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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241

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#### Complaint

The Commissioner received a complaint concerning services provided to the complainant's father ("the consumer") by two hospitals, run by two Crown Health Enterprises.

#### *The first hospital*

- *In mid-August 1996, the consumer was admitted to the first hospital coronary care unit. The consumer had suffered a heart attack and had a temporary pacemaker inserted four days later. When the pacemaker was turned down after two days the consumer suffered a relapse.*
- *The pacemaker was removed on the next day. The consumer suffered a stroke later that day. The consumer's family were told he didn't require blood thinning agents, yet once he had suffered the stroke he was given large quantities of these.*
- *The consumer's daughter, the complainant, says the family were not told of the stroke until approximately 6.15pm when they visited the hospital. The complainant had phoned the hospital earlier at 3.00pm to see how the consumer was and was told he was fine. The consumer's stroke occurred at approximately 2.30pm. The hospital had the family mobile phone number.*
- *The consumer's family requested copies of blood test results from the first hospital, following the consumer's death in early September 1996. Several of the results seemed to be for a different patient. The medical notes indicate the specimens were taken from the wrong patient.*
- *The consumer did not have an identity bracelet for the first 8 days that he was in the first hospital.*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Complaint,  
continued**

*The second hospital*

- *The consumer was transferred from the first hospital to a second hospital two weeks after admission. The consumer was discharged to a rehabilitation unit on the same day, where emphasis was on rehabilitation from his stroke which occurred a week earlier. The consumer's family believe the consumer's heart condition was not monitored appropriately while he was at the rehabilitation unit.*
- *After four days the consumer was given weekend leave from the hospital and returned to his home. His condition deteriorated and he was readmitted to the second hospital the next day at approximately 7.05pm. The complainant has concerns about what happened to the consumer from then until his subsequent death at approximately 5.30am the following morning.*
- *The complainant says the consultant from coronary care unit at the second hospital should have known the consumer's wife would want to be with her husband when she arrived at the hospital at approximately 5.15am, but the consultant wasted precious time telling the consumer's wife details of her husband's condition.*
- *The consumer should not have had to wait 1½ hours in accident and emergency at the second hospital before being admitted to the ward.*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Investigation** The Commissioner received the complaint on 25 June 1997 and an investigation was undertaken. Information was obtained from:

The Complainant (Consumer's daughter)  
Chief Executive, First Crown Health Enterprise  
Senior House Officer, Second Hospital  
Consultant, Coronary Care Unit, Second Hospital  
Customer Services Manager, Second Crown Health Enterprise

Other information obtained and considered as part of this investigation included:

- Correspondence between the complainant and the first Crown Health Enterprise.
- Correspondence between the complainant and the second Crown Health Enterprise.
- The consumer's medical records from both hospitals.

The Commissioner also sought independent advice from a cardiologist.

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**Outcome of Investigation** The consumer was admitted to the first hospital in the early hours of the day in mid-August 1996 suffering from severe abdominal pain. The consumer was initially examined by a surgical registrar, who made a tentative diagnosis of an inferior myocardial infarction (heart attack). Upon viewing the results of an electrocardiogram, a medical registrar, who later examined the consumer, was able to confirm this diagnosis and the consumer was transferred to the coronary care unit at 6.30am.

#### ***Pacemaker***

The consumer developed a heart block and had a temporary pacemaker inserted four days later. The consumer's heart rhythm was regulated by the pacemaker for the next 24 hours or so. When the consumer's heart rate had returned to a normal rhythm (normal cardiac conduction) after two days the pacemaker was turned down. The complainant stated that approximately one hour after the pacemaker was turned down the consumer became breathless, agitated and restless. The complainant further stated that when she informed the nurse of this, the pacemaker was promptly turned up again.

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### Report on Opinion - Case 97HDC7241, continued

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#### **Outcome of Investigation, continued**

The first Crown Health Enterprise ("CHE") advised:

*"The pacemaker was left 'on demand' i.e. was placed in a mode where it was acting purely as a back-up facility and would pace at a relatively low rate so as not to interfere with [the consumer's] own conduction. [The consumer] maintained normal conduction for some hours and again heart block developed."*

The medical notes for the day six days after admission record that:

*"[at 6.00am] Remained in paced rhythm... [later, no time stated] ...pacing well ... keep rate (BPM) low and if rhythm is stable we could turn off pm and leave for backup only ...[at 2.30pm] Became very agitated and clammy when pacemaker turned down to 60 BPM – BP 100/70, rate increased up to 80 BPM – now feeling much better."*

The following day the pacemaker was turned down again and the consumer's heart rhythm remained stable. Later that day at approximately 2.30pm the consumer suffered a cerebrovascular accident (stroke). The first CHE advised:

*"At no time during the evolution of the subsequent cerebrovascular accident were any abnormal rhythms present. ...it would almost be impossible for isolated periods of bradycardia (slowness of heart beat) to account for the neurological symptoms [the consumer] developed several days later."*

#### ***Transfer to tertiary care hospital***

The complainant questioned whether the consumer would have benefited from transfer to a tertiary care hospital. The cardiologist advisor agreed with the first CHE that transfer to a different hospital would only have been necessary if surgical intervention was required.

#### ***Administration of blood thinning agents***

The complainant stated that the family were told the consumer did not require blood thinning agents, but that once the consumer had suffered the stroke he was given large quantities of these.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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#### Outcome of Investigation, continued

The first CHE stated:

*“[The consumer] was treated with streptokinase, heparin, and aspirin over the period of his myocardial infarction. When someone suffers a thrombo-embolic cerebrovascular accident anticoagulation is usually withheld for a few days because of the potential risks of converting these types of strokes into haemorrhagic strokes which tend to be more debilitating. Subsequent to that anticoagulation to prevent recurrent strokes is initiated, usually only with aspirin, but warfarin is administered occasionally, particularly where risks are relatively high as was the case with [the consumer].”*

The complainant stated that the family were not told of the consumer's stroke until approximately 6.15pm. The complainant said she had phoned the hospital earlier at 3.00pm to see how her father was and was told he was fine. The complainant stated that the consumer's stroke occurred at approximately 2.30pm. The complainant said the hospital had the family's mobile phone number.

The first CHE stated:

*“[The consumer] had been settled for a rest during the ward's designated rest period, which is from 1pm – 3pm. It is recorded that [he] was feeling very tired and was really pleased that he was able to sleep quite solidly during this time. One of the nursing staff who was caring for [him] at this time noted that [he] was sleeping peacefully. This nurse finished her shift at 3.30pm. Another member of the nursing staff who had come on for the next shift noted that [the consumer] was feeling unwell and that he had been incontinent. A medical officer was therefore called to review [the consumer] at this time. Unfortunately there is no time noted in the clinical records against this instalment and we are unable to clarify this with the nurse concerned who has since left our employ. If a nurse is concerned about a patient's condition they may be reluctant to discuss the medical aspects of the case with the family until after the patient has been seen by the medical officer. Every endeavour is made to keep patients' families updated at all times and we are sorry if [this man's] family felt let down in this regard.”*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Outcome of Investigation, continued**

***Identity bracelet***

The complainant stated that the consumer did not have an identity bracelet for the first eight days that he was in the first hospital. The first CHE stated that most patients come to the coronary care unit via the emergency department. The expectation is that the emergency department bracelets should be replaced with a coronary care unit bracelet, which has the same details but includes the unit name.

*“This practice is routinely audited and the results of these serve as a reminder to the nursing staff that there is room for improvement. We sincerely regret if in [the consumer’s] own case, an identity bracelet was not put in place.”*

***Blood test results***

The complainant received copies of the consumer’s medical records from the first hospital. Several of the blood test results on the file seemed to be for a different patient. The laboratory notes stated:

*“Medical staff informed laboratory that specimen was taken from wrong patient.”*

The first CHE advised the Commissioner that:

*“Blood tests belonging to a different patient were inadvertently filed in [the consumer’s] notes. There is no evidence that there was any confusion with regard to any of these blood tests during [the consumer’s] admission to the ward. The biochemical results that the clinical decisions were made on were handwritten in the clinical notes of the patient and at no time were any results acted upon which did not belong to [the consumer]. Whilst there are systems in place to minimise the potential for filing test results in the wrong patient’s records these problems do occur from time to time and are rectified as soon as the error is discovered.”*

***Transfer to second hospital***

The consumer was transferred from the coronary care unit to a medical ward the day after his stroke. The complainant said the consumer was transferred back to the coronary care unit two days later due to bradycardia (slowness of heartbeat). The consumer was transferred to a general medical ward three days after that. He was then transferred to the assessment and rehabilitation department at the second hospital the next day.

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### Report on Opinion - Case 97HDC7241, continued

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#### **Outcome of Investigation, continued**

Before his transfer the consumer was assessed by an occupational therapist, speech and language therapist and physiotherapist. The cardiology registrar at the first hospital noted, in the letter of transfer to the assessment and rehabilitation department at the second hospital dated the day of transfer, that the consumer had made good progress and was mobilising with a frame.

A physician in geriatric medicine at the first hospital, in a letter to the assessment and rehabilitation department, in essence stated that the consumer's problems were an inferior myocardial infarction, embolic stroke, and resolving left lower lobe pneumonia.

#### ***Monitoring in the second hospital***

The complainant stated that the consumer's heart was not specifically monitored while he was at the rehabilitation unit. The rehabilitation unit doctor stated:

*"While [the consumer] had clearly had a significant myocardial infarction a week prior to his stroke with a complication of complete heart block, by the time of his transfer from [the first hospital to the second hospital], it was considered that his cardiac condition was no longer causing concern. Specific monitoring of his heart by electronic means was therefore not required. ...Whilst on our ward, [his] general conditions including his heart pressure were monitored clinically, (by examination and by regular monitoring of pulse and blood pressure). No abnormality was apparent during this time."*

The consumer was fully assessed by an occupational therapist, a physiotherapist, a social worker, nursing and medical staff during his time in the rehabilitation unit.

#### ***Weekend leave***

The consumer was given weekend leave from the hospital to return to his home. Medical records note that he was eager to be allowed to return home. The next day his condition deteriorated and his family contacted their GP who wrote a referral letter to the second hospital. This stated the consumer was suffering from "*myocardial instability*." An ambulance arrived at the consumer's house at about 5.30pm. The ambulance report states the consumer was complaining of "*chest pain*."

The rehabilitation unit doctor stated that when people are close to returning home the hospital encourages weekend leave to allow a smoother transition from hospital to community and also to identify any issues relating to the disability which need addressing prior to formal discharge.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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#### Outcome of Investigation, continued

##### *Readmission*

The consumer was assessed in triage in the emergency department at the second hospital at 7.05pm. The medical notes record: *"blood tinged sputum... feeling breathless pain in shoulders and back. Nitrolingnal spray given at 1930 hours under tongue. 1950hrs BP95/58... Admit CCU"*. The consumer was then seen at 7.45pm where he was assessed and treated by a house surgeon. The medical notes record at 7.45pm: *"Acute admission via GP. PC: Chest pain..."*. The consumer's medical notes state he was admitted to the ward at 9.00pm. The customer services manager, for the second hospital stated:

*"A further one hour was spent in the emergency department. The explanation for this is that the ward was busy and staff and bed resources needed to be re-arranged prior to [the consumer] being transferred to the ward.*

*[...The ] medical co-ordinator emergency department, does not accept that the time spent in the emergency department contributed significantly to the outcome."*

The rehabilitation unit doctor stated that people on weekend leave always have their beds in the rehabilitation ward held available for them should they need to return earlier. He stated:

*"A visit via the accident and emergency department should not have been required as [the consumer] could have gone directly to the rehabilitation ward when he became acutely unwell. I am not sure why he was requested to go to the accident and emergency department, unless it was considered that he was so unwell that a rehabilitation ward was felt to be an inappropriate place to be held, by his general practitioner."*

##### *Subsequent treatment*

The senior house officer at the second hospital was called to see the consumer at approximately 2.00am the day after his readmission, as his respiratory condition had deteriorated. The senior house officer said he reviewed the consumer's notes and saw that he had been admitted the previous evening with a presumed diagnosis of angina pectoris, his chest X-ray had shown some evidence of an early pneumonia and his white blood cell count was raised so he had been started on augmentin.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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#### Outcome of Investigation, continued

The senior house officer stated:

*“When I examined [the consumer] I found him to be unwell with a tachypnoea and low oxygen saturations. On auscultating his chest I found no evidence of significant pulmonary oedema and therefore did not feel that diuretics were indicated. There was no auscultatory evidence of a pneumothorax, pleural effusion or pneumonia at this stage. I therefore performed an arterial blood gas and ran it through the analyser at 02h33. The findings from this test confirmed the hypoxia. My differential diagnosis included:*

- 1. a progression of the pneumonia*
- 2. a pulmonary embolism*
- 3. another myocardial infarction.*

*[The consumer] was already on warfarin with an INR of 2,6 and I therefore felt that a pulmonary embolism was highly unlikely. [He] had already been started on intravenous antibiotics to cover the possibility of pneumonia. I therefore felt that it was important to investigate the possibility of a myocardial infarction. A repeat electrocardiogram showed no significant changes from his admission ECG. As it had been approximately 6 hours since his admission I felt that cardiac enzyme levels would be extremely helpful in making a definitive diagnosis. I therefore drew blood for this investigation and had it taken to the laboratory for analysis. I also arranged for [the first hospital] to fax us a copy of [his] ECG's from his previous admission there. I felt that comparing these previous ECG's with the recent ones would also be extremely helpful diagnostically. I then left [the consumer] to attend to other patients in the hospital. I returned to review [him] at 04h45. I found that his condition had deteriorated and that the cardiac enzymes did not show a marked rise. I then ordered a portable chest x-ray and contacted [the consultant, coronary care unit] for advice. [The consumer's] condition then rapidly deteriorated and he was extremely unwell by the time [the consultant] arrived at the hospital.*

*My reason for not contacting [the consultant] immediately was that I felt that the repeat cardiac enzymes and old ECG's were important in order to make an accurate diagnosis.”*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Outcome of  
Investigation,  
*continued***

The complainant stated that when the consumer's wife arrived at the hospital at approximately 5.15am the consultant told her the details of her husband's condition rather than let her go straight in to see her husband. The consultant stated:

*"...it is my normal practice to inform family members when patients are seriously ill. I do not remember the exact sequence of events on the morning of [the consumer's] death as to when I spoke to [his wife] or for how long. I do remember that when I first saw [the consumer] his condition was extremely poor and shortly after that he had his final cardiac arrest.*

*There certainly was no deliberate action on my part to waste precious time and prevent [the consumer's wife] from reaching her husband's side and I do apologise if my actions have been perceived to have caused such a delay."*

The consumer died on at 5.30am. His wife was present.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Advice to  
Commissioner**

The Commissioner sought advice from an independent cardiologist who noted that while in the first hospital the consumer experienced several of the complications associated with this condition including recurrent pain, defects in heart rhythm, lung infection with pleurisy and a stroke. The consumer's chest x-ray features indicated cardiac enlargement and the presence of fluid around the left lung.

***Pacemaker***

There were good reasons for using the pacemaker and for making intermittent tests to see whether the natural rhythm of the heart was able to be maintained without further assistance. A permanent pacemaker would not have prevented the consumer's subsequent deterioration in heart function and stroke. He stated:

*"...the chief function of a pacemaker was to ensure that the heart rate was not too slow to satisfy the requirement to circulate blood around the body. When [the consumer's] heart had recovered the ability to maintain an adequate heart rate the pacemaker was not required and its continued presence would not protect the heart from further damage, nor would it protect against stroke."*

*"[Streptokinase] is not useful in everyone who is affected by heart attack. ... I would agree with the views of his doctors that the balance of risks and benefits was against the use of streptokinase. A few hours after his admission there was recurrent pain and new ECG abnormalities suggesting that the coronary thrombosis had become more advanced. At that stage the balance of risks favoured the use of streptokinase and it was given. Similar pros and cons apply to the use of heparin and aspirin. I consider that the use of these drugs was appropriate."*

***Transfer to second hospital***

Once the problems of heart block had been dealt with and the treatment for pneumonia and pleurisy had been established, the main goal of the consumer's treatment was to rehabilitate him from his stroke. The consumer's transferral to the second hospital was appropriate.

***Monitoring in the second hospital***

The monitoring of the consumer's cardiac function was appropriate.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Advice to  
Commissioner,  
continued**

#### *Weekend leave*

It was appropriate for the consumer to go on weekend leave. He stated:

*“[The consumer] was very keen to return home. His therapist reported that he had reached a good level of independence in ward activities and his clinicians felt that weekend leave would provide a useful trial of the state of his recovery. Prompt mobility after heart attack is a feature of the modern treatment of this condition.”*

#### *Subsequent treatment*

*“At 2.20am [the senior house officer] was called to see [the consumer] and recognised that the patient had a serious breathing problem. In my opinion he acted appropriately in all of the following activities: 1) making a review of the medical records and noting the recent cardiac and pulmonary illnesses, 2) conducting a thorough physical examination and noting features of poor circulation, a murmur and cyanosis indicating respiratory failure, 3) reviewing the results of tests and 4) arranging specific investigations such as the blood gas analysis that confirmed the severity of the respiratory disease.*

*The notes that [the senior house officer] made about the chest X-ray indicate that he interpreted the film to show lung inflammation and hence his main line of treatment was directed towards pneumonia. His mind was not closed to other conditions and the question marks made against recurrent heart attack and pulmonary embolism indicate that appropriate alternative conditions were considered.*

*Having concluded that the main problem was pneumonia he confirmed that antibiotic treatment was in use and then arranged to obtain more information about possible heart attack (he called for the old ECGs from [the first hospital] and checked blood enzyme levels). These checks would take time but, in the context of his assessment of the patient, I can understand why he wanted to obtain that information before he called [the consultant, coronary care unit].*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Advice to  
Commissioner,  
continued**

[The consumer's] *condition deteriorated quite rapidly and by 4am it was evident that he was in extremis. [The consultant] was called. The possibilities of pulmonary embolism and of pulmonary oedema were treated with heparin and frusemide respectively. When [the consultant] examined [the consumer] he found evidence of severe pulmonary oedema and shock. Soon afterwards [the consumer] had cardiac arrest and died.*

*The reason why it is possible to conclude that [the senior house officer] acted appropriately in diagnosing and treating pneumonia while at the same time concluding that [he] died from another condition (severe pulmonary oedema) lies in the 1) difficulty of interpretation of the chest X-rays [...], 2) the distinct possibility that an unexpected new cardiac lesion was present and 3) the understandable benefit of hindsight that a reviewer has when all the facts can be displayed together."*

***Interpretation of the X-rays***

*"The chest x-ray taken on [the day before the consumer died] shows several important features. First the size of the heart shadow was not notably enlarged and the collection of fluid that was present around the left lung before [the consumer] was transferred [...] had cleared. These two features support the view that [the consumer] had stable, or even improving, cardio-respiratory function during the week of his rehabilitation in [the second hospital] and suggest that his final illness was a sudden new condition rather than the relapse of an ongoing left lung infection.*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Advice to  
Commissioner,  
continued**

*This x-ray of the [day before the consumer died] also shows a fine reticular shadowing in both lungs that is a subtle but serious indication of pulmonary oedema or acute congestion of the lungs. There are additional features pointing to this diagnosis – particularly the horizontal lines at the edges of the right lung (Kerley's lines). Although some of the opacities are subtle they are seen more readily when the x-ray from [that day] is compared directly with x-rays taken at [the first hospital]. This comparison was not possible for [the senior house officer at the second hospital] and so the diagnosis was more difficult. Further, there are two features that are not present in the x-ray that I anticipate [the senior house officer] would have expected to find if he was looking to confirm severe pulmonary congestion caused by heart disease. These are 1) engorgement of the upper lobe veins and 2) some evidence of enlargement of the heart. It is surprising that these features are absent but there are exceptional circumstances when this can occur (see below). Not finding them is likely to have contributed to [the senior house officer's] view that the principle problem was severe lung infection. (This point is made even more firmly by the comments and reports of others who were involved in the acute management or in reporting the x-rays at a later time. Both [the consultant, coronary care unit] and [the radiologist who made the formal report about the X-rays a few days later] comment that the radiographic features indicated likely pneumonia)...*

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Advice to  
Commissioner,  
continued**

*There is suggestive evidence that [the consumer] had a new heart attack on the [day before he died]. His [later] ECG shows new abnormalities (progressive elevation of the ST segments) in comparison with the last ECG done at [the first hospital] and the blood enzyme tests show an increase to abnormal levels by the [day he died] (CPK enzymes). The consumer had had a heart attack in a similar cardiac territory [the day he was first admitted in mid-August] and on that occasion there had not been acute pulmonary oedema – why did it occur [the day before he died?] I feel that there is a distinct likelihood that this second heart attack caused severe disturbance to the function of the mitral valve and that the gross dysfunction or even rupture of this valve would have been responsible for the progressive and fatal illness that followed. Without specific tests for this condition or evidence from a post mortem examination it is not possible to prove that severe mitral regurgitation was the fatal complication but this diagnosis would be favoured by finding a murmur and such a murmur is recorded in the house-surgeon's notes on the [day he died].*

*Rupture of the mitral valve is rare but it is a condition that would explain why a patient with a second heart attack would deteriorate so markedly in comparison with his status after a first attack. It would also explain the physical findings that were made, the unusual appearances in the chest X-ray and the results of the blood tests and blood gas analysis. Acute and severe mitral regurgitation caused by recent heart attack is one of the causes of acute pulmonary oedema when the x-ray may show a normal sized outline of the heart shadow and lack of engorgement of the pulmonary veins.”*

The independent cardiologist advised that if he is correct in his assessment of the consumer's final illness then he did not believe that resuscitation or any of the range of treatments that would be expected to be available at the second hospital would have been able to reverse his deterioration.

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## Two Crown Health Enterprises

### Report on Opinion - Case 97HDC7241, continued

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

*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.*
- 3) *Every consumer has the right to have services provided in a manner consistent with his or her needs.*
- 4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*

**Opinion:  
No Breach,  
First Crown  
Health  
Enterprise**

In my opinion the first hospital did not breach Rights 4(2), 4(3) or 4(4) of the Code of Health and Disability Services Consumers' Rights as follows.

**Right 4(2)**

In my opinion the clinical assessment and care given to the consumer at the first hospital during the period of his admission for two weeks in August 1996 was appropriate.

***Pacemaker***

The consumer developed heart block after a heart attack. In my opinion, the hospital's insertion of a temporary pacemaker and its subsequent management of the pacemaker was consistent with the consumer's needs. Intermittent tests were made to see whether the consumer's heart could maintain a normal rhythm without assistance. When his heart rate slowed the pacemaker was turned up and his heart rhythm returned to normal. I was advised that once his heart could maintain an adequate heart rate the pacemaker was no longer required. I was also advised that a pacemaker, temporary or permanent would not have protected him against his subsequent stroke.

***Transfer to tertiary care hospital***

The consumer did not require transfer to a tertiary care hospital as surgical intervention was not at any stage an appropriate clinical response to his condition.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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

***Blood thinning agents***

There are often benefits and risks of using particular drugs, such as blood thinning agents. These must be balanced to determine whether a particular drug should be used in the circumstances. In my opinion, based on the advice I was given, the hospital's use of streptokinase, heparin, warfarin and aspirin was appropriate in the circumstances.

***Identity bracelet***

The first CHE has acknowledged that the consumer did not receive an identity bracelet in a timely fashion. However, I note that there is no evidence that this affected the services the consumer received. The consumer was also competent at all times and able to identify himself.

***Blood tests***

There appears to be some confusion over some of the blood tests filed in the consumer's file. However, in my opinion this did not affect the standard of care the consumer received.

**Rights 4(3) and 4(4)**

In my opinion, the consumer's transfer to the second hospital was consistent with his needs and was to help optimise his quality of life.

The consumer's heart block problem had been dealt with and the treatment for pneumonia and pleurisy had been established when he was transferred to the second hospital. He had been at the first hospital for over two weeks and his condition had stabilised. At this point, the main goal of the consumer's treatment was to rehabilitate him from his stroke. I was advised that the goal of rehabilitation and the transfer to the second hospital were appropriate in the circumstances.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Opinion:  
No Breach,  
Second  
Crown  
Health  
Enterprise**

**Right 4(2)**

In my opinion the second hospital did not breach Right 4(2) of the Code of Health and Disability Services Consumers' Rights as follows.

*Monitoring of consumer's heart*

In my opinion electronic monitoring of the consumer's heart was not required in the rehabilitation unit. The emphasis at this point of the consumer's care was on rehabilitation. He was thoroughly examined on entry to the rehabilitation unit and the medical staff kept daily progress notes of his condition. The consumer's general condition was monitored clinically and there was an opportunity to note any adverse cardiac symptoms on the notes. None were mentioned.

*Weekend leave*

The medical notes indicate that the consumer's recovery was progressing well prior to his weekend leave, that he had reached a good level of independence in ward activities, that weekend leave would provide a useful trial of his recovery and that he wished to return home. My advisor noted that modern treatment advocates prompt mobility of a patient after a heart attack. In my opinion the decision to allow the consumer to go on weekend leave complied with professional standards.

**Rights 4(3) and (4)**

In my opinion the second hospital did not breach Right 4(3) and Right 4(4) of the Code of Rights as follows.

In my opinion the time spent by the consumer waiting for admission via the emergency department at the second hospital the day before he died was reasonable in the circumstances. The GP's referral letter stated the consumer was suffering from myocardial instability, the ambulance report stated he had chest pain and the triage assessment stated he was feeling breathless. The consumer was assessed by a nurse and was within 45 minutes of arrival fully assessed by a house surgeon. It was important that the consumer was fully assessed at this time and it was appropriate that this was done in the emergency department rather than in the rehabilitation ward.

While it would have been preferable to admit the consumer to the coronary care unit in a more timely fashion I accept the second CHE's advice that the unit was busy and a bed space needed to be organised. During his stay in the emergency department, the consumer received medication and had various investigative tests performed including blood tests, x-rays and an ECG.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Opinion:** **Right 4(3)**  
**No Breach,** In my opinion the consultant in the coronary care unit at the second  
**Consultant,** hospital did not breach Right 4(3) of the Code of Health and Disability  
**CCU** Services Consumers' Rights.

While I recognise that the consumer's wife wished to be with her husband during the period immediately preceding his death, the consultant's desire to inform her of the serious nature of the consumer's condition was understandable and the resulting slight delay was unavoidable.

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**Opinion:** **Right 4(2)**  
**No Breach** In my opinion the senior house officer at the second hospital did not breach  
**Senior House** Right 4(2) of the Code of Health and Disability Services Consumers'  
**Officer,** Rights.  
**Second**

**Crown** I was advised by my independent cardiologist that the senior house officer  
**Health** acted appropriately in his assessment and treatment of the consumer. He  
**Enterprise** said he took a number of factors into account in coming to this conclusion, including the senior house officer's inexperience, particularly about this type of acute illness, and the lack of resident clinical cover with whom the senior house officer could have discussed or sought guidance about the consumer. He also pointed out that the second hospital only has facilities and equipment appropriate for the management of secondary levels of medical and surgical care. It does not have tertiary cardiac care facilities and the staff would be unlikely to have experience with rare complications of heart attack.

In my opinion, although the senior house officer did not diagnose the consumer's severe pulmonary oedema, he made a review of the medical records and conducted a thorough physical examination. He noted various features, reviewed the results of the tests and arranged specific investigations. The senior house officer concluded that the main problem was pneumonia and hence his main line of treatment was directed towards this. However, his mind was not closed to other conditions and he considered alternative conditions. He also arranged to obtain more information about possible heart attack by calling for the old ECGs from the first hospital and checking the blood enzyme levels. I was advised that in the circumstances it was appropriate for the senior house officer to wait for this information before consulting with the coronary care unit consultant. When he checked the consumer and found his condition had deteriorated he promptly contacted the consultant.

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## Two Crown Health Enterprises

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### Report on Opinion - Case 97HDC7241, continued

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**Actions:  
First Crown  
Health  
Enterprise**

I suggest that in future the first Crown Health Enterprise takes the following actions:

- Endeavours to communicate better with the families of its patients. In particular, it should ensure that families are given adequate explanations about what has happened to a patient and why. It should ensure that families understand the explanations given.
  - Carefully monitors administrative matters such as the filing of blood test results and identity bracelets. Procedures should be in place, which should be audited from time to time.
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**Actions:  
Second  
Crown  
Health  
Enterprise**

I suggest the second Crown Health Enterprise takes the following actions:

- Reviews its policy of admissions to its emergency department, to ensure patients with serious conditions are assessed and treated promptly. Every effort should be made to streamline admission procedures, particularly for patients with severe breathlessness and chest pain.
  - I take this opportunity to remind the second Crown Health Enterprise that when a person dies unexpectedly clinicians must provide the patient's family with as much information as possible about the likely cause of death. Good channels must exist for complaints to be addressed. Further where there are doubts about the cause of death a patient's family should be consulted regarding the need for a post-mortem examination. If a post-mortem occurs the results should be discussed with the patient's family.
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