the multidisciplinary team.
2. Family is involved and is able to ask questions or express concerns.

Such a discussion may have identified how Mrs [C] was expressing her pain. This may have alerted staff and they may have undertaken a full physical assessment. Staff appear to have treated her for her anxiety rather than assessing her pain. I cannot find anywhere in the clinical notes where a full pain assessment was undertaken. There are several recognized pain assessment charts and much of the nursing literature identifies how patients with dementia are not adequately assessed for pain. It is acknowledged that patients who are confused express pain in different ways. It does not appear that staff considered this but rather put this down to her confusion.

Paracetamol is an analgesic of choice and it is my nursing experience if taken regularly it has a good effect. Mrs [C] was charted 1gm QID (four times a day) this was charted on the short course and PRN medication sheet. Hence I am unsure if this was given regularly following admission. It was then charted on the regular medication sheet on 11/7/00 and at this time would have been put into the blister packs. In December 1999 the doctor charted Methotrimeprazine (Nozinan) 12.5 mg in the morning and afternoon. This was put into the blister packs. (New Ethicals note this drug is used as an antipsychotic, management of terminal pain and accompanying restlessness or distress.)

Mrs [C] was also charted Aropax 20 mg, Melleril 25mg PRN and in July 01 Chlorpromazine.

The drugs do indicate that Mrs [C] was treated for anxiety and confusion rather than pain.

Adequacy of steps which [the rest home] has taken to improve its procedures and training.

It is my opinion that [the rest home] has carried out a thorough investigation of the complaint. The complaint was acknowledged and an internal investigation was undertaken. The process has been undertaken in a logical order and communication has been noted between the family and the Hospital.

I do not agree with points 15 to 17.
Point 15: Throughout the nursing admission, nursing care plan and progress notes there was no evidence that a thorough pain assessment had been undertaken.
Point 16 & 17: Mrs [C] did show signs of pain. This may not have been in such a statement as "I am in pain" but she did demonstrate anxiety and increasing confusion. This should have lead the nursing staff to assess her for pain. It was evident when she was being transferred or moved that her anxiety increased. This may have been due to pain. I do not think nursing or medical staff could rule this out.

The hospital has identified shortcomings in operation practice and I agree with the recommendations in points between 19 and 24.

Point 23.6 states: Extending 3 monthly medical checks to include a full physical examination if requested by the resident or the resident's family.
It would be my recommendation that 3 monthly multidisciplinary reviews are undertaken that will if possible include the resident and their family. Full assessment of the patient is undertaken. These reviews should be documented in the clinical notes.

General
I would like to comment on the nursing assessment and progress notes. It is important that nursing staff write their designation beside each entry. When viewing the progress notes it is impossible to know who made the entries. Were they all written by caregivers or Registered Nurses or a mixture of both? There obviously is a greater expectation of nursing knowledge in relation to assessment and care planning. If they were written by caregivers then the organization needs very clear policies of how that information is passed on to senior staff.

It is my opinion that the dislocation of Mrs [C's] L hip would have been detected had there been regular assessment of both physical and cognitive function.

Please note that this opinion is a nursing opinion. Please don't hesitate to contact me should you require further information."